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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 096L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00898

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245149**

2.STATE VENDOR OR MEDICAID NO.
(L2) **564214100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - AMBASSADOR**
(L4) **8100 MEDICINE LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55427**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/22/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (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
	77			
(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 :
Jessica Sellner, Unit Supervisor — 03/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 04/05/2016 (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
02/26/1968
(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.
00140
(L31)

30. REMARKS
Posted 04/06/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/11/2016
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245149
April 5, 2016

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, Minnesota 55427

Dear Ms. Barta:

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 March 18, 2016 the above facility is certified for or recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 5, 2016

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, Minnesota 55427

RE: Project Number S5149026

Dear Ms. Barta:

On February 25, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 11, 2016. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 22, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 22, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 11, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 11, 2016, effective March 18, 2016 and therefore remedies outlined in our letter to you dated February 25, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245149 Y1	A. Building B. Wing Y2	3/22/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0241	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed
LSC	03/16/2016	LSC	03/16/2016	LSC	03/16/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0314	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(c)	Completed
LSC	03/16/2016	LSC	03/16/2016	LSC	03/16/2016
ID Prefix F0315	Correction	ID Prefix F0323	Correction	ID Prefix F0325	Correction
Reg. # 483.25(d)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(i)	Completed
LSC	03/16/2016	LSC	03/16/2016	LSC	03/16/2016
ID Prefix F0412	Correction	ID Prefix F0441	Correction	ID Prefix F0456	Correction
Reg. # 483.55(b)	Completed	Reg. # 483.65	Completed	Reg. # 483.70(c)(2)	Completed
LSC	03/16/2016	LSC	03/16/2016	LSC	03/16/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☑	JS/KJ	04/05/2016	29249	03/22/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/11/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245149 (Y1)	A. Building 01 - MAIN BUILDING 01 B. Wing (Y2)	3/22/2016 (Y3)

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0012	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0143	Correction Completed 03/18/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/KJ	DATE 04/05/2016	SIGNATURE OF SURVEYOR 19251	DATE 03/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245149	A. Building 02 - NEW ADDITION B. Wing	3/22/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0012	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/18/2016	ID Prefix Reg. # NFPA 101 LSC K0143	Correction Completed 03/18/2016
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☑	REVIEWED BY (INITIALS) TL/KJ	DATE 04/05/2016	SIGNATURE OF SURVEYOR 19251	DATE 03/22/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/12/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 096L

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00898

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245149**

2.STATE VENDOR OR MEDICAID NO.
(L2) **564214100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - AMBASSADOR**
(L4) **8100 MEDICINE LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55427**

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 **02/11/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (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
	77			
(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 :
Mardelle Trettel, HFE NE II 03/07/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 03/10/2016 (L20)

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

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

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
02/26/1968
(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.
00140
(L31)

30. REMARKS
Posted 03/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 25, 2016

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, Minnesota 55427

RE: Project Number S5149026

Dear Ms. Barta:

On February 11, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed. In addition, at the time of the February 11, 2016 standard survey the Minnesota Department of Health completed an investigation of complaint number H5149028 that was found to be unsubstantiated.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the

Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Jessica Sellner, Unit Supervisor
Minnesota Department of Health
St. Cloud B Survey Team
Licensing & Certification
Health Regulation Division
Midtown Square
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320)223-7343
Fax: (320)223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 22, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 22, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 11, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 11, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure

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
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) was also completed at the time of the standard survey. An investigation of complaint H5149028 was not substantiated during this survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		3/16/16

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

Electronically Signed | 03/04/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 225	Continued From page 1 including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator, for 2 of 2 residents (R20 and R65) whose made allegations of staff mistreatment. Findings include: R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s.	F 225	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section	

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F 225	Continued From page 2 R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit related to cerebral vascular accident (CVA). A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant) [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath. [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility	F 225	7305 of the State Operations Manual. F225 R65 alleged incident was reported to state agency on 2/9/16 and thoroughly investigated. R20 alleged incident was reported to the state agency on 2/11/16 and thoroughly investigated. Concern forms since 2-8-16 have been reviewed for other potential residents affected and reported and investigated as appropriate. Staff were re-educated on facility vulnerable adult policy and procedure that include abuse definitions, reporting and investigating responsibilities by 3/16/16 Random audits of concern forms will be completed for identifying and reporting of potential abuse, neglect or maltreatment by the director of social services daily for 1 week, weekly for 1 month, monthly for 3 months and quarterly thereafter. Results of audits and investigations will be reported to the QAPI committee for further evaluation and recommendations.	

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F 225	Continued From page 3	F 225		

investigated R20's allegation of mistreatment, it was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident.

During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations need to be reported immediately to the state agency.

R65's quarterly MDS, completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living.
R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.
During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident,

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F 225	Continued From page 4 and reported it to a nurse. A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency because the other interviewed residents all felt safe.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		3/16/16

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F 226	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator according to the facility abuse and neglect policy for 2 of 2 residents (R20 and R65) who made allegations of staff mistreatment. Findings include: A facility Policy titled Abuse And Neglect revised 9/13, indicated "Notify the location administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse, and injury of unknown origin, neglect, financial exploitation or involuntary seclusion. In case absence of the administrator, follow the chain of command for notification (DNS, SW, etc)... Document this notification. "Immediately," in this procedure means "as soon as possible after discovery of the incident, and ought not to exceed the end of the shift, in the absence of a shorter state time frame requirement." The policy also directed staff to notify the designated stated agency immediately, and to interview staff, residents, or other witnesses to the incident. R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s. R20's care plan dated 4/9/15, indicated the	F 226	F226 R65 alleged incident was reported to state agency on 2/9/16 and thoroughly investigated. R20 alleged incident was reported to the state agency on 2/11/16 and thoroughly investigated. Concern forms since 2-8-16 have been reviewed for other potential residents affected and reported and investigated as appropriate. All allegations of mistreatment will be immedicately reported to the administrator and state agency and then a thorough investigation will be conducted Staff were re-educated on facility vulnerable adult policy and procedure that include abuse definitions, reporting and investigating responsibilities by 3/16/16 Random audits of concern forms will be completed for identifying and reporting of potential abuse, neglect or maltreatment by the director of social services daily for 1 week, weekly for 1 month, monthly for 3 months and quarterly thereafter. Results of audits and investigations will be reported to the QAPI committee for further evaluation and recommendations.	

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F 226	Continued From page 6	F 226		

resident had a ADL self care performance deficit related to cerebral vascular accident (CVA).

A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant) [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath. [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility investigated R20's allegation of mistreatment, it

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F 226	Continued From page 7 was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident, and not immediately according to the facility policy. During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations needed to be reported immediately to the state agency prior to a full investigation according to the facility policy. Although R20 made an allegation of abuse the facility investigated the incident, and did not notify the state agency, nor did they notify the administrator immediately according to facility policy. R65's quarterly MDS completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living. R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.	F 226		

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F 226	Continued From page 8	F 226		

During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident, and reported it to a nurse.

A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency according to the facility policy, nor were any other staff interviewed as part of the investigation.

When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been

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F 226	Continued From page 9 reported to the State agency according to the facility policy because the other interviewed residents all felt safe.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity with toileting needs for 2 of 5 residents (R163 and R154) observed for toileting. Findings include: R163's quarterly Minimum Data Set (MDS) dated 12/21/15, indicated the resident was cognitively intact, needed extensive assist with toileting, and was frequently incontinent of urine. R163's care plan dated 10/08/15, indicated he had bladder incontinence and wore briefs. During observation 2/10/16, at 6:51 a.m. R163 was sitting in his recliner chair, and a soiled, white incontinence brief was observed from the hall way sitting on the floor behind his wheelchair. During interview 2/10/16, at 6:52 a.m. R163 stated he was not aware the incontinence pad was on the floor next to him and stated, "I have grand kids I would not want them to see that."	F 241	F241 Incontinent product for R163 was properly disposed of immediately upon notification by Licensed Nurse on 2/10/16. Bowel and Bladder Assessment completed 3/2/16 for R154. Careplan reviewed and ammended to reflect R154 current plan of care for toileting. All Residents careplans were reviewed and revised as needed to support individualized care provided in a dignified manner. Nursing staff will be re-educated 2/16/16 thru 3/11/16 on facility policy and procedure for resident dignity including proper disposal of incontinent products and timely assistance with resident toileting needs Random audits for implementation of	3/16/16

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F 241	Continued From page 10 During interview 2/10/16, at 7:00 a.m. registered nurse (RN)-E stated the pad should not be on the floor for people to see, and RN-E then entered the room and removed the pad. R154's quarterly MDS dated 11/12/15, indicated he was cognitively intact, needed extensive assistance with toileting, and was frequently incontinent of urine. R154's care plan dated 9/01/15, indicated he had bladder incontinence and preferred a urinal or toilet, and wore a brief. During interview 2/10/16, at 7:12 a.m. R154 stated at times his call light was left on for over 30 minutes, and stated, "I am in bed wanting to go into the bathroom. It's embarrassing when I have to tell them I peed by pants again, please change me." R154 stated he had incontinence episodes every day because he had to wait so long for staff to answer, especially at night. A Bowel and Bladder Documentation Survey Report dated from 2/1/16, to 2/11/16, R154 was incontinent of urine five times at 7:00 p.m. During interview 2/11/16, at 10:58 a.m. RN-A stated the facility does random call light audits, however, they were not able to do a computerized print out to see how long R154's call light was being left on. RN-A was able to provide one call audit on 1/28/16, however, only the morning hours were included, and the facility was unable to provide any evening audits. A facility policy titled Resident Dignity dated	F 241	toileting plan as careplanned, and proper disposal of incontinent products will be done weekly for 1 month, monthly for 3 months, and quarterly thereafter as coordinated by the nurse manager. Findings will be reported to the QAPI committee for further evaluation and recommendations.	

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F 241	Continued From page 11 February 2013, indicated, "The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." The policy further indicated "Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a residents request for toileting."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions were followed by staff for 1 of 3 residents (R34) reviewed for accidents and for 1 of 3 residents (R37) reviewed for toileting and pressure ulcers. Findings include: R34's admission Minimum Data Set (MDS) dated 1/13/16, indicated R34 had moderate cognitive impairment, had cancer, anemia, and heart failure. The MDS indicated the resident needed extensive assist of two with transfers, toileting, dressing, bed mobility, was incontinent of bowel and bladder, and had no falls in the last month. R34's care plan dated 1/14/16, indicated the	F 282	F282 R34 had care plan reviewed on 2/18/16 for current fall interventions including fall mats, low bed and call light within reach all interventions were in place. R37 was reassessed for toileting plan on 2/18/16 and care plan was revised to reflect change in tolieting plan. Care plan interventions for R34 and R37 are appropriately implemented by care staff. All residents care plans were reviewed and revised as needed to reflect individualized current plan of care.	3/16/16

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F 282	Continued From page 12 resident had metastic breast cancer with brain mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach. During observation 2/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor. During observation 2/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank. During interview 2/9/16, at 11:39 a.m. registered nurse (RN)-I stated the fall mat should be on the floor and the bed should be in the low position at all times. RN-I entered R34's room and placed the fall mat on the floor next to resident. During observation 2/10/16, at 8:01 a.m. R34 was observed laying in bed and the bed was in the low position with fall mat on the floor. However, the residents call light was observed laying on the floor out of R34's reach. Director of nursing (DON) was informed of the call light being out of R34's reach, and she entered the residents room and gave her the call light. During interview 2/10/16, at 12:31 p.m. RN-A stated she didn't know why R34's bed was not in the low position, and stated she had talked to the NA who was working with R34 on 02/9/16, and the NA stated she thought during a physician visit he had left the bed up. RN-A stated R34 was a	F 282	Nursing staff will be re-educated 2/16/16 thru 3/11/16 on facility policy and procedure for following resident□s individualized care planned interventions. Random audits on care provided following residents individualized plan of care will be done weekly for 1 month, monthly for 3 months, and quarterly thereafter as coordinated by the nurse manager. Results of audits will be reviewed and analyzed by nurse manager with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations.	

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fall risk and should have all the assessed interventions in place according to the care plan, including having the call light available because the resident will use it to call for staff assistance. R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility.

R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift.

During continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes.

During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing. RN-A stated the facility staff should specifically

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F 282	Continued From page 14 ask R37 if she would like to be repositioned to offload her bottom, have her brief changed, and utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. A facility Care Plan Policy dated September 2013, indicated, "Residents will receive and be provided the necessary care and services to maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively	F 309	F309	3/16/16

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F 309	Continued From page 15 reassess pain to ensure adequate interventions were in place to relieve pain for 1 of 1 residents (R154) with pain. Findings include: R154's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated he was cognitively intact and was on a scheduled pain regimen, received prn (as needed) pain medications, and had occasional to moderate pain. R154's care plan dated 5/28/15, indicated he had chronic pain/discomfort related to osteoarthritis, gout, and neuropathy which was managed with medications. The care plan further instructed staff to, "Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s (signs and symptoms) or c/o (complaints of) pain or discomfort. Notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain." A Care Area Assessment (CAA) Worksheet dated 5/25/15, indicated he had osteoarthritis with worsening right hip pain, rated his pain as 7, and indicated the pain affected his sleep and mood. R154 Pain Data Collection form dated 11/28/15, indicated R154 had pain in the last 5 days that was frequent on all of his back and whole leg. The form indicated the resident rated his pain at a 6 (on a scale from 1-10, with 10 being the worst pain) and had vocal complaints and facial expressions of pain daily. In addition, the pain was stabbing, pain meds relieved the pain, pain increased with movement, the pain did not disrupt	F 309	R165 had pain data tool completed on 2/15/16. Orders were received for new medication, Gabapentin on 2/15/16. Orders for OT and PT were received on 2/15/16 to evaluate and treat for hand pain, knee pain, e-stim and TENS unit. Pain assessment completed on 2/22/16. Careplan was reviewed and revised with new interventions for pain management All residents at risk for pain were reassessed for pain and effectiveness of pain management interventions. Changes to pain management program were received and implemented as needed. Care plans were reviewed and revised as needed with changes in pain management interventions Licensed Nurses were re-educated 2/17/16 - 3/11/16 on facility policy and procedures for pain management including effectiveness of pain management interventions. Random Audits of residents to review effectiveness of pain interventions will be done weekly for 1 month, monthly for 3 months and quarterly thereafter as directed by Nurse Managers with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations.	

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his sleep at night or limit his day to day activities, had no changes in appetite/eating ability, and was on a scheduled pain medication regimen. Under Resident/Family Education indicated, "Resident c/o increased pain (nothing new) over a few days. Goal is tolerable pain. PRN's to be offered as needed."

A Pain Data Collection dated 2/7/16, indicated R154 had pain in his entire back and right lower extremity, rated his pain at a 5, made protective body movements or postures due to pain, limited day-to-day activities because of pain, decreased interest pursuits, and had irritability and anger. The Pain Data Collection also indicated he had not received PRN pain medication and the, "Current Treatment plan addresses resident's pain".

R154's current physician orders dated February 2016, indicated he received Oxycodone HCL (hydrochloride) 5 milligrams (mg) (a narcotic analgesic used for moderate to severe pain) one tablet three times a day for pain. The orders indicated the start date of the medication was 8/14/15. R154 also had an order for Oxycodone HCL 5 mg every four hours as needed for pain; do not exceed six tablets per day with a start date of 6/26/15. R154 also had an order for Tylenol 325 mg two tablets by mouth every 4 hours as needed for headache pain with a start date of 5/31/15.

R154's medication administration record (MAR) dated 2/1/16, to 2/10/16, at 2:31 p.m. indicated R154 did not receive any of his PRN pain medications.

A HealthPartners Subsequent Visit dated 11/6/15,

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indicated R154 had gout in his knee and the physician had increased allopurinol (a medication used for gout) and added cholchicine (medication used for gout), and he had been receiving morephine (a pain medication for severe pain), however, his morphine tablets were stopped due to sedation and needing narcan (reverses the effects of opioid).

A HealthPartners Subsequent visit dated 1/4/16, indicated R154 used a scooter for mobility and his "Mobility limited by chronic right lower ext pain."

A Park Nicollet Senior Services Nursing Home Visit Note dated 2/3/16, indicated he was new to Park Nicollet team, and R154 had chronic pain syndrome and had been on narcotics for several years and was receiving oxycodone three times a day as well as prn. There was no indication if the current pain regimen was effective.

During interview on 2/8/16, 6:43 p.m. R154 stated he felt his leg pain was getting worse, he wanted his pain medications increased, and he had told the nurses he wanted more pain medication, however, "I get no answer and they [the nurses] say they will contact the nurse practioner. I never heard back and I ask again and never hear back. The nurse practioner comes and see's me but rarely. I haven't had a chance to talk to her about the pain, she doesn't come and ask me about my pain. They are doing nothing for me." R154 stated his pain was at an 8.

During a follow up interview 2/10/16, at 12:44 p.m. R154 stated he had an order for oxycodone but it didn't help, so he doesn't take the PRN. R154 stated his pain was usually at an 8 and

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F 309	Continued From page 18 sometimes a 10 and that he is very rarely at a level of 5. During interview 2/10/16, at 1:01 p.m. nursing assistant (NA)-B stated she worked with R154 and he has a lot of pain in his right leg and his back, and because of the pain R154 would refuse to transfer or ambulate, and at times would just stay in bed because of the pain. During observation 2/10/16, at 2:27 p.m. NA-C was observed to transfer R154 in his room. NA-C situated a chair at a 45 degree angle from the bed and placed a four wheeled walker (4WW) in front of R154 with the brakes applied. R154 briefly repositioned himself in his wheelchair and an audible sigh and vocalization of "Ah" were noted. NA-C asked "Are you hurting today?...Where?" R154 stated "Yes... my hands, my legs." Once all set up to transfer, NA-C said "Take your time" several times as R154 made his first attempt to stand. As he began to bear weight on his legs and feet he yelled out "Ow" and quickly returned to a seated position back in his wheelchair. He was breathing quickly and heavily, and then began the 2nd attempt to transfer, and again was observed to breath heavily with his mouth open and eyes tightly closed, as he took steps to turn his back to the bed. With contact guard assist he stood from his wheelchair and placed his hands on the 4WW. The NA repeated several times "Take your time... do you want me to get a nurse for you?" R154 declined for the aide to get the nurse. Once seated on the bed, R154 stated his pain level was 10/10. During the transfer his right knee was visibly shaking.	F 309		

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Review of R154's progress notes/orders indicated the following:
-On 2/3/16, 4:26 p.m. Communication/Visit with Physician Note Text: "Labs from today called to NP (nurse practioner). Also questioning tens (Transcutaneous Electrical Nerve Stimulation which is predominately used for nerve related pain conditions) unit for residents pain in his right knee if that was possible per resident request. Awaiting return call."
-A physician order was received 2/11/16, eight days after the request for physical therapy to evaluate right knee pain and appropriateness of tens unit.

-On 2/4/16, at 3:00 p.m. staff approached to walk resident but he refused due to pain.

-On 2/5/16, at 8:58 p.m. resident refused to walk.

-On 2/9/16, at 10:00 p.m. patient did not walk to dinner. He wheeled himself out in his electric wheelchair.

-On 2/10/16, at 3:24 p.m. Communication/Visit with Physician Note Text: NP updated on residents c/o pain in bilateral hands. Resident continues to c/o "sharp pain" in his hands. He denied that it is radiating from anywhere. He has requested PRN pain pills this shift, with little relief. Continue to monitor and update NP.

- On 2/10/16, at 10:01 p.m. resident refused shower, "Stating have been in pain all day." Pain meds were administered.

During interview on 2/10/16, at 1:15 p.m. trained medical assistant (TMA) stated R154 had been

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having increased pain and he asked for a PRN today and had been asking more for his pain medication.

During interview on 2/10/16, at 2:30 p.m. registered nurse (RN)-A stated she was the manager for R154's unit and was not aware R154 was having pain. RN-A stated he had recently switched to a new doctor and his previous nurse practioner and physician were not very receptive to additional pain medication requests from the nurses. In addition RN-A stated she was not aware a request for a tens unit was made and she would call the NP and re-request the order.

During interview on 2/11/16, at 9:31 a.m. RN-F stated she worked the day shift and R154 usually had a pain rating of 7/10, and recently the resident has had increased complaints of pain.

During interview on 2/11/16, at approximelty 1:50 p.m. NA-C stated R154 complained of pain in the morning and afternoons and had been requesting his pain medication more often, and felt in the last three weeks R154's pain has been increasing.

Although R154 reported increased pain, was refusing to ambulate, and was observed to be in the pain, the facility did not reassess to determine if any further interventions could be implemented to decrease the residents pain.

A facility policy titled Pain Management-Resident Assistance policy issued September 2012, indicated the purpose was to provide resident assistance in pain management and, "All residents will receive interdisciplinary consultations on assistance in managing pain." The policy futher indicated "The registered nurse

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F 309	Continued From page 21 will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological as well as pharmacological. The registered nurse will review response to medication interventions and work closely with the physician to assist in the individualized pain measurement plan."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting and repositioning were completed as assessed to prevent pressure ulcers for 1 of 3 residents (R37) reviewed who was identified at risk for pressure ulcer development. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and	F 314	F314 Turning/repositioning plan for R37 was reviewed and careplan reflects current plan of care. Reviewed with staff to ensure care planned intervention is implemented. R37 was reassesed for toileting plan on 2/18/16 and care plan was revised to reflect current tolieting plan. Residents at risk for pressure ulcers will have careplan reviewed, and revised if needed and implemented to prevent skin breakdown.	3/16/16

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F 314	Continued From page 22 personal hygiene, and was totally dependent on staff for transfers and bed mobility. R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was weak, de-conditioned, and non-weight bearing on her right, lower extremity. The CAA identified a goal for R37 to remain free from skin breakdown related to incontinence and use of an incontinence brief. R37's Positioning Assessment & Evaluation dated 1/3/16, identified R37 required total assistance with repositioning and directed staff to offer repositioning every two hours. R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift. R37's Braden Scale for Predicting Pressure Sore Risk dated 2/6/16, indicated a score of 16/18, identifying R37 was at mild risk for the development of pressure ulcers. During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated R37 did not get assisted with toileting timely, and stated she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed. During continuous observation on 2/10/16, from	F 314	All nursing staff will be re-education 2/16/16 thru 3/11/16 on individualized toileting programs, incontinence care, and turning and repositioning following individualized plan of care. Random audits on turning and repositioning toileting and incontinence care will be done weekly for 1 month, monthly for 3 months, and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed and analyzed by nurse manager team with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations	

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	245149	A. BUILDING _____ B. WING _____	02/11/2016

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F 314	Continued From page 23 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes. Observations included the following: At 7:23 a.m., R37 was lying in bed and nursing assistant (NA)-G was present in the room. At 7:30 a.m., NA-G checked/ changed R37's incontinence product before assisting R37 to sit in her wheelchair using a mechanical lift and two staff to transfer. At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal. At 9:00 a.m., R37 was moved from the dining room after breakfast, to an alcove/ day room area (across from the dining room), where the resident watched television with two of her peers. At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and R37 stated, "See how late they get?" The resident stated she had not yet received her morning medications, nor had she been assisted with her exercises, and R37 visibly and audibly sighed several times. At 9:40 a.m. R37 asked the surveyor to find a staff member on her behalf and registered nurse (RN)-G was asked to assist R37. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light, and exited the room. RN-G did not offer toileting, checking/ changing or turning/ repositioning to R37. At 9:57 a.m., NA-G entered R37's room and offered to assist her into bed. R37 accepted and NA-G got another staff member to assist with transferring R37 into bed. At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed and proceeded to change R37's incontinence brief, with two hours and 37 minutes between changes. NA-G confirmed R37's incontinence	F 314		

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F 314	Continued From page 24	F 314		

brief contained a small void of urine.
R37 was not observed to offload or reposition herself during this observation.
At 10:17 a.m., NA-G stated R37 was to be checked/ changed, and turned/ repositioned every two hours.

Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including turning/ repositioning and checking/ changing her incontinence product.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes. Observations included the following:
At 8:23 a.m., R37 was seated at the dining room table, awaiting her breakfast meal.
At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached her, brought her to her room, administered eye drop medication and then returned R37 to the day room. RN-H did not offer to toilet or check/ change, or reposition R37.
At 10:09 a.m., NA-A approached R37 and asked if she wanted to lay down. R37 declined to lay down, however, NA-A did not offer to toilet, check/ change her brief, or offer to reposition or offload R37. No encouragement or education was provided to prevent skin breakdown.
At 10:31 a.m., an activities staff invited R37 to attend an exercise group. R37 declined this offer and remained seated in her wheelchair in the day room.
At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed and turned/ repositioned every two hours, using a mechanical

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F 314	Continued From page 25	F 314		

lift to transfer her into bed. NA-A stated R37 was last checked/ changed and turned/ repositioned at 8:00 a.m. NA-A stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined to lay down. NA-A stated she interpreted R37's response as a refusal to be checked/ changed and/ or repositioned. NA-A stated she attempted to approach R37 every two hours and ask if she wanted to lay down, and if the resident agreed to lay down staff would check and change her. NA-A then proceeded with assisting other residents, and R37 had still not been offered to toilet and/or checked/ changed or turned/ repositioned.
At 11:05 a.m., the surveyor asked NA-A when staff would expect to offer toileting, checking/ changing and turning/ repositioning to R37, at which time NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought the resident to her room, and asked RN-H to assist. NA-A and RN-H proceeded with transferring R37 to her bed and checked and changed her incontinence brief, with three hours and five minutes between changes and offloading. R37's bottom was observed as slightly pink, but blanchable, which RN-H confirmed.
At 11:29 a.m., NA-A stated when changing R37's brief she had a small bowel movement and a small void of urine in her incontinence brief.

During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be repositioned and toileted every two hours and was usually incontinent. RN-H stated she felt NA-A's offer for R37 to lay down did constitute an offer for turning/ repositioning and toileting or checking/ changing,

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F 314	Continued From page 26 and stated if R37's decline to lay down, that was considered a refusal for toileting and repositioning. During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing; and R37's declining to lay down did not equate refusals for these cares. RN-A stated the facility staff should have specifically asked if she would have liked to be repositioned to offload her bottom, have her brief changed, and utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. The facility's policy titled Skin Assessment, Pressure Ulcer Prevention, and Documentation Requirements dated 12/15, directed, "Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		3/16/16

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F 315	Continued From page 27 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely toileting in accordance with assessed needs, in order to maintain as much urinary function as possible, for 1 of 3 residents (R37) reviewed for urinary incontinence. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37's cognition was intact, was frequently incontinent of both bladder and bowel, was not on a toileting program, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility. R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was non-weight bearing on her right, lower extremity, and required a total lift with assistance from two staff to transfer. The CAA identified R37 required maximum assistance with toileting, had functional incontinence, was at an increased risk for urinary incontinence and infection due to a previous UTI, and may have had increased urinary frequency secondary to her use of diuretic medications. R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility. The care plan directed staff to, "Offer and assist with toileting "every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep.	F 315	F315 R37 Bladder assessement was completed on 2/18/16 and toileting plan was reviewed and revised to reflect R37 current toileting needs of checking and offer changing every 2 hours. Changes communicated to staff. Staff are following current plan of care. All residents with toileting programs had careplan reviewed and revised if needed to reflect individualized toileting needs. All nursing staff will be re-educated 2/16/16 thru 3/11/16 on toileting programs, incontinence care and following individualized plan of care. Random audits on toileting and incontinence care will be done weekly for 1 month, monthly for 3 months, and quarterly thereafter as coordinated by the Nurse Manager. Results of audits will be reviewed and analyzed by nurse manager team with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations	

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During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated staff did not assist R37 with toileting timely, and she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed.

During a continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting or checked/ changed for two hours and 37 minutes. Observations included the following:
At 7:23 a.m., R37 was lying in her bed and nursing assistant (NA)-G was present in the room.
At 7:30 a.m., NA-G checked/ changed R37's incontinence product before she was assisted to sit in her wheelchair, using a mechanical lift and two staff to transfer her.
At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal.
At 9:00 a.m., R37 was moved from the dining room, to an alcove/ day room area (across from the dining room), where she watched television with two of her peers.
At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and stated, "See how late they get?" R37 stated she had not yet received her morning medications, nor had she been assisted with her exercises, and was sighing as she was talking.
At 9:40 a.m. R37 asked the surveyor to find a staff member to assist her, and Registered nurse (RN)-G was made aware of R37's request for assistance. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light and exited the room. RN-G did not offer toileting assistance, nor did she check/ change R37.

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F 315	Continued From page 29 At 9:57 a.m., NA-G entered R37's room and offered to assist her into bed. R37 accepted and NA-G sought another staff person to assist with the transfer. At 10:05 a.m., while NA-G had again stepped out of the room to find another staff person, R37 stated staff did not offer her use of the toilet, commode or bedpan for toileting, and stated she did not believe she could use the toilet or commode because of her leg injury and non-weight bearing status. At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed, and NA-G then proceeded with changing R37's incontinence brief, with two hours and 37 minutes between changes. R37 was not offered use of a toilet or bedpan. At 10:17 a.m., NA-G stated R37 was to be checked/ changed every two hours and did not use a bedpan or toilet because she was always incontinent, and NA-G confirmed R37's incontinence brief contained a small void of urine. Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including toileting/ use of a bedpan and checking/ changing her incontinence product. During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting or checked/ changed for three hours and five minutes. Observations included the following: At 8:23 a.m., R37 was seated at the dining room table waiting for breakfast. At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached the resident, brought her to her room, administered	F 315		

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eye drop medication, and then returned R37 to the day room. RN-H did not offer to toilet or check/ change R37.
At 10:09 a.m., NA-A approached R37 and asked if she wanted to lay down. R37 declined this offer, however, NA-A did not offer to toilet or check/ change R37.
At 10:31 a.m., an activities staff invited R37 to attend an exercise group, which R37 declined and remained seated in her wheelchair in the day room.
At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed every two hours, using a mechanical lift to transfer her into bed. NA-A stated R37 was last checked/ changed at 8:00 a.m. and stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined. NA-A stated she interpreted R37's response as a refusal to be checked/ changed, and typically she would approach R37 every two hours and ask if she wanted to lay down, which is when she would check and change R37. NA-A stated R37 did not use a toilet or commode because she required a mechanical sling lift for transfers, and stated R37 did not use a bedpan either. NA-A then proceeded with assisting other residents and R37 had still not been offered to toilet or be checked/ changed.
At 11:05 a.m., the surveyor asked NA-A when R37 would be offered toileting again, and NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought her to her room before seeking a second staff person to help with the transfer. NA-A returned and RN-H entered the room to assist with transferring R37 to bed and checking/ changing her incontinence brief, with three hours and five minutes between

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changes.
At 11:29 a.m., NA-A stated R37 had a small bowel movement and a small void of urine in her incontinence brief. Though staff were not observed offering R37 the use of a bedpan during this observation, NA-A stated she did offer the bedpan and R37 declined.

During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be toileted every two hours and was usually incontinent. RN-H stated that she and NA-A did offer a bedpan to R37 during the above noted observation, but R37 declined. RN-H stated that she felt NA-A's offer for R37 to lay down did constitute an offer for toileting or checking/ changing, and R37's decline to this offer equated a refusal.

During interview on 2/11/16, at 3:01 p.m. RN-A confirmed R37 was to be offered the use of a bedpan every two hours, and should have been offered a bedpan despite identification of urine or bowel in her incontinence brief. RN-A stated an offer to lay down in bed was not indicative of an offer for toileting or checking/ changing, and R37's declining to lay down did not equate a refusal for toileting. RN-A stated staff should have specifically asked if she would have liked to have her brief changed and use the bedpan, and staff were not following R37's care planned interventions for toileting.

The facility's Bowel and Bladder Assessment Evaluation and Retraining policy dated 9/12, directed staff to ensure each resident with bowel or bladder incontinence received appropriate treatment and services to restore as much normal bowel or bladder function as possible.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and implement interventions to reduce the risk of falls for 1 of 3 residents (R34) reviewed for accidents hazards. Findings include: R34's admission Minimum Data Set (MDS) dated 1/13/16, indicated R34 had moderate cognitive impairment, had cancer, anemia, and heart failure. The MDS indicated the resident needed extensive assist of two with transfers, toileting, dressing, bed mobility, was incontinent of bowel and bladder, and had no falls in the last month. R34's Care Area Assessment (CAA) dated 1/13/16, indicated the resident was not steady with transfers, received an antidepressant, had difficulty maintaining balance, and had impaired balance during transitions. The CAA indicated falls would be addressed in the care plan with a goal of preventing falls. R34's care plan dated 1/14/16, indicated the resident had metastic breast cancer with brain	F 323	F323 R34 was assessed for a need of a call light clip. Call light clip was attached to call light cord on 2/10/16. Falls assessment was completed for R34 3/1/16. Care plan reviewed and revised with additional fall interventions. Residents at risk for falls had assessments and care plans reviewed to ensure all care planned interventions were appropriate and in place. Revisions were completed if needed. Nursing Staff were re-educated 2/16/16 through 3/11/16 on fall prevention, management, assessing and care planning with fall interventions and ensuring all careplanned interventions are consistently followed. Random audits of fall assessments and visual observations of careplanned fall interventions will be completed weekly for 1 month, monthly for 3 months, and	3/16/16

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F 323	Continued From page 33 mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach. An Incident Report dated 1/20/16, at 3:49 a.m. indicated, "Writer was walking down the hall to answer a light, when I heard a resident yelling for help. Resident [R34] was found lying on her left side on the floor by her bed." The report indicated she received a skin tear on her left wrist, and an air overlay mattress was removed and a low bed and concave mattress was provided to resident. An Incident Report dated 1/25/16, at 2:30 a.m. indicated, "Resident [R34] noted to be lying on floor in resident's room, she was lying on her stomach at foot of bed. Resident is confused to place and time. She states: "I slipped out of bed." The report indicated she had facial bruising on her nose and the center of her forehead, and a raised area on the lower part of the back of her head. The report also indicated she had gripper slippers on and a floor mat was placed on the floor near her bed. During observation 02/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor. During observation 02/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank.	F 323	quarterly thereafter as coordinated by the DNS. Results of audits and investigations will be reported to the QAPI committee for further evaluation and recommendations.	

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F 323	Continued From page 34 During interview 02/9/16, at 11:39 a.m. registered nurse (RN)-I stated the fall mat should be on the floor and the bed should be in the low position at all times. RN-I entered R34's room and placed the fall mat on the floor next to resident. During observation 2/10/16, at 8:01 a.m. R34 was observed laying in bed and the bed was in the low position with fall mat on the floor. However, the residents call light was observed laying on the floor out of R34's reach. Director of nursing (DON) was informed of the call light being out of R34's reach, and she entered the residents room and gave her the call light. During interview 2/10/16, at 12:31 p.m. RN-A stated she didn't know why R34's bed was not in the low position, and stated she had talked to the NA who was working with R34 on 02/9/16, and the NA stated she thought during a physician visit he had left the bed up. RN-A stated R34 was a fall risk and should have all the assessed interventions in place, including having the call light available because the resident will use it to call for staff assistance. A facility Fall Prevention And Management policy issued July 2015, indicated to take a "Reactive Approach-requires identifying actual risk factors and taking steps to prevent the fall from occurring again. In a fall prevention program, a reactive approach will include a post-fall investigation to determine the cause of the fall (root cause analysis), identifying risk factors and taking steps (interventions) to prevent the fall from happening again."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		3/16/16

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F 325	Continued From page 35 Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively reassess nutritional needs for a significant weight loss for 1 of 4 residents (R72) reviewed for nutritional needs and weight loss. Findings include: R72's quarterly Minimum Data Set (MDS) dated 12/08/15, indicated the resident had no cognitive impairment, felt depressed and tired, had dementia and heart failure, needed set up help with eating, and had no swallowing problems. R72's care plan dated 2/14/14, indicated the resident had obesity related to energy intakes exceeding needs, limited mobility, and choosing high calorie foods at meals/snacks. The care plan goal was for the resident to maintain a weight of 278 lbs (pounds); or a gradual loss of 2-4 lbs a month. The care plan indicated R72 had an amputee of her lower extremity, gastro-esophageal reflux disease, (a chronic condition of mucosal damage caused by stomach	F 325	F325 R72 was reassessed for nutritional needs by Dietitian on 2/17/16. Recommended increased assistance with feeding at meals and order for nutritional supplement was received on 2/19/16. R72 was added to Nutrition Risk List and will continue to be monitored monthly and as needed. Care plan updated to reflect current dietary plan of care. All residents in facility were reviewed for significant weight loss on 2/15/16. Residents with significant weight loss were reassessed by the dietitian. Nursing staff re-educated 2/16/16 through 3/11/16 on policy and procedure for weight monitoring and notifications to Dietitian with changes in weights. Dietitian was re-educated on Policy and	

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F 325	Continued From page 36 acid coming up from the stomach) and heart failure. A Dietary Profile dated 12/07/15, indicated R72 received a regular diet, did not receive supplements, and had an amputation. A Mini-Nutritional Assessment dated 12/07/15, indicated she had no decrease in her food intake and had weight loss greater than 3 kilograms (6.6 lbs). A Nutrition Risk Note dated 1/4/16, indicated resident was at nutrition risk, and her oral intake was sporadic and had 11 meal refusals with in the last 14 days. The note further indicated the facility would continue to assess for food preferences, offer substitutions for meals, and would continue to monitor her oral intake and weight. R72's physician orders dated 2/11/16, indicated the resident received Lasix (diuretic to remove fluid) 20 milligrams (mg) twice a day for edema. On 2/9/16, at 5:47 p.m. R72 was observed eating a hamburger on a bun, salad, and apple crisp. R72 ate 50% of her meal. R72 was sitting in her wheelchair which had a sticker taped to the back of her wheelchair indicating the foot pedals weighed 51.8 lbs. On 2/10/16, at 12:22 p.m. R72 was observed eating shrimp scampi and a baked potato, and she ate 75% of her meal. A facility Percentage Of Meal Eaten form dated 1/13/16, to 2/10/16, indicated R72 refused 19 meals. R72's Vital Results identified the following weights: 12/2/15 - 260 lbs 12/23/15 - 281 lbs (281-260 lbs weight gain of 21 lbs, no documentation as to why). 12/30/15 - 283 lbs	F 325	Procedures for Monitoring Residents with Impaired Nutrition, Nutritional Risk and Interventions for Nutritional Risk on 2/15/16. Dietitian will monitor weights and vitals weekly to help identify weight fluctuations and residents that require Nutrition risk monitoring. Random audits to ensure appropriate assessment for significant weight loss interventions are in place will be done weekly for one month, monthly for 3 months and quarterly thereafter. Results of audits will be reviewed by Dietitian and DNS with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations.	

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F 325	Continued From page 37 1/20/16 - 286 lbs 1/27/16 - 285 lbs 2/03/16 - 263 lbs (285 to 263 lbs weight loss of 22 lbs, no documentation as to why). 2/11/16 - 245 lbs (263- 245 weight loss of 18 lbs, no documentation as to why). Although R72's weights fluctuated and R72 had a 5.8 % weight loss from 12/02/15, to 2/11/16, there was no indication the facility reassessed R72 to determine why there were significant weight changes. During interview on 2/10/16, at 12:22 p.m. registered nurse (RN)-A stated R72 was on Lasix, however, after reviewing the weights she stated it looked as if there was some inconsistency with the weights because, "You wouldn't loose 20 lbs in one week," and stated she would have staff reweigh the resident. In a follow-up interview at 2:22 p.m. RN-A stated R72 was weighed and the weight was 242.6 lbs. RN-A stated she felt the weight fluctuation could be from R72 not having her prosthetic leg on, however, RN-A weighed R72's prosthetic leg which weighed 4.4 lbs. During interview 2/11/16, at 1:27 p.m. registered dietician (RD) stated R72 had a decline in health and felt the weights which were recorded in the 280's were inaccurate. The RD stated she felt the weight from 12/2/15, which was 260 lbs was accurate for R72. The RD stated she had been working with staff to ensure they obtained accurate weights, and RD stated she had staff reweigh the resident and she now weighed 243 lbs. RD stated R72 had a weight loss and indicated it could be due to the resident requiring more staff assistance, and the resident had also	F 325		

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F 325	Continued From page 38 been eating meals in her room more often. RD stated R72 should have been reassessed and had further interventions put into place when the decline in weight was initially noted, from January to early February. During interview 2/11/6, director of nursing (DON) stated R72 had been refusing to get out of bed more often and seemed to be more confused. The DON stated the nuses used to do weights on paper so they could see a weight loss, however, the weights are now entered electronically and staff are not able to see the previous weight. A facility policy titled Nutritional Risk Policy revised 2/16, indicated Nursing staff members with notify the dietary department with in 24 hours by sending an alert significant weight change, gain or loss, 3 pounds in one week, 5 percent in one month, 7.5 percent in three months, 10 percent in six months. The policy further indicated the director of dietary services (DDS) or designee will review resident weights monthly or more often to identify residents with significant weight loss or gain or insidious weigh loss or gain refers to a gradual unintended, progressive weight loss or gain over time.	F 325		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for	F 412		3/16/16

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F 412	Continued From page 39 transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dental follow up appointments were completed for 1 of 3 residents (R15) reviewed for dental services. Findings include: R15's significant change Minimum Data Set (MDS) dated 1/6/16, indicated the resident had moderate cognitive impairment and need for extensive assistance to complete activities of daily living. R15's care plan dated 2/10/16, directed staff to provide resident with assistance to complete dressing and grooming, and the resident performed oral care independently. During interview on 2/9/16, at 10:42 a.m. R15 stated he had missing teeth on the upper right side of his mouth and had been seen for evaluation by the dentist because of the missing teeth and discomfort on the right side of his upper jaw. R15 stated he had understood there was to be a follow up appointment, however, he had heard nothing regarding this since his last visit with the dentist. During observation on 2/10/16, at 1:03 p.m. R15 was observed eating his meal with no visible problems chewing. During interview at this time, R15 stated he continued to have discomfort on	F 412	F412 Resident #15 agreed to a follow up dental appointment scheduled for 3/4/16 at an outpatient Dental office. Center will review the medical records on the long term care residents for the past 6 months to identify any other residents who had dental appointment follow-up recommendations. Any affected residents will have their dental recommendations followed-up on as needed. Health Information Management Department and Licensed Nurses will be re-educated on the process of reviewing recommendations from the dental service and ensuring the recommendations are followed-up on including scheduling the related transportation, if needed. Center will complete audits of dental visits monthly for the next three months and quarterly thereafter. The results will be reviewed, shared and followed-up with the QAPI Committee for further recommendations.	

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F 412	Continued From page 40 the upper right side of his mouth with chewing, and again stated he had broken teeth and, "I was supposed to follow up a long time ago [with the dentist], and I haven't heard anything." Review of the Apple Tree Coon Rapids progress note dated 9/10/15, indicated (R15) was seen on that date for a recall exam. The progress note indicated, "Diagnosis/Assessment: Caries risk: High;rampant decay . See oral exam form. Tooth #12 and 13 had buccal cusps have fractured off; non-restorable, Recommend extractions " Several no [sic] cavities noted since last exam." Treatment recommendations were made for fillings and extractions, in addition to follow up for prophylaxis treatment every three months. Review of R15's medical records indicated the resident had no further follow up dental appointments, nor were there any follow up dental appointments scheduled. During interview on 2/11/16, at 1:55 p.m. registered nurse (RN)-A stated it appeared the dental recommendations were not processed because when a follow up of recommendation of appointments is completed, the nurse will write, "Noted," on the form. A review of R15's record indicated there had been no follow up or communication with Apple Tree dental services since R15's visit of 9/10/15. A review of the policy titled Dental/Oral Health Services and Assessments, issued September 2012, indicated the purpose of dental assessments was for treatment to begin as early as necessary.	F 412		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		3/16/16

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F 441 SS=D	Continued From page 41 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 42 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure proper disinfecting procedure of the glucometer after blood glucose monitoring for 2 of 3 residents (R42 and R90) who utilized the facility community glucometer on the Sunny Ridges unit. Findings include: R42 was observed for a blood glucose testing on 2/10/16 at 8:23 a.m. by registered nurse (RN)-B who pierced R42's finger using a lancet and placed a large drop of blood on the collection strip of the glucometer to measure the glucose level. After disposing of the lancet and blood collection strip, the glucometer was then wiped down with alcohol prep pads and placed on a paper tissue in the tote. At 8:30 a.m., RN-B proceeded to test blood glucose on R90 with the same glucometer used for R42. Upon completion of blood glucose testing, the glucometer, was cleaned with alcohol wipes and placed on a clean paper tissue in the nurses tote and allowed to air dry. During an interview on 2/10/16 at 8:35 a.m., RN-B stated that the glucometer is wiped down with alcohol wipes between residents. Residents of Sunny Ridges use a community glucose meter. On 2/11/16, registered nurse (RN)-C identified R42, R90, and R20 all had orders for routine blood glucose monitoring on Sunny Ridges unit. On 2/11/16 at 9:29 a.m., RN-D stated that the residents have their own glucometer on the short term care units. The long term care units, glucometers are to be wiped with sani cloth plus	F 441	F441 R20, R42, and R90 were each provided with a glucometer for individual use on 2/12/16. Staff caring for them instructed on individual use and cleaning and disinfecting procedures. All residents with ordered blood glucose checks were provided a glucometer for individual use. New system was developed to provide a glucometer for individual use for all residents requiring blood glucose checks. Glucometers will be disinfected per facility Policy and Procedure. Licensed Nurses will be trained on new system of each resident having an assigned glucometer for individual use. Staff re-educated on Policy and procedure of cleaning glucometers 2/17/16-3/11/16. Audits of individual glucometer use, proper cleaning and storage will be completed weekly for 1 month, monthly for 3 months, and quarterly thereafter as coordinated by the Infection Preventionist Nurse. Results of audits will be reviewed and analyzed by Nurse Manager team with changes implemented as needed. Infection Preventionist Nurse will report findings to the QAPI committee for further evaluation and recommendations.	

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F 441	Continued From page 43 wipes before and after use, taking time to assure the surfaces for remained visibly wet for 3 minutes. RN-D stated "It is not our procedure to wipe glucometer with alcohol wipes." The facility policy of Blood Glucose Monitoring, Disinfecting, and Cleaning, issued September 2012, was reviewed and indicates the process to disinfectant the meter may be completed in one of two ways, either with a process of using a dilute 1 ml of house bleach in 9 ml of water to achieve a 1;10 dilution, using a lint-free cloth or paper towel to wipe down the meter, paying attention to the time the meter must remain wet. The other option that may be used is the use of a germicidal disposable wipe supplied by the Society's preferred vendor. After disinfecting, the meter should be left a few minutes to ensure that it is dry.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely repair of the walk-in cooler to ensure adequate temperatures were maintained. This had the potential to affect all 66 residents who ate in the facility. Findings include:	F 456	F456 Walk-in cooler door will be repaired. Dietary staff were re-educated on documentation of maintenance work order process. Random audits will be performed on walk-in cooler ensuring proper seal daily for one week, weekly for one month, and quarterly thereafter. Results will be	3/16/16

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F 456	Continued From page 44 On 2/8/16, at 1:12 p.m. an initial tour of the facility's kitchen was conducted with certified dietary manager (CDM), and the door of the walk-in cooler was observed resting slightly open and was not sealed shut. CDM stated the door no longer automatically sealed and had to be pressed shut after each entry, and he had already informed the maintenance department of this issue. On 2/11/16, at 1:23 p.m. a follow-up tour was conducted with CDM and the walk-in cooler was again observed to be resting slightly open/ not sealed shut. CDM stated again he had informed maintenance of the door/seal needing repair approximately two weeks prior, however, the facility had experienced a turn-over of maintenance personnel and he suspected the departments response time to maintenance requests may have been somewhat delayed as a result. CDM was unable to provide any documentation regarding the request for the repair, and stated he did not document the request but just spoke to the maintence department. During this follow-up tour, cook-A entered and exited the walk-in cooler, but failed to press the door shut behind him, leaving the door to rest slightly opened/ unsealed, until CDM noticed and pressed the door closed. During interview on 2/11/16, at 4:13 p.m. the environmental services director (ESD) reported he had started working at the facility approximately three weeks prior. He stated he was not aware of the facility's walk-in cooler door not sealing. He stated the facility had a maintenance log where staff entered needs or requests for repairs, and stated the walk-in cooler door was not identified in the log as per the	F 456	reviewed in the QAPI Committee for further evaluation and follow-up.	

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F 456	Continued From page 45 facility's process. ESD stated though some of the preventative maintenance tasks were slightly back logged, he was on schedule with maintenance/ repair requests, and stated if he had known about the issue, he would have repaired it immediately. The facility's Food Storage policy dated 2/16, directed the CDM was responsible for monitoring refrigerator temperatures. The policy added, repair needs were to be brought to the attention of maintenance staff.	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 12, 2016. At the time of this survey, Good Samaritan Society Ambassador was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2016

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
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(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 Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Ambassador is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 68 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

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K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for proper separation of multiple construction types. This deficient practice could affect all 68 residents. Findings include: During a tour of the facility between 9:30 AM and 1:30 PM on February 12, 2016, observation revealed that the 2-hour fire separation had fiberglass insulation and no fire caulking around the large penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed. This deficient practice was verified by the administrator at the time of the inspection.	K 012	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K 012 Center will remove fiberglass insulation from two- hour fire separation wall, and will install mineral wool and seal barrier with appropriate fire rated caulk. Environmental Services Director is responsible for correction and monitoring to prevent a reaccurance of the deficiency	3/18/16
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

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K 050	Continued From page 3 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. This deficient practice was confirmed by the Director of Environmental Services at the time of discovery.	K 050	K050 Missing fire drill was second quarter 2015, time of drill was not noted am/pm. Unable to correct second quarter Drill. Going forward, Environmental Services Director will document fire drills using military time and once per shift per quarter for all staff under varying times and conditions.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated,	K 143		3/18/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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K 143	Continued From page 4 sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for the proper arrangement of room intended for the transferring of liquid oxygen from one container to another per NFPA 99 8-6.2.5.2. This deficient practice could affect all 44 residents. Findings include: During a tour of the facility between 9:30 AM and 1:30 PM on February 12, 2016, observation revealed that the oxygen transfilling room in 1963 building had vinyl floor tiles. This deficient practice was verified by the Administrator at the time of the inspection.	K 143	K143 Vinyl tile in the oxygen trans-fill room will be removed. Environmental Services Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**02/12/2016**

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GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/04/2016

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

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K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and	K 050		3/18/16

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K 050	Continued From page 3 conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. This deficient practice was confirmed by the Director of Environmental Services at the time of discovery.	K 050	K050 Missing fire drill was second quarter 2015, time of drill was not noted am/pm. Unable to correct second quarter Drill. Going forward, Environmental Services Director will document fire drills using military time and once per shift per quarter for all staff under varying times and conditions.	
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated,	K 143		3/18/16

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

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K 143	Continued From page 4 sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for the proper arrangement of room intended for the transferring of liquid oxygen from one container to another per NFPA 99 8-6.2.5.2. This deficient practice could affect all 24 residents. Findings include: During a tour of the facility between 9:30 AM and 1:30 PM on February 12, 2016, observation revealed that the oxygen transfilling room in 2010 building had vinyl floor tiles. This deficient practice was verified by the Administrator at the time of the inspection.	K 143	K143 Vinyl tile in the oxygen trans-fill room will be removed. Environmental Services Director is responsible for correction and monitoring to prevent reoccurrence of the deficiency	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

February 25, 2016

Ms. Marie Barta, Administrators
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, Minnesota 55427

Re: Enclosed State Supervised Living Facility Licensing Orders - Project Number S5149026

Dear Ms. Barta:

The above facility was surveyed on February 8, 2016 through February 11, 2016 for the purpose of assessing compliance with Minnesota Department of Health Supervised Living Facility Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144.56. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

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

When all orders are corrected, the first page of the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Jessica Sellner, Unit Supervisor at (320)223-7343. A written plan for correction of licensing orders is not required.

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.

Feel free to contact me with any questions related to this letter.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 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. On February 8-11 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. A complaint investigation (s) H5149028 was also completed at the time of the standard survey and was not substantiated during this survey.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions were followed by staff for 1 of 3 residents (R34) reviewed for accidents and for 1 of 3 residents (R37) reviewed for toileting and pressure ulcers. Findings include: R34's admission Minimum Data Set (MDS) dated 1/13/16, indicated R34 had moderate cognitive impairment, had cancer, anemia, and heart failure. The MDS indicated the resident needed extensive assist of two with transfers, toileting, dressing, bed mobility, was incontinent of bowel and bladder, and had no falls in the last month. R34's care plan dated 1/14/16, indicated the	2 565		

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2 565	Continued From page 3 resident had metastic breast cancer with brain mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach. During observation 2/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor. During observation 2/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank. During interview 2/9/16, at 11:39 a.m. registered nurse (RN)-I stated the fall mat should be on the floor and the bed should be in the low position at all times. RN-I entered R34's room and placed the fall mat on the floor next to resident. During observation 2/10/16, at 8:01 a.m. R34 was observed laying in bed and the bed was in the low position with fall mat on the floor. However, the residents call light was observed laying on the floor out of R34's reach. Director of nursing (DON) was informed of the call light being out of R34's reach, and she entered the residents room and gave her the call light. During interview 2/10/16, at 12:31 p.m. RN-A stated she didn't know why R34's bed was not in the low position, and stated she had talked to the NA who was working with R34 on 02/9/16, and the NA stated she thought during a physician visit he had left the bed up. RN-A stated R34 was a fall risk and should have all the assessed	2 565		

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2 565	Continued From page 4	2 565		

interventions in place according to the care plan, including having the call light available because the resident will use it to call for staff assistance.

R37's admission MDS dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility.

R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift.

During continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes.

During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing. RN-A stated the facility staff should specifically ask R37 if she would like to be repositioned to offload her bottom, have her brief changed, and

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2 565	Continued From page 5 utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. A facility Care Plan Policy dated September 2013, indicated, "Residents will receive and be provided the necessary care and services to maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff to follow care plans in regards to specific resident cares and services. The DON or designee could monitor for compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		

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2 830	Continued From page 6 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess pain to ensure adequate interventions were in place to relieve pain for 1 of 1 residents (R154) with pain. Findings include: R154's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated he was cognitively intact and was on a scheduled pain regimen, received prn (as needed) pain medications, and had occasional to moderate pain. R154's care plan dated 5/28/15, indicated he had chronic pain/discomfort related to osteoarthritis, gout, and neuropathy which was managed with medications. The care plan further instructed staff to, "Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s (signs and symptoms) or c/o (complaints of) pain or discomfort. Notify health care provider if interventions are unsuccessful or if current complaint is a	2 830		

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2 830	Continued From page 7	2 830		

significant change from residents past experience of pain."

A Care Area Assessment (CAA) Worksheet dated 5/25/15, indicated he had osteoarthritis with worsening right hip pain, rated his pain as 7, and indicated the pain affected his sleep and mood.

R154 Pain Data Collection form dated 11/28/15, indicated R154 had pain in the last 5 days that was frequent on all of his back and whole leg. The form indicated the resident rated his pain at a 6 (on a scale from 1-10, with 10 being the worst pain) and had vocal complaints and facial expressions of pain daily. In addition, the pain was stabbing, pain meds relieved the pain, pain increased with movement, the pain did not disrupt his sleep at night or limit his day to day activities, had no changes in appetite/eating ability, and was on a scheduled pain medication regimen. Under Resident/Family Education indicated, "Resident c/o increased pain (nothing new) over a few days. Goal is tolerable pain. PRN's to be offered as needed."

A Pain Data Collection dated 2/7/16, indicated R154 had pain in his entire back and right lower extremity, rated his pain at a 5, made protective body movements or postures due to pain, limited day-to-day activities because of pain, decreased interest pursuits, and had irritability and anger. The Pain Data Collection also indicated he had not received PRN pain medication and the, "Current Treatment plan addresses resident's pain".

R154's current physician orders dated February 2016, indicated he received Oxycodone HCL (hydrochloride) 5 milligrams (mg) (a narcotic analgesic used for moderate to severe pain) one

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2 830	Continued From page 8 tablet three times a day for pain. The orders indicated the start date of the medication was 8/14/15. R154 also had an order for Oxycodone HCL 5 mg every four hours as needed for pain; do not exceed six tablets per day with a start date of 6/26/15. R154 also had an order for Tylenol 325 mg two tablets by mouth every 4 hours as needed for headache pain with a start date of 5/31/15. R154's medication administration record (MAR) dated 2/1/16, to 2/10/16, at 2:31 p.m. indicated R154 did not receive any of his PRN pain medications. A HealthPartners Subsequent Visit dated 11/6/15, indicated R154 had gout in his knee and the physician had increased allopurinol (a medication used for gout) and added cholchicine (medication used for gout), and he had been receiving morephine (a pain medication for severe pain), however, his morphine tablets were stopped due to sedation and needing narcan (reverses the effects of opioid). A HealthPartners Subsequent visit dated 1/4/16, indicated R154 used a scooter for mobility and his "Mobility limited by chronic right lower ext pain." A Park Nicollet Senior Services Nursing Home Visit Note dated 2/3/16, indicated he was new to Park Nicollet team, and R154 had chronic pain syndrome and had been on narcotics for several years and was receiving oxycodone three times a day as well as prn. There was no indication if the current pain regimen was effective. During interview on 2/8/16, 6:43 p.m. R154 stated he felt his leg pain was getting worse, he wanted	2 830		

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2 830	Continued From page 9	2 830		

his pain medications increased, and he had told the nurses he wanted more pain medication, however, "I get no answer and they [the nurses] say they will contact the nurse practioner. I never heard back and I ask again and never hear back. The nurse practioner comes and see's me but rarely. I haven't had a chance to talk to her about the pain, she doesn't come and ask me about my pain. They are doing nothing for me." R154 stated his pain was at an 8.

During a follow up interview 2/10/16, at 12:44 p.m. R154 stated he had an order for oxycodone but it didn't help, so he doesn't take the PRN. R154 stated his pain was usually at an 8 and sometimes a 10 and that he is very rarely at a level of 5.

During interview 2/10/16, at 1:01 p.m. nursing assistant (NA)-B stated she worked with R154 and he has a lot of pain in his right leg and his back, and because of the pain R154 would refuse to transfer or ambulate, and at times would just stay in bed because of the pain.

During observation 2/10/16, at 2:27 p.m. NA-C was observed to transfer R154 in his room. NA-C situated a chair at a 45 degree angle from the bed and placed a four wheeled walker (4WW) in front of R154 with the brakes applied. R154 briefly repositioned himself in his wheelchair and an audible sigh and vocalization of "Ah" were noted. NA-C asked "Are you hurting today?...Where?" R154 stated "Yes... my hands, my legs." Once all set up to transfer, NA-C said "Take your time" several times as R154 made his first attempt to stand. As he began to bear weight on his legs and feet he yelled out "Ow" and quickly returned to a seated position back in his

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wheelchair. He was breathing quickly and heavily, and then began the 2nd attempt to transfer, and again was observed to breath heavily with his mouth open and eyes tightly closed, as he took steps to turn his back to the bed. With contact guard assist he stood from his wheelchair and placed his hands on the 4WW. The NA repeated several times "Take your time... do you want me to get a nurse for you?" R154 declined for the aide to get the nurse. Once seated on the bed, R154 stated his pain level was 10/10. During the transfer his right knee was visibly shaking.

Review of R154's progress notes/orders indicated the following:
-On 2/3/16, 4:26 p.m. Communication/Visit with Physician Note Text: "Labs from today called to NP (nurse practioner). Also questioning tens (Transcutaneous Electrical Nerve Stimulation which is predominately used for nerve related pain conditions) unit for residents pain in his right knee if that was possible per resident request. Awaiting return call."
-A physician order was received 2/11/16, eight days after the request for physical therapy to evaluate right knee pain and appropriateness of tens unit.

-On 2/4/16, at 3:00 p.m. staff approached to walk resident but he refused due to pain.

-On 2/5/16, at 8:58 p.m. resident refused to walk.

-On 2/9/16, at 10:00 p.m. patient did not walk to dinner. He wheeled himself out in his electric wheelchair.

-On 2/10/16, at 3:24 p.m. Communication/Visit

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with Physician Note Text: NP updated on residents c/o pain in bilateral hands. Resident continues to c/o "sharp pain" in his hands. He denied that it is radiating from anywhere. He has requested PRN pain pills this shift, with little relief. Continue to monitor and update NP.

- On 2/10/16, at 10:01 p.m. resident refused shower, "Stating have been in pain all day." Pain meds were administered.

During interview on 2/10/16, at 1:15 p.m. trained medical assistant (TMA) stated R154 had been having increased pain and he asked for a PRN today and had been asking more for his pain medication.

During interview on 2/10/16, at 2:30 p.m. registered nurse (RN)-A stated she was the manager for R154's unit and was not aware R154 was having pain. RN-A stated he had recently switched to a new doctor and his previous nurse practioner and physician were not very receptive to additional pain medication requests from the nurses. In addition RN-A stated she was not aware a request for a tens unit was made and she would call the NP and re-request the order.

During interview on 2/11/16, at 9:31 a.m. RN-F stated she worked the day shift and R154 usually had a pain rating of 7/10, and recently the resident has had increased complaints of pain.

During interview on 2/11/16, at approximelty 1:50 p.m. NA-C stated R154 complained of pain in the morning and afternoons and had been requesting his pain medication more often, and felt in the last three weeks R154's pain has been increasing.

Although R154 reported increased pain, was

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2 830	Continued From page 12 refusing to ambulate, and was observed to be in the pain, the facility did not reassess to determine if any further interventions could be implemented to decrease the residents pain. A facility policy titled Pain Management-Resident Assistance policy issued September 2012, indicated the purpose was to provide resident assistance in pain management and, "All residents will receive interdisciplinary consultations on assistance in managing pain." The policy futher indicated "The registered nurse will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological as well as pharmacological. The registered nurse will review response to medication interventions and work closely with the physician to assist in the individualized pain measurement plan." SUGGESTED METHOD OF CORRECTION: The DON or designee could train all staff and monitor to ensure all residents are assessed for pain and receiving appropriate nursing care and treatment. The DON or designee could report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 840		

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2 840	Continued From page 13 B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely toileting in accordance with assessed needs, in order to maintain as much urinary function as possible, for 1 of 3 residents (R37) reviewed for urinary incontinence. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37's cognition was intact, was frequently incontinent of both bladder and bowel, was not on a toileting program, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility. R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was non-weight bearing on her right, lower extremity, and required a total lift with assistance from two staff to transfer. The CAA identified R37 required maximum assistance with toileting, had functional incontinence, was at an increased risk for urinary incontinence and infection due to a previous UTI, and may have had increased urinary frequency secondary to her use of diuretic medications. R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility. The care plan directed staff to, "Offer and assist with toileting "every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. During a telephone interview on 2/8/16, at 7:36	2 840		

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	00898	A. BUILDING: _____ B. WING _____	02/11/2016

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2 840	Continued From page 15 p.m. family member (FM)-A stated staff did not assist R37 with toileting timely, and she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed. During a continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting or checked/ changed for two hours and 37 minutes. Observations included the following: At 7:23 a.m., R37 was lying in her bed and nursing assistant (NA)-G was present in the room. At 7:30 a.m., NA-G checked/ changed R37's incontinence product before she was assisted to sit in her wheelchair, using a mechanical lift and two staff to transfer her. At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal. At 9:00 a.m., R37 was moved from the dining room, to an alcove/ day room area (across from the dining room), where she watched television with two of her peers. At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and stated, "See how late they get?" R37 stated she had not yet received her morning medications, nor had she been assisted with her exercises, and was sighing as she was talking. At 9:40 a.m. R37 asked the surveyor to find a staff member to assist her, and Registered nurse (RN)-G was made aware of R37's request for assistance. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light and exited the room. RN-G did not offer toileting assistance, nor did she check/ change R37. At 9:57 a.m., NA-G entered R37's room and offered to assist her into bed. R37 accepted and NA-G sought another staff person to assist with	2 840		

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2 840	Continued From page 16	2 840		

the transfer.
At 10:05 a.m., while NA-G had again stepped out of the room to find another staff person, R37 stated staff did not offer her use of the toilet, commode or bedpan for toileting, and stated she did not believe she could use the toilet or commode because of her leg injury and non-weight bearing status.
At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed, and NA-G then proceeded with changing R37's incontinence brief, with two hours and 37 minutes between changes. R37 was not offered use of a toilet or bedpan.
At 10:17 a.m., NA-G stated R37 was to be checked/ changed every two hours and did not use a bedpan or toilet because she was always incontinent, and NA-G confirmed R37's incontinence brief contained a small void of urine.

Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including toileting/ use of a bedpan and checking/ changing her incontinence product.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting or checked/ changed for three hours and five minutes. Observations included the following:
At 8:23 a.m., R37 was seated at the dining room table waiting for breakfast.
At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached the resident, brought her to her room, administered eye drop medication, and then returned R37 to the day room. RN-H did not offer to toilet or check/ change R37.
At 10:09 a.m., NA-A approached R37 and asked

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2 840	Continued From page 17	2 840		

if she wanted to lay down. R37 declined this offer, however, NA-A did not offer to toilet or check/ change R37.
At 10:31 a.m., an activities staff invited R37 to attend an exercise group, which R37 declined and remained seated in her wheelchair in the day room.
At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed every two hours, using a mechanical lift to transfer her into bed. NA-A stated R37 was last checked/ changed at 8:00 a.m. and stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined. NA-A stated she interpreted R37's response as a refusal to be checked/ changed, and typically she would approach R37 every two hours and ask if she wanted to lay down, which is when she would check and change R37. NA-A stated R37 did not use a toilet or commode because she required a mechanical sling lift for transfers, and stated R37 did not use a bedpan either. NA-A then proceeded with assisting other residents and R37 had still not been offered to toilet or be checked/ changed.
At 11:05 a.m., the surveyor asked NA-A when R37 would be offered toileting again, and NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought her to her room before seeking a second staff person to help with the transfer. NA-A returned and RN-H entered the room to assist with transferring R37 to bed and checking/ changing her incontinence brief, with three hours and five minutes between changes.
At 11:29 a.m., NA-A stated R37 had a small bowel movement and a small void of urine in her incontinence brief. Though staff were not observed offering R37 the use of a bedpan during

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2 840	Continued From page 18 this observation, NA-A stated she did offer the bedpan and R37 declined. During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be toileted every two hours and was usually incontinent. RN-H stated that she and NA-A did offer a bedpan to R37 during the above noted observation, but R37 declined. RN-H stated that she felt NA-A's offer for R37 to lay down did constitute an offer for toileting or checking/ changing, and R37's decline to this offer equated a refusal. During interview on 2/11/16, at 3:01 p.m. RN-A confirmed R37 was to be offered the use of a bedpan every two hours, and should have been offered a bedpan despite identification of urine or bowel in her incontinence brief. RN-A stated an offer to lay down in bed was not indicative of an offer for toileting or checking/ changing, and R37's declining to lay down did not equate a refusal for toileting. RN-A stated staff should have specifically asked if she would have liked to have her brief changed and use the bedpan, and staff were not following R37's care planned interventions for toileting. The facility's Bowel and Bladder Assessment Evaluation and Retraining policy dated 9/12, directed staff to ensure each resident with bowel or bladder incontinence received appropriate treatment and services to restore as much normal bowel or bladder function as possible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance	2 840		

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2 840	Continued From page 19 with toileting receive timely services. The director of nursing (DON) or designee could educate staff as appropriate. The director of nursing (DON) or designee could monitor or audit to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting and repositioning were completed as assessed to prevent pressure ulcers for 1 of 3 residents (R37) reviewed who was identified at risk for pressure	2 900		

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2 900	Continued From page 20 ulcer development. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility. R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was weak, de-conditioned, and non-weight bearing on her right, lower extremity. The CAA identified a goal for R37 to remain free from skin breakdown related to incontinence and use of an incontinence brief. R37's Positioning Assessment & Evaluation dated 1/3/16, identified R37 required total assistance with repositioning and directed staff to offer repositioning every two hours. R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift. R37's Braden Scale for Predicting Pressure Sore Risk dated 2/6/16, indicated a score of 16/18, identifying R37 was at mild risk for the development of pressure ulcers.	2 900		

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2 900	Continued From page 21 During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated R37 did not get assisted with toileting timely, and stated she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed. During continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes. Observations included the following: At 7:23 a.m., R37 was lying in bed and nursing assistant (NA)-G was present in the room. At 7:30 a.m., NA-G checked/ changed R37's incontinence product before assisting R37 to sit in her wheelchair using a mechanical lift and two staff to transfer. At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal. At 9:00 a.m., R37 was moved from the dining room after breakfast, to an alcove/ day room area (across from the dining room), where the resident watched television with two of her peers. At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and R37 stated, "See how late they get?" The resident stated she had not yet received her morning medications, nor had she been assisted with her exercises, and R37 visibly and audibly sighed several times. At 9:40 a.m. R37 asked the surveyor to find a staff member on her behalf and registered nurse (RN)-G was asked to assist R37. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light, and exited the room. RN-G did not offer toileting, checking/ changing or turning/ repositioning to R37. At 9:57 a.m., NA-G entered R37's room and	2 900		

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2 900	Continued From page 22 offered to assist her into bed. R37 accepted and NA-G got another staff member to assist with transferring R37 into bed. At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed and proceeded to change R37's incontinence brief, with two hours and 37 minutes between changes. NA-G confirmed R37's incontinence brief contained a small void of urine. R37 was not observed to offload or reposition herself during this observation. At 10:17 a.m., NA-G stated R37 was to be checked/ changed, and turned/ repositioned every two hours. Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including turning/ repositioning and checking/ changing her incontinence product. During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes. Observations included the following: At 8:23 a.m., R37 was seated at the dining room table, awaiting her breakfast meal. At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached her, brought her to her room, administered eye drop medication and then returned R37 to the day room. RN-H did not offer to toilet or check/ change, or reposition R37. At 10:09 a.m., NA-A approached R37 and asked if she wanted to lay down. R37 declined to lay down, however, NA-A did not offer to toilet, check/ change her brief, or offer to reposition or offload R37. No encouragement or education was provided to prevent skin breakdown.	2 900		

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2 900	Continued From page 23 At 10:31 a.m., an activities staff invited R37 to attend an exercise group. R37 declined this offer and remained seated in her wheelchair in the day room. At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed and turned/ repositioned every two hours, using a mechanical lift to transfer her into bed. NA-A stated R37 was last checked/ changed and turned/ repositioned at 8:00 a.m. NA-A stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined to lay down. NA-A stated she interpreted R37's response as a refusal to be checked/ changed and/ or repositioned. NA-A stated she attempted to approach R37 every two hours and ask if she wanted to lay down, and if the resident agreed to lay down staff would check and change her. NA-A then proceeded with assisting other residents, and R37 had still not been offered to toilet and/or checked/ changed or turned/ repositioned. At 11:05 a.m., the surveyor asked NA-A when staff would expect to offer toileting, checking/ changing and turning/ repositioning to R37, at which time NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought the resident to her room, and asked RN-H to assist. NA-A and RN-H proceeded with transferring R37 to her bed and checked and changed her incontinence brief, with three hours and five minutes between changes and offloading. R37's bottom was observed as slightly pink, but blanchable, which RN-H confirmed. At 11:29 a.m., NA-A stated when changing R37's brief she had a small bowel movement and a small void of urine in her incontinence brief.	2 900		

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2 900	Continued From page 24 During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be repositioned and toileted every two hours and was usually incontinent. RN-H stated she felt NA-A's offer for R37 to lay down did constitute an offer for turning/ repositioning and toileting or checking/ changing, and stated if R37's decline to lay down, that was considered a refusal for toileting and repositioning. During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing; and R37's declining to lay down did not equate refusals for these cares. RN-A stated the facility staff should have specifically asked if she would have liked to be repositioned to offload her bottom, have her brief changed, and utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. The facility's policy titled Skin Assessment, Pressure Ulcer Prevention, and Documentation Requirements dated 12/15, directed, "Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches." SUGGESTION METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise the current policy and procedures on pressure ulcers. The DON or designee could provide education to all staff on turning and repositioning schedules. The DON or designee could provide monitoring for compliance to treatment and prevention of	2 900		

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2 900	Continued From page 25 pressure ulcers and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dental follow up appointments were completed for 1 of 3 residents (R15) reviewed for dental services. Findings include: R15's significant change Minimum Data Set (MDS) dated 1/6/16, indicated the resident had moderate cognitive impairment and need for extensive assistance to complete activities of daily living. R15's care plan dated 2/10/16, directed staff to	21325		

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provide resident with assistance to complete dressing and grooming, and the resident performed oral care independently.

During interview on 2/9/16, at 10:42 a.m. R15 stated he had missing teeth on the upper right side of his mouth and had been seen for evaluation by the dentist because of the missing teeth and discomfort on the right side of his upper jaw. R15 stated he had understood there was to be a follow up appointment, however, he had heard nothing regarding this since his last visit with the dentist.

During observation on 2/10/16, at 1:03 p.m. R15 was observed eating his meal with no visible problems chewing. During interview at this time, R15 stated he continued to have discomfort on the upper right side of his mouth with chewing, and again stated he had broken teeth and, "I was supposed to follow up a long time ago [with the dentist], and I haven't heard anything."

Review of the Apple Tree Coon Rapids progress note dated 9/10/15, indicated (R15) was seen on that date for a recall exam. The progress note indicated, "Diagnosis/Assessment: Caries risk: High;rampant decay . See oral exam form. Tooth #12 and 13 had buccal cusps have fractured off; non-restorable, Recommend extractions " Several no [sic] cavities noted since last exam." Treatment recommendations were made for fillings and extractions, in addition to follow up for prophylaxis treatment every three months.

Review of R15's medical records indicated the resident had no further follow up dental appointments, nor were there any follow up dental appointments scheduled.

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GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21325	Continued From page 27 During interview on 2/11/16, at 1:55 p.m. registered nurse (RN)-A stated it appeared the dental recommendations were not processed because when a follow up of recommendation of appointments is completed, the nurse will write, "Noted," on the form. A review of R15's record indicated there had been no follow up or communication with Apple Tree dental services since R15's visit of 9/10/15. A review of the policy titled Dental/Oral Health Services and Assessments, issued September 2012, indicated the purpose of dental assessments was for treatment to begin as early as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and revise policies and procedures to ensure dental services are provide. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21325		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and	21685		

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21685	Continued From page 28 well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely repair of the walk-in cooler to ensure adequate temperatures were maintained. This had the potential to affect all 66 residents who ate in the facility. Findings include: On 2/8/16, at 1:12 p.m. an initial tour of the facility's kitchen was conducted with certified dietary manager (CDM), and the door of the walk-in cooler was observed resting slightly open and was not sealed shut. CDM stated the door no longer automatically sealed and had to be pressed shut after each entry, and he had already informed the maintenance department of this issue. On 2/11/16, at 1:23 p.m. a follow-up tour was conducted with CDM and the walk-in cooler was again observed to be resting slightly open/ not sealed shut. CDM stated again he had informed maintenance of the door/seal needing repair approximately two weeks prior, however, the facility had experienced a turn-over of maintenance personnel and he suspected the departments response time to maintenance requests may have been somewhat delayed as a result. CDM was unable to provide any documentation regarding the request for the repair, and stated he did not document the request but just spoke to the maintence department. During this follow-up tour, cook-A	21685		

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21685	Continued From page 29	21685		

entered and exited the walk-in cooler, but failed to press the door shut behind him, leaving the door to rest slightly opened/ unsealed, until CDM noticed and pressed the door closed.

During interview on 2/11/16, at 4:13 p.m. the environmental services director (ESD) reported he had started working at the facility approximately three weeks prior. He stated he was not aware of the facility's walk-in cooler door not sealing. He stated the facility had a maintenance log where staff entered needs or requests for repairs, and stated the walk-in cooler door was not identified in the log as per the facility's process. ESD stated though some of the preventative maintenance tasks were slightly back logged, he was on schedule with maintenance/ repair requests, and stated if he had known about the issue, he would have repaired it immediately.

The facility's Food Storage policy dated 2/16, directed the CDM was responsible for monitoring refrigerator temperatures. The policy added, repair needs were to be brought to the attention of maintenance staff.

SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and revise policies and procedures to ensure kitchen equipment was maintained appropriately. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance.

TIME PERIOD FOR CORRECTION: Twenty one

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21685	Continued From page 30 (21) days	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity with toileting needs for 2 of 5 residents (R163 and R154) observed for toileting. Findings include: R163's quarterly Minimum Data Set (MDS) dated 12/21/15, indicated the resident was cognitively intact, needed extensive assist with toileting, and was frequently incontinent of urine. R163's care plan dated 10/08/15, indicated he had bladder incontinence and wore briefs. During observation 2/10/16, at 6:51 a.m. R163 was sitting in his recliner chair, and a soiled, white incontinence brief was observed from the hall way sitting on the floor behind his wheelchair. During interview 2/10/16, at 6:52 a.m. R163 stated he was not aware the incontinence pad was on the floor next to him and stated, "I have grand kids I would not want them to see that."	21805		

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21805	Continued From page 31 During interview 2/10/16, at 7:00 a.m. registered nurse (RN)-E stated the pad should not be on the floor for people to see, and RN-E then entered the room and removed the pad. R154's quarterly MDS dated 11/12/15, indicated he was cognitively intact, needed extensive assistance with toileting, and was frequently incontinent of urine. R154's care plan dated 9/01/15, indicated he had bladder incontinence and preferred a urinal or toilet, and wore a brief. During interview 2/10/16, at 7:12 a.m. R154 stated at times his call light was left on for over 30 minutes, and stated, "I am in bed wanting to go into the bathroom. It's embarrassing when I have to tell them I peed by pants again, please change me." R154 stated he had incontinence episodes every day because he had to wait so long for staff to answer, especially at night. A Bowel and Bladder Documentation Survey Report dated from 2/1/16, to 2/11/16, R154 was incontinent of urine five times at 7:00 p.m. During interview 2/11/16, at 10:58 a.m. RN-A stated the facility does random call light audits, however, they were not able to do a computerized print out to see how long R154's call light was being left on. RN-A was able to provide one call audit on 1/28/16, however, only the morning hours were included, and the facility was unable to provide any evening audits. A facility policy titled Resident Dignity dated February 2013, indicated, "The facility will promote care for residents in a manner and in an	21805		

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21805	Continued From page 32 environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." The policy further indicated "Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a residents request for toileting." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff on dignity and respect. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21805		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe	21980		

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21980	Continued From page 33 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator according to the facility abuse and neglect policy for 2 of 2 residents (R20 and R65) who made allegations of	21980		

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21980	Continued From page 34 staff mistreatment. Findings include: A facility Policy titled Abuse And Neglect revised 9/13, indicated "Notify the location administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse, and injury of unknown origin, neglect, financial exploitation or involuntary seclusion. In case absence of the administrator, follow the chain of command for notification (DNS, SW, etc)... Document this notification. "Immediately," in this procedure means "as soon as possible after discovery of the incident, and ought not to exceed the end of the shift, in the absence of a shorter state time frame requirement." The policy also directed staff to notify the designated stated agency immediately, and to interview staff, residents, or other witnesses to the incident. R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s. R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit related to cerebral vascular accident (CVA). A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant) [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath.	21980		

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21980	Continued From page 35 [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility investigated R20's allegation of mistreatment, it was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident, and not immediately according to the facility policy. During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they	21980		

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21980	Continued From page 36	21980		

needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations needed to be reported immediately to the state agency prior to a full investigation according to the facility policy.

Although R20 made an allegation of abuse the facility investigated the incident, and did not notify the state agency, nor did they notify the administrator immediately according to facility policy.

R65's quarterly MDS completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living.
R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.

During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident, and reported it to a nurse.

A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on

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21980	Continued From page 37 the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency according to the facility policy, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency according to the facility policy because the other interviewed residents all felt safe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could in-service all staff on the need to follow the facility abuse policy in regards to immediately reporting suspected abuse to the designated state agency, document re-education of staff. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21980		

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21995	Continued From page 38	21995		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator, for 2 of 2 residents (R20 and R65) whose made allegations of staff mistreatment. Findings include: R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s. R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit related to cerebral vascular accident (CVA). A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant)	21995		

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21995	Continued From page 39 [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath. [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility investigated R20's allegation of mistreatment, it was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident. During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the	21995		

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GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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21995	Continued From page 40	21995		

resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations need to be reported immediately to the state agency.

R65's quarterly MDS, completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living.
R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.
During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident, and reported it to a nurse.

A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident

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21995	Continued From page 41 [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency because the other interviewed residents all felt safe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could in-service all staff on the need to immediately report suspected abuse/neglect to the designated state agency. The director of nurses could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21995		

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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: 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 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. On February 8-11 2016, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. 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. 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.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES. A complaint investigation (s) H5149028 was also completed at the time of the standard survey and was not substantiated during this survey.	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions were followed by staff for 1 of 3 residents (R34) reviewed for accidents and for 1 of 3 residents (R37) reviewed for toileting and pressure ulcers. Findings include: R34's admission Minimum Data Set (MDS) dated 1/13/16, indicated R34 had moderate cognitive impairment, had cancer, anemia, and heart failure. The MDS indicated the resident needed extensive assist of two with transfers, toileting, dressing, bed mobility, was incontinent of bowel and bladder, and had no falls in the last month. R34's care plan dated 1/14/16, indicated the	2 565	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3/16/16

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2 565	Continued From page 3	2 565		

resident had metastic breast cancer with brain mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach.

During observation 2/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor.

During observation 2/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank.

During interview 2/9/16, at 11:39 a.m. registered nurse (RN)-I stated the fall mat should be on the floor and the bed should be in the low position at all times. RN-I entered R34's room and placed the fall mat on the floor next to resident.

During observation 2/10/16, at 8:01 a.m. R34 was observed laying in bed and the bed was in the low position with fall mat on the floor. However, the residents call light was observed laying on the floor out of R34's reach. Director of nursing (DON) was informed of the call light being out of R34's reach, and she entered the residents room and gave her the call light.

During interview 2/10/16, at 12:31 p.m. RN-A stated she didn't know why R34's bed was not in the low position, and stated she had talked to the NA who was working with R34 on 02/9/16, and the NA stated she thought during a physician visit he had left the bed up. RN-A stated R34 was a fall risk and should have all the assessed

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2 565	Continued From page 4	2 565		

interventions in place according to the care plan, including having the call light available because the resident will use it to call for staff assistance.

R37's admission MDS dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility.

R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift.

During continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes.

During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing. RN-A stated the facility staff should specifically ask R37 if she would like to be repositioned to offload her bottom, have her brief changed, and

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2 565	Continued From page 5 utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. A facility Care Plan Policy dated September 2013, indicated, "Residents will receive and be provided the necessary care and services to maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could in-service all staff to follow care plans in regards to specific resident cares and services. The DON or designee could monitor for compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must	2 830		3/16/16

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2 830	Continued From page 6 receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess pain to ensure adequate interventions were in place to relieve pain for 1 of 1 residents (R154) with pain. Findings include: R154's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated he was cognitively intact and was on a scheduled pain regimen, received prn (as needed) pain medications, and had occasional to moderate pain. R154's care plan dated 5/28/15, indicated he had chronic pain/discomfort related to osteoarthritis, gout, and neuropathy which was managed with medications. The care plan further instructed staff to, "Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s (signs and symptoms) or c/o (complaints of) pain or discomfort. Notify health care provider if interventions are unsuccessful or if current complaint is a	2 830	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 830	Continued From page 7 significant change from residents past experience of pain." A Care Area Assessment (CAA) Worksheet dated 5/25/15, indicated he had osteoarthritis with worsening right hip pain, rated his pain as 7, and indicated the pain affected his sleep and mood. R154 Pain Data Collection form dated 11/28/15, indicated R154 had pain in the last 5 days that was frequent on all of his back and whole leg. The form indicated the resident rated his pain at a 6 (on a scale from 1-10, with 10 being the worst pain) and had vocal complaints and facial expressions of pain daily. In addition, the pain was stabbing, pain meds relieved the pain, pain increased with movement, the pain did not disrupt his sleep at night or limit his day to day activities, had no changes in appetite/eating ability, and was on a scheduled pain medication regimen. Under Resident/Family Education indicated, "Resident c/o increased pain (nothing new) over a few days. Goal is tolerable pain. PRN's to be offered as needed." A Pain Data Collection dated 2/7/16, indicated R154 had pain in his entire back and right lower extremity, rated his pain at a 5, made protective body movements or postures due to pain, limited day-to-day activities because of pain, decreased interest pursuits, and had irritability and anger. The Pain Data Collection also indicated he had not received PRN pain medication and the, "Current Treatment plan addresses resident's pain". R154's current physician orders dated February 2016, indicated he received Oxycodone HCL (hydrochloride) 5 milligrams (mg) (a narcotic analgesic used for moderate to severe pain) one	2 830		

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2 830	Continued From page 8	2 830		

tablet three times a day for pain. The orders indicated the start date of the medication was 8/14/15. R154 also had an order for Oxycodone HCL 5 mg every four hours as needed for pain; do not exceed six tablets per day with a start date of 6/26/15. R154 also had an order for Tylenol 325 mg two tablets by mouth every 4 hours as needed for headache pain with a start date of 5/31/15.

R154's medication administration record (MAR) dated 2/1/16, to 2/10/16, at 2:31 p.m. indicated R154 did not receive any of his PRN pain medications.

A HealthPartners Subsequent Visit dated 11/6/15, indicated R154 had gout in his knee and the physician had increased allopurinol (a medication used for gout) and added cholchicine (medication used for gout), and he had been receiving morephine (a pain medication for severe pain), however, his morphine tablets were stopped due to sedation and needing narcan (reverses the effects of opioid).

A HealthPartners Subsequent visit dated 1/4/16, indicated R154 used a scooter for mobility and his "Mobility limited by chronic right lower ext pain."

A Park Nicollet Senior Services Nursing Home Visit Note dated 2/3/16, indicated he was new to Park Nicollet team, and R154 had chronic pain syndrome and had been on narcotics for several years and was receiving oxycodone three times a day as well as prn. There was no indication if the current pain regimen was effective.

During interview on 2/8/16, 6:43 p.m. R154 stated he felt his leg pain was getting worse, he wanted

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2 830	Continued From page 9 his pain medications increased, and he had told the nurses he wanted more pain medication, however, "I get no answer and they [the nurses] say they will contact the nurse practioner. I never heard back and I ask again and never hear back. The nurse practioner comes and see's me but rarely. I haven't had a chance to talk to her about the pain, she doesn't come and ask me about my pain. They are doing nothing for me." R154 stated his pain was at an 8. During a follow up interview 2/10/16, at 12:44 p.m. R154 stated he had an order for oxycodone but it didn't help, so he doesn't take the PRN. R154 stated his pain was usually at an 8 and sometimes a 10 and that he is very rarely at a level of 5. During interview 2/10/16, at 1:01 p.m. nursing assistant (NA)-B stated she worked with R154 and he has a lot of pain in his right leg and his back, and because of the pain R154 would refuse to transfer or ambulate, and at times would just stay in bed because of the pain. During observation 2/10/16, at 2:27 p.m. NA-C was observed to transfer R154 in his room. NA-C situated a chair at a 45 degree angle from the bed and placed a four wheeled walker (4WW) in front of R154 with the brakes applied. R154 briefly repositioned himself in his wheelchair and an audible sigh and vocalization of "Ah" were noted. NA-C asked "Are you hurting today?...Where?" R154 stated "Yes... my hands, my legs." Once all set up to transfer, NA-C said "Take your time" several times as R154 made his first attempt to stand. As he began to bear weight on his legs and feet he yelled out "Ow" and quickly returned to a seated position back in his	2 830		

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2 830	Continued From page 10 wheelchair. He was breathing quickly and heavily, and then began the 2nd attempt to transfer, and again was observed to breath heavily with his mouth open and eyes tightly closed, as he took steps to turn his back to the bed. With contact guard assist he stood from his wheelchair and placed his hands on the 4WW. The NA repeated several times "Take your time... do you want me to get a nurse for you?" R154 declined for the aide to get the nurse. Once seated on the bed, R154 stated his pain level was 10/10. During the transfer his right knee was visibly shaking. Review of R154's progress notes/orders indicated the following: -On 2/3/16, 4:26 p.m. Communication/Visit with Physician Note Text: "Labs from today called to NP (nurse practioner). Also questioning tens (Transcutaneous Electrical Nerve Stimulation which is predominately used for nerve related pain conditions) unit for residents pain in his right knee if that was possible per resident request. Awaiting return call." -A physician order was received 2/11/16, eight days after the request for physical therapy to evaluate right knee pain and appropriateness of tens unit. -On 2/4/16, at 3:00 p.m. staff approached to walk resident but he refused due to pain. -On 2/5/16, at 8:58 p.m. resident refused to walk. -On 2/9/16, at 10:00 p.m. patient did not walk to dinner. He wheeled himself out in his electric wheelchair. -On 2/10/16, at 3:24 p.m. Communication/Visit	2 830		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 830	Continued From page 11 with Physician Note Text: NP updated on residents c/o pain in bilateral hands. Resident continues to c/o "sharp pain" in his hands. He denied that it is radiating from anywhere. He has requested PRN pain pills this shift, with little relief. Continue to monitor and update NP. - On 2/10/16, at 10:01 p.m. resident refused shower, "Stating have been in pain all day." Pain meds were administered. During interview on 2/10/16, at 1:15 p.m. trained medical assistant (TMA) stated R154 had been having increased pain and he asked for a PRN today and had been asking more for his pain medication. During interview on 2/10/16, at 2:30 p.m. registered nurse (RN)-A stated she was the manager for R154's unit and was not aware R154 was having pain. RN-A stated he had recently switched to a new doctor and his previous nurse practioner and physician were not very receptive to additional pain medication requests from the nurses. In addition RN-A stated she was not aware a request for a tens unit was made and she would call the NP and re-request the order. During interview on 2/11/16, at 9:31 a.m. RN-F stated she worked the day shift and R154 usually had a pain rating of 7/10, and recently the resident has had increased complaints of pain. During interview on 2/11/16, at approximelty 1:50 p.m. NA-C stated R154 complained of pain in the morning and afternoons and had been requesting his pain medication more often, and felt in the last three weeks R154's pain has been increasing. Although R154 reported increased pain, was	2 830		

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	00898	A. BUILDING: _____ B. WING _____	02/11/2016

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2 830	Continued From page 12 refusing to ambulate, and was observed to be in the pain, the facility did not reassess to determine if any further interventions could be implemented to decrease the residents pain. A facility policy titled Pain Management-Resident Assistance policy issued September 2012, indicated the purpose was to provide resident assistance in pain management and, "All residents will receive interdisciplinary consultations on assistance in managing pain." The policy futher indicated "The registered nurse will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological as well as pharmacological. The registered nurse will review response to medication interventions and work closely with the physician to assist in the individualized pain measurement plan." SUGGESTED METHOD OF CORRECTION: The DON or designee could train all staff and monitor to ensure all residents are assessed for pain and receiving appropriate nursing care and treatment. The DON or designee could report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include:	2 840		3/16/16

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2 840	Continued From page 13 B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident, if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors.	2 840		

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2 840	Continued From page 14 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure timely toileting in accordance with assessed needs, in order to maintain as much urinary function as possible, for 1 of 3 residents (R37) reviewed for urinary incontinence. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37's cognition was intact, was frequently incontinent of both bladder and bowel, was not on a toileting program, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility. R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was non-weight bearing on her right, lower extremity, and required a total lift with assistance from two staff to transfer. The CAA identified R37 required maximum assistance with toileting, had functional incontinence, was at an increased risk for urinary incontinence and infection due to a previous UTI, and may have had increased urinary frequency secondary to her use of diuretic medications. R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility. The care plan directed staff to, "Offer and assist with toileting "every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. During a telephone interview on 2/8/16, at 7:36	2 840	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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2 840	Continued From page 15 p.m. family member (FM)-A stated staff did not assist R37 with toileting timely, and she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed. During a continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting or checked/ changed for two hours and 37 minutes. Observations included the following: At 7:23 a.m., R37 was lying in her bed and nursing assistant (NA)-G was present in the room. At 7:30 a.m., NA-G checked/ changed R37's incontinence product before she was assisted to sit in her wheelchair, using a mechanical lift and two staff to transfer her. At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal. At 9:00 a.m., R37 was moved from the dining room, to an alcove/ day room area (across from the dining room), where she watched television with two of her peers. At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and stated, "See how late they get?" R37 stated she had not yet received her morning medications, nor had she been assisted with her exercises, and was sighing as she was talking. At 9:40 a.m. R37 asked the surveyor to find a staff member to assist her, and Registered nurse (RN)-G was made aware of R37's request for assistance. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light and exited the room. RN-G did not offer toileting assistance, nor did she check/ change R37. At 9:57 a.m., NA-G entered R37's room and offered to assist her into bed. R37 accepted and NA-G sought another staff person to assist with	2 840		

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2 840	Continued From page 16 the transfer. At 10:05 a.m., while NA-G had again stepped out of the room to find another staff person, R37 stated staff did not offer her use of the toilet, commode or bedpan for toileting, and stated she did not believe she could use the toilet or commode because of her leg injury and non-weight bearing status. At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed, and NA-G then proceeded with changing R37's incontinence brief, with two hours and 37 minutes between changes. R37 was not offered use of a toilet or bedpan. At 10:17 a.m., NA-G stated R37 was to be checked/ changed every two hours and did not use a bedpan or toilet because she was always incontinent, and NA-G confirmed R37's incontinence brief contained a small void of urine. Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including toileting/ use of a bedpan and checking/ changing her incontinence product. During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting or checked/ changed for three hours and five minutes. Observations included the following: At 8:23 a.m., R37 was seated at the dining room table waiting for breakfast. At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached the resident, brought her to her room, administered eye drop medication, and then returned R37 to the day room. RN-H did not offer to toilet or check/ change R37. At 10:09 a.m., NA-A approached R37 and asked	2 840		

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2 840	Continued From page 17	2 840		

if she wanted to lay down. R37 declined this offer, however, NA-A did not offer to toilet or check/ change R37.
At 10:31 a.m., an activities staff invited R37 to attend an exercise group, which R37 declined and remained seated in her wheelchair in the day room.
At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed every two hours, using a mechanical lift to transfer her into bed. NA-A stated R37 was last checked/ changed at 8:00 a.m. and stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined. NA-A stated she interpreted R37's response as a refusal to be checked/ changed, and typically she would approach R37 every two hours and ask if she wanted to lay down, which is when she would check and change R37. NA-A stated R37 did not use a toilet or commode because she required a mechanical sling lift for transfers, and stated R37 did not use a bedpan either. NA-A then proceeded with assisting other residents and R37 had still not been offered to toilet or be checked/ changed.
At 11:05 a.m., the surveyor asked NA-A when R37 would be offered toileting again, and NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought her to her room before seeking a second staff person to help with the transfer. NA-A returned and RN-H entered the room to assist with transferring R37 to bed and checking/ changing her incontinence brief, with three hours and five minutes between changes.
At 11:29 a.m., NA-A stated R37 had a small bowel movement and a small void of urine in her incontinence brief. Though staff were not observed offering R37 the use of a bedpan during

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2 840	Continued From page 18 this observation, NA-A stated she did offer the bedpan and R37 declined. During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be toileted every two hours and was usually incontinent. RN-H stated that she and NA-A did offer a bedpan to R37 during the above noted observation, but R37 declined. RN-H stated that she felt NA-A's offer for R37 to lay down did constitute an offer for toileting or checking/ changing, and R37's decline to this offer equated a refusal. During interview on 2/11/16, at 3:01 p.m. RN-A confirmed R37 was to be offered the use of a bedpan every two hours, and should have been offered a bedpan despite identification of urine or bowel in her incontinence brief. RN-A stated an offer to lay down in bed was not indicative of an offer for toileting or checking/ changing, and R37's declining to lay down did not equate a refusal for toileting. RN-A stated staff should have specifically asked if she would have liked to have her brief changed and use the bedpan, and staff were not following R37's care planned interventions for toileting. The facility's Bowel and Bladder Assessment Evaluation and Retraining policy dated 9/12, directed staff to ensure each resident with bowel or bladder incontinence received appropriate treatment and services to restore as much normal bowel or bladder function as possible. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures to ensure that residents who require assistance	2 840		

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2 840	Continued From page 19 with toileting receive timely services. The director of nursing (DON) or designee could educate staff as appropriate. The director of nursing (DON) or designee could monitor or audit to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 840		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting and repositioning were completed as assessed to prevent pressure ulcers for 1 of 3 residents (R37) reviewed who was identified at risk for pressure	2 900	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3/16/16

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2 900	Continued From page 20 ulcer development. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility. R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was weak, de-conditioned, and non-weight bearing on her right, lower extremity. The CAA identified a goal for R37 to remain free from skin breakdown related to incontinence and use of an incontinence brief. R37's Positioning Assessment & Evaluation dated 1/3/16, identified R37 required total assistance with repositioning and directed staff to offer repositioning every two hours. R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift. R37's Braden Scale for Predicting Pressure Sore Risk dated 2/6/16, indicated a score of 16/18, identifying R37 was at mild risk for the development of pressure ulcers.	2 900		

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2 900	Continued From page 21 During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated R37 did not get assisted with toileting timely, and stated she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed. During continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes. Observations included the following: At 7:23 a.m., R37 was lying in bed and nursing assistant (NA)-G was present in the room. At 7:30 a.m., NA-G checked/ changed R37's incontinence product before assisting R37 to sit in her wheelchair using a mechanical lift and two staff to transfer. At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal. At 9:00 a.m., R37 was moved from the dining room after breakfast, to an alcove/ day room area (across from the dining room), where the resident watched television with two of her peers. At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and R37 stated, "See how late they get?" The resident stated she had not yet received her morning medications, nor had she been assisted with her exercises, and R37 visibly and audibly sighed several times. At 9:40 a.m. R37 asked the surveyor to find a staff member on her behalf and registered nurse (RN)-G was asked to assist R37. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light, and exited the room. RN-G did not offer toileting, checking/ changing or turning/ repositioning to R37. At 9:57 a.m., NA-G entered R37's room and	2 900		

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2 900	Continued From page 22 offered to assist her into bed. R37 accepted and NA-G got another staff member to assist with transferring R37 into bed. At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed and proceeded to change R37's incontinence brief, with two hours and 37 minutes between changes. NA-G confirmed R37's incontinence brief contained a small void of urine. R37 was not observed to offload or reposition herself during this observation. At 10:17 a.m., NA-G stated R37 was to be checked/ changed, and turned/ repositioned every two hours. Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including turning/ repositioning and checking/ changing her incontinence product. During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes. Observations included the following: At 8:23 a.m., R37 was seated at the dining room table, awaiting her breakfast meal. At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached her, brought her to her room, administered eye drop medication and then returned R37 to the day room. RN-H did not offer to toilet or check/ change, or reposition R37. At 10:09 a.m., NA-A approached R37 and asked if she wanted to lay down. R37 declined to lay down, however, NA-A did not offer to toilet, check/ change her brief, or offer to reposition or offload R37. No encouragement or education was provided to prevent skin breakdown.	2 900		

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2 900	Continued From page 23 At 10:31 a.m., an activities staff invited R37 to attend an exercise group. R37 declined this offer and remained seated in her wheelchair in the day room. At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed and turned/ repositioned every two hours, using a mechanical lift to transfer her into bed. NA-A stated R37 was last checked/ changed and turned/ repositioned at 8:00 a.m. NA-A stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined to lay down. NA-A stated she interpreted R37's response as a refusal to be checked/ changed and/ or repositioned. NA-A stated she attempted to approach R37 every two hours and ask if she wanted to lay down, and if the resident agreed to lay down staff would check and change her. NA-A then proceeded with assisting other residents, and R37 had still not been offered to toilet and/or checked/ changed or turned/ repositioned. At 11:05 a.m., the surveyor asked NA-A when staff would expect to offer toileting, checking/ changing and turning/ repositioning to R37, at which time NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought the resident to her room, and asked RN-H to assist. NA-A and RN-H proceeded with transferring R37 to her bed and checked and changed her incontinence brief, with three hours and five minutes between changes and offloading. R37's bottom was observed as slightly pink, but blanchable, which RN-H confirmed. At 11:29 a.m., NA-A stated when changing R37's brief she had a small bowel movement and a small void of urine in her incontinence brief.	2 900		

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	00898	A. BUILDING: _____ B. WING _____	02/11/2016

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2 900	Continued From page 24 During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be repositioned and toileted every two hours and was usually incontinent. RN-H stated she felt NA-A's offer for R37 to lay down did constitute an offer for turning/ repositioning and toileting or checking/ changing, and stated if R37's decline to lay down, that was considered a refusal for toileting and repositioning. During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing; and R37's declining to lay down did not equate refusals for these cares. RN-A stated the facility staff should have specifically asked if she would have liked to be repositioned to offload her bottom, have her brief changed, and utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. The facility's policy titled Skin Assessment, Pressure Ulcer Prevention, and Documentation Requirements dated 12/15, directed, "Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches." SUGGESTION METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise the current policy and procedures on pressure ulcers. The DON or designee could provide education to all staff on turning and repositioning schedules. The DON or designee could provide monitoring for compliance to treatment and prevention of	2 900		

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2 900	Continued From page 25 pressure ulcers and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 900		
21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure dental follow up appointments were completed for 1 of 3 residents (R15) reviewed for dental services. Findings include: R15's significant change Minimum Data Set (MDS) dated 1/6/16, indicated the resident had moderate cognitive impairment and need for extensive assistance to complete activities of daily living. R15's care plan dated 2/10/16, directed staff to	21325	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3/16/16

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21325	Continued From page 26 provide resident with assistance to complete dressing and grooming, and the resident performed oral care independently. During interview on 2/9/16, at 10:42 a.m. R15 stated he had missing teeth on the upper right side of his mouth and had been seen for evaluation by the dentist because of the missing teeth and discomfort on the right side of his upper jaw. R15 stated he had understood there was to be a follow up appointment, however, he had heard nothing regarding this since his last visit with the dentist. During observation on 2/10/16, at 1:03 p.m. R15 was observed eating his meal with no visible problems chewing. During interview at this time, R15 stated he continued to have discomfort on the upper right side of his mouth with chewing, and again stated he had broken teeth and, "I was supposed to follow up a long time ago [with the dentist], and I haven't heard anything." Review of the Apple Tree Coon Rapids progress note dated 9/10/15, indicated (R15) was seen on that date for a recall exam. The progress note indicated, "Diagnosis/Assessment: Caries risk: High;rampant decay . See oral exam form. Tooth #12 and 13 had buccal cusps have fractured off; non-restorable, Recommend extractions " Several no [sic] cavities noted since last exam." Treatment recommendations were made for fillings and extractions, in addition to follow up for prophylaxis treatment every three months. Review of R15's medical records indicated the resident had no further follow up dental appointments, nor were there any follow up dental appointments scheduled.	21325		

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21325	Continued From page 27 During interview on 2/11/16, at 1:55 p.m. registered nurse (RN)-A stated it appeared the dental recommendations were not processed because when a follow up of recommendation of appointments is completed, the nurse will write, "Noted," on the form. A review of R15's record indicated there had been no follow up or communication with Apple Tree dental services since R15's visit of 9/10/15. A review of the policy titled Dental/Oral Health Services and Assessments, issued September 2012, indicated the purpose of dental assessments was for treatment to begin as early as necessary. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review and revise policies and procedures to ensure dental services are provide. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21325		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and	21685		3/16/16

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21685	Continued From page 28 well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely repair of the walk-in cooler to ensure adequate temperatures were maintained. This had the potential to affect all 66 residents who ate in the facility. Findings include: On 2/8/16, at 1:12 p.m. an initial tour of the facility's kitchen was conducted with certified dietary manager (CDM), and the door of the walk-in cooler was observed resting slightly open and was not sealed shut. CDM stated the door no longer automatically sealed and had to be pressed shut after each entry, and he had already informed the maintenance department of this issue. On 2/11/16, at 1:23 p.m. a follow-up tour was conducted with CDM and the walk-in cooler was again observed to be resting slightly open/ not sealed shut. CDM stated again he had informed maintenance of the door/seal needing repair approximately two weeks prior, however, the facility had experienced a turn-over of maintenance personnel and he suspected the departments response time to maintenance requests may have been somewhat delayed as a result. CDM was unable to provide any documentation regarding the request for the repair, and stated he did not document the request but just spoke to the maintence department. During this follow-up tour, cook-A	21685	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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21685	Continued From page 29 entered and exited the walk-in cooler, but failed to press the door shut behind him, leaving the door to rest slightly opened/ unsealed, until CDM noticed and pressed the door closed. During interview on 2/11/16, at 4:13 p.m. the environmental services director (ESD) reported he had started working at the facility approximately three weeks prior. He stated he was not aware of the facility's walk-in cooler door not sealing. He stated the facility had a maintenance log where staff entered needs or requests for repairs, and stated the walk-in cooler door was not identified in the log as per the facility's process. ESD stated though some of the preventative maintenance tasks were slightly back logged, he was on schedule with maintenance/ repair requests, and stated if he had known about the issue, he would have repaired it immediately. The facility's Food Storage policy dated 2/16, directed the CDM was responsible for monitoring refrigerator temperatures. The policy added, repair needs were to be brought to the attention of maintenance staff. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop, review, and revise policies and procedures to ensure kitchen equipment was maintained appropriately. The administrator or designee could educate all appropriate staff on the policies and procedures. The administrator or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one	21685		

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21685	Continued From page 30 (21) days	21685		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity with toileting needs for 2 of 5 residents (R163 and R154) observed for toileting. Findings include: R163's quarterly Minimum Data Set (MDS) dated 12/21/15, indicated the resident was cognitively intact, needed extensive assist with toileting, and was frequently incontinent of urine. R163's care plan dated 10/08/15, indicated he had bladder incontinence and wore briefs. During observation 2/10/16, at 6:51 a.m. R163 was sitting in his recliner chair, and a soiled, white incontinence brief was observed from the hall way sitting on the floor behind his wheelchair. During interview 2/10/16, at 6:52 a.m. R163 stated he was not aware the incontinence pad was on the floor next to him and stated, "I have grand kids I would not want them to see that."	21805	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3/16/16

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21805	Continued From page 31 During interview 2/10/16, at 7:00 a.m. registered nurse (RN)-E stated the pad should not be on the floor for people to see, and RN-E then entered the room and removed the pad. R154's quarterly MDS dated 11/12/15, indicated he was cognitively intact, needed extensive assistance with toileting, and was frequently incontinent of urine. R154's care plan dated 9/01/15, indicated he had bladder incontinence and preferred a urinal or toilet, and wore a brief. During interview 2/10/16, at 7:12 a.m. R154 stated at times his call light was left on for over 30 minutes, and stated, "I am in bed wanting to go into the bathroom. It's embarrassing when I have to tell them I peed by pants again, please change me." R154 stated he had incontinence episodes every day because he had to wait so long for staff to answer, especially at night. A Bowel and Bladder Documentation Survey Report dated from 2/1/16, to 2/11/16, R154 was incontinent of urine five times at 7:00 p.m. During interview 2/11/16, at 10:58 a.m. RN-A stated the facility does random call light audits, however, they were not able to do a computerized print out to see how long R154's call light was being left on. RN-A was able to provide one call audit on 1/28/16, however, only the morning hours were included, and the facility was unable to provide any evening audits. A facility policy titled Resident Dignity dated February 2013, indicated, "The facility will promote care for residents in a manner and in an	21805		

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21805	Continued From page 32 environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." The policy further indicated "Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a residents request for toileting." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could educate staff on dignity and respect. The DON or designee could then interview residents routinely to ensure residents feel their dignity and respect are being maintained. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21805		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless: (1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or (2) the reporter knows or has reason to believe	21980		3/16/16

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21980	Continued From page 33 that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4). (b) A person not required to report under the provisions of this section may voluntarily report as described above. (c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point. (d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency. (e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator according to the facility abuse and neglect policy for 2 of 2 residents (R20 and R65) who made allegations of	21980	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	

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21980	Continued From page 34 staff mistreatment. Findings include: A facility Policy titled Abuse And Neglect revised 9/13, indicated "Notify the location administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse, and injury of unknown origin, neglect, financial exploitation or involuntary seclusion. In case absence of the administrator, follow the chain of command for notification (DNS, SW, etc)... Document this notification. "Immediately," in this procedure means "as soon as possible after discovery of the incident, and ought not to exceed the end of the shift, in the absence of a shorter state time frame requirement." The policy also directed staff to notify the designated stated agency immediately, and to interview staff, residents, or other witnesses to the incident. R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s. R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit related to cerebral vascular accident (CVA). A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant) [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath.	21980		

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21980	Continued From page 35 [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility investigated R20's allegation of mistreatment, it was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident, and not immediately according to the facility policy. During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they	21980		

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21980	Continued From page 36 needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations needed to be reported immediately to the state agency prior to a full investigation according to the facility policy. Although R20 made an allegation of abuse the facility investigated the incident, and did not notify the state agency, nor did they notify the administrator immediately according to facility policy. R65's quarterly MDS completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living. R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary. During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident, and reported it to a nurse. A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21980	Continued From page 37 the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency according to the facility policy, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency according to the facility policy because the other interviewed residents all felt safe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could in-service all staff on the need to follow the facility abuse policy in regards to immediately reporting suspected abuse to the designated state agency, document re-education of staff. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21995	Continued From page 38	21995		
21995	MN St. Statute 626.557 Subd. 4a Reporting - Maltreatment of Vulnerable Adults Subd. 4a. Internal reporting of maltreatment. (a) Each facility shall establish and enforce an ongoing written procedure in compliance with applicable licensing rules to ensure that all cases of suspected maltreatment are reported. If a facility has an internal reporting procedure, a mandated reporter may meet the reporting requirements of this section by reporting internally. However, the facility remains responsible for complying with the immediate reporting requirements of this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator, for 2 of 2 residents (R20 and R65) whose made allegations of staff mistreatment. Findings include: R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s. R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit related to cerebral vascular accident (CVA). A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant)	21995	THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	3/16/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21995	Continued From page 39 [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath. [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility investigated R20's allegation of mistreatment, it was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident. During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the	21995		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21995	Continued From page 40	21995		

resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations need to be reported immediately to the state agency.

R65's quarterly MDS, completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living.
R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.
During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident, and reported it to a nurse.

A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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
21995	Continued From page 41 [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency because the other interviewed residents all felt safe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could in-service all staff on the need to immediately report suspected abuse/neglect to the designated state agency. The director of nurses could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Twenty one (21) days	21995		

Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

MINNESOTA MDH DEPARTMENT of HEALTH

Confirmation page! Thank you for using the data entry system.
If you have comments please send to:
monica.larson@health.state.mn.us

Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-672 form for data entry?	Go to CMS-672
I'm finished and would like to exit the application.	Exit

Standard Survey Date Format: mm/dd/yy From F1: **02/08/16** To F2: **02/11/16**	Extended Survey Date Format: mm/dd/yy From F3: To F4:	
Name of Facility: **GOOD SAMARITAN SOCIETY - AMBAS**	Provider Number: **245149**	Fiscal Year ending:
Address: **8100 MEDICINE LAKE ROAD, NEW HOPE, HENNEPIN, MN 55427**		
Telephone Number: F6 **763-544-4171**	State/County Code: **MN / HENNEPIN**	State/Region Code: **MN / 05**
A. F9 **01 - Skilled Nursing Facility (SNF) - Medicare Participation** B. Is this facility hospital based? F10 **No** If yes, indicate Hopsital Provider Number: F11		
Ownership: F12 **05 - Non Profit - Nonprofit Corporation**		
Owned or leased by Multi-Facility Organization: F13 **Yes** Name of Multi-Facility Organization: F14 **The Evangelical Lutheran Good Samarita**		
Dedicated Special Care Units (show number of beds for all that apply)		
AIDS F15 **0** Dialysis F17 **0** Head Trama F19 **0**	Alzheimer's Disease F16 **0** Disabled Child Young Adult F18 **0** Hospice F20 **0**	

Huntington's Disease F21 **0** Ventilator/Respiratory Care F22 **0**
Other Spec Rehab. F23 **33**

Does the facility currently have an organized resident group? F24	**Yes**
Does the facility currently have an organized group of family members of residents? F25	**No**
Does the facility conduct experimental research? F26	**No**
Is the facility part of a continuing care retirement community (CCRC)? F27	**No**

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of the last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement.	Date: mm/dd/yy F28	Hours waived per week: F29
Waiver of 24 hr licensed nursing requirement.	Date: mm/dd/yy F30	Hours waived per week: F31

Does the facility currently have an approved nurse aide training and competency program? F32	**No**

The following three questions are to be completed by the survey team.

1) Was this a staggered Survey?	**No - Not Staggered**
2) If staggered, day of the week starting?	**Surveyor to Complete**
3) If staggered, starting time?	**Surveyor to complete AM**

FACILITY STAFFING

		A	B	C	D
	Tag #	Services Provided 1 2 3	Full-Time Staff (hours)	Part-Time Staff (hours)	Contract (hours)
Administration	F33		**272**	**249**	**0**
Physician Services	F34	**Yes No No**			
Medical Director	F35		**0**	**0**	**4**
Other Physician	F36		**0**	**0**	**0**
Physician Extender	F37	**No No No**	**0**	**0**	**0**

Nursing Services	F38	Yes No No			
RN Director of Nursing	F39		80	0	0
Nurses with Admin Duties	F40		472	0	0
Registered Nurses	F41		1163	3	0
Licensed Practical/ Vocational Nurses	F42		575	58	0
Certified Nurse Aides	F43		1490	521	0
Nurse Aides in Training	F44		0	0	0
Medication	F45		227	114	0
Pharmacists	F46	Yes No No	0	0	8
Dietary Services	F47	Yes No No			
Dietitian	F48		59	0	0
Food Service Workers	F49		443	142	0
Therapeutic Services	F50				
Occupational Therapist	F51	Yes No No	90	0	0
Occupational Therapy Assistant	F52		281	0	0
Occupational Therapy Aides	F53		0	0	0
Physical Therapist	F54	Yes No No	94	0	0
Physical Therapy Assist	F55		150	0	0
Physical Therapy Aides	F56		0	0	0
Speech/Language	F57	Yes No No	74	0	0
Therapeutic Recreation Spec.	F58	No No No		0	0
Qualified Activities Prof.	F59	Yes No No	156	0	0
Other Activities Staff	F60	Yes No No	61	27	0
Qualified Social Workers	F61	Yes No No	160	0	0

Other Social Services Staff	F62	Yes No No	76	12	0
Dentists	F63	Yes No No	0	0	0
Podiatrists	F64	Yes No No	0	0	0
Mental Health Services	F65	Yes No No	0	0	4
Vocational Services	F66	No No No			
Clinical Laboratory Services	F67	No No No			
Diagnostic X-ray Services	F68	No No No			
Administration Storage of Blood	F69	No No No			
Housekeeping Services	F70	Yes No No	276	196	0
Other	F71		0	58	0
Name of Person Completing Form: **marie barta**					Date: **02/16/16**

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See also > Compliance Monitoring Home

For questions about this page, please contact our Compliance Monitoring Division: health.fpc-web@state.mn.us

- Certificates & Records
- Data & Statistics
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- Emergency Preparedness
- Environments & Your Health
- Facilities & Professions
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- Injury, Violence & Safety
- Life Stages & Populations
- Policy, Economics & Legislation
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Minnesota Department of Health
Protecting, maintaining and improving the health of all Minnesotans

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Please print this page and give it to your state survey team. A page for both the CMS-671 and CMS-672 will be required to complete the process.	Print this Page
Would you like to go to the CMS-671 form for data entry?	Go to CMS-671
I'm finished and would like to exit the application.	Exit

GOOD SAMARITAN SOCIETY - AMBAS				
Provider No. **245149**	Medicare F75 **15**	Medicaid F76 **17**	Other F77 **39**	Total Residents F78 **71**

ADL	Independent	Assist of One Two Staff	Dependent
Bathing	F79 **1**	F80 **63**	F81 **7**
Dressing	F82 **3**	F83 **62**	F84 **6**
Transferring	F85 **8**	F86 **51**	F87 **12**
Toilet Use	F88 **5**	F89 **58**	F90 **8**
Eating	F91 **61**	F92 **5**	F93 **5**

A. Bowel/Bladder Status	**B. Mobility**
F94 **9** With indwelling or external catheter.	F100 **3** Bedfast all or most of time..
F95 Of total number of residents with catheters, **9** were present on admission.	F101 **47** In chair all or most of time.
	F102 **2** Independently ambulatory.

F96 **39** Occasionally or frequently incontinent of bladder.

F97 **29** Occasionally or frequently incontinent of bowel.

F98 **21** On individually written bladder training program.

F99 **0** On individually written bowel training program.

F103 **19** Ambulation with assistance or assistive device.

F104 **0** Physically restrained.

F105 Of total number of residents with restrained, **0** were admitted with orders for restraints.

F106 **6** With contractures.

F107 Of total number of residents with contractures, **6** had contractures on admission.

C. Mental Status

F108 **0** With mental retardation.

F109 **25** With documentation signs and symptoms of depression.

F110 **12** With documentation psychiatric diagnosis (excluding dementias and depression).

F111 **20** Dementia: multi-infarct, senile, Alzheimer's type, or other than Alzheimer's type.

F112 **6** With behavioral symptoms.

F113 **2** Of the total number of residents with behavioral symptoms, the total number receiving a behavior management prpgram.

F114 **0** Receiving health rehabilitative services for MI/MR.

D. Skin Integrity

F115 **1** With pressure sores (exclude stage I).

F116 **0** Of the total number of residents with pressure sores excluding stage I, how many residents had pressure sores on admission?

F117 **60** Receiving preventive skin care.

F118 **0** With rashes.

E. Special Care

F119 **10** Receiving hospice care benefit.

F120 **0** Receiving radiation therapy.

F121 **0** Receiving chemotherapy.

F127 **0** Receiving suction.

F128 **13** Receiving injections (exclude vitamin B12 injections)

F129 **2** Receiving tube feedings.

F122 **2** Receiving dialysis.	F130 **8** Receiving mechanically altered diets including pureed and all chopped food (not only meat).
F123 **0** Receiving intravenous therapy, parenteral nutrition, and/or blood transfusion.	F131 **35** Receiving specialized rehabilitative services (Physical therapy, speech-language therapy, occupational therapy).
F124 **6** Receiving respiratory treatment.	F132 **7** Assistive devices while eating.
F125 **0** Receiving tracheostomy care.	
F126 **2** Receiving ostomy care.	

F. Medication	**G. Other**
F133 **40** Receiving any psychoactive medication.	F140 **9** With unplanned significant weight loss/gain.
F134 **9** Receiving antipsychotic medications.	F141 **1** Who do not communicate in the dominant language of the facility (includes those who use sign language).
F135 **14** Receiving antianxiety medications.	F142 **2** Who use non-oral communicationdevices.
F136 **30** Receiving antidepressant medications.	F143 **41** With advance directives.
F137 **1** Receiving hypnotic medication.	F144 **65** Received influenza immunization.
F138 **4** Receiving antibiotics.	F145 **68** Received pneumococcal vaccine.
F139 **63** On pain management program.	

I certify that this Information is accurate to the best of my knowledge.		
Name of Person Completing	Title	Date
marie barta	**administrator**	**02/16/2016**

To be completed by MDH survey team.
F146 Was ombudsman office notified prior to survey? **Yes**
F147 Was ombudsman present during any portion of the survey? **No**
F148 Medication error rate **0%**

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245149	GOOD SAM SOCIETY AMBASSADOR

Type of Survey (select all that apply):

A	I	K			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

Please enter the workload information for each surveyor. Use the surveyor's information number.

Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 27955	02-08-2016	02-11-2016	0.25	1.25	29.50	3.25	2.50	0.00
2. 28598	02-08-2016	02-11-2016	0.50	1.25	26.50	3.50	1.25	18.75
3. 29437	02-08-2016	02-11-2016	0.25	1.25	29.75	3.00	2.50	7.00
4. Team Leader 34987	02-08-2016	02-11-2016	1.50	1.25	29.50	3.50	2.50	3.75
5. 35992	02-08-2016	02-11-2016	0.50	1.25	29.50	3.25	2.50	14.50
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 8.00

Total Clerical/Data Entry Hours..... 3.25

Was Statement of Deficiencies given to the provider on-site at completion of the survey? ..... Y

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245149	GOOD SAM SOCIETY AMBASSADOR

Type of Survey (select all that apply):

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
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H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A Routine/Standard (all providers/suppliers)
B Extended Survey (HHA or long term care facility)
C Partial Extended Survey (HHA)
D Other Survey

SURVEY TEAM AND WORKLOAD DATA

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1. 28598	02-10-2016	02-10-2016	0.00	0.00	3.00	0.00	1.25	0.00
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours..... 2

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINSTRATION

FORM APPROVED
OMB No. 0938-0391

SURVEY TEAM COMPOSITION AND WORKLOAD REPORT

Provider/Supplier Number	Provider/Supplier Name
245149	GOOD SAM SOCIETY AMBASSADOR

Type of Survey (select all that apply):

H	I	K			

A Complaint Investigation
B Dumping Investigation
C Federal Monitoring
D Follow-up Visit
E Initial Certification
F Inspection of Care
G Validation
H Life safety Code
I Recertification
J Sanction/Hearing
K State License
L Chow

Extent of Survey (Select all that apply):

A					

A Routine/Standard (all providers/suppliers)
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SURVEY TEAM AND WORKLOAD DATA

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Surveyor Id Number (A)	First Date Arrived (B)	Last Date Departed (C)	Pre-Survey Preparation Hours (D)	On-Site Hours 12am-8am (E)	On-Site Hours 8am-6pm (F)	On-Site Hours 6pm-12am (G)	Travel Hours (H)	Off-Site Report Preparation Hours (I)
1. 19251	02-12-2016	02-12-2016	1.00	0.00	3.00	0.00	3.00	0.00
2. Team Leader 37009	02-12-2016	02-12-2016	1.00	0.00	4.00	0.00	1.00	1.00
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								

Total Supervisory Review Hours 0.00

Total Clerical/Data Entry Hours.....

Was Statement of Deficiencies given to the provider on-site at completion of the survey? .....

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245149	**GOOD SAMARITAN SOCIETY - AMBASSADOR**	*K4 **02/12/2016**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 01

A

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [12] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]
1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]
4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]
7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[X]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

FIRE SAFETY SURVEY REPORT
CRUCIAL DATA EXTRACT
(TO BE USED WITH CMS-2786 FORMS)

PROVIDER NUMBER	FACILITY NAME	SURVEY DATE
K1 245149	**GOOD SAMARITAN SOCIETY - AMBASSADOR**	*K4 **02/12/2016**

K6 DATE OF PLAN APPROVAL

K3 : MULTIPLE CONSTRUCTION

TOTAL NUMBER OF BUILDINGS 2

NUMBER OF THIS BUILDING 02

[A]

A BUILDING
B WING
C FLOOR
D APARTMENT UNIT

LSC FORM INDICATOR

Health Care Form		
12	2786 R	2000 EXISTING
13	2786 R	2000 NEW

ASC Form		
14	2786 U	2000 EXISTING
15	2786 U	2000 NEW

ICF/MR Form		
16	2786 V, W, X	2000 EXISTING
17	2786 V, W, X	2000 NEW

*K7 [13] SELECT NUMBER OF FORM USED FROM ABOVE

(Check if K29 or K56 are marked as not applicable in the 2786 M, R, T, U, V, W, X, Y and Z.)

K29: [ ] K56: [ ]

COMPLETE IF ICF/MR IS SURVEYED UNDER CHAPTER 21

SMALL (16 BEDS OR LESS)

K8: [ ]

1 PROMPT
2 SLOW
3 IMPRACTICAL

LARGE

K8: [ ]

4 PROMPT
5 SLOW
6 IMPRACTICAL

APARTMENT HOUSE

K8: [ ]

7 PROMPT
8 SLOW
9 IMPRACTICAL

ENTER E-SCORE HERE

K5: [ ] e.g 2.5

*K9 : FACILITY MEETS LSC BASED ON: (*Check all that apply*)

A1	A2	A3	A4	A5
[ ]	[ ]	[ ]	[ ]	[ ]
(COMP. WITH ALL PROVISIONS)	(ACCEPTABLE POC)	(WAIVERS)	(FSES)	(PERFORMANCE BASED DESIGN)

FACILITY DOES NOT MEET LSC:

B. [ ]

K180:

A.	B.	C.
[X]	[ ]	[ ]
FULLY SPRINKLERED (All required areas are sprinklered)	PARTIALLY SPRINKLERED (Not all required areas are sprinklered)	NONE (No sprinkler system)

*MANDATORY

S5149026

MINNESOTA DEPARTMENT OF HEALTH
Division of Health Policy, Information and Compliance Monitoring
85 East Seventh Place, Suite 300, P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email for Administrator: mbarta@good-sam.com

National Provider Identifier (NPI) Number: 1114908878
One facility may have multiple NPI Numbers. Please verify the NPI number associated with the provider type for this survey, i.e. for a nursing home survey, the NPI Number will be associated with the Nursing Home.

OWNERSHIP INFORMATION AT THE TIME OF SURVEY

Name of Facility: GOOD SAM SOCIETY AMBASSADOR City: NEW HOPE

Name of Legal Entity Operating Provider: THE EVANGELICAL LUTHERAN GOOD SAMARITAN SOCIETY

Name and Address of Governing Board President:

Name: DAVID HORAZDOVSKY
Address: 1112 EAST DOVE TRAIL
City/State/Zip: SIOUX FALLS, ~~MN~~ SD 57108

If legal entity or president of the governing board is different than what is noted above, please provide the information below.

Name of Facility: _____ City: _____

Name of Legal Entity Operating Provider: _____

Name and Address of Governing Board President:

Name: _____
Address: _____
City/State/Zip: _____

SIGNATURE

Completed by: Marie Barta
Title: Administrator
Date: 2-8-16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A standard recertification survey was conducted and a complaint investigation(s) was also completed at the time of the standard survey. An investigation of complaint H5149028 was not substantiated during this survey.	F 000		
F 225 SS=D	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse,	F 225		

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

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
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 225	Continued From page 1	F 225		

including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification 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 allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator, for 2 of 2 residents (R20 and R65) whose made allegations of staff mistreatment.

Findings include:

R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 225	Continued From page 2	F 225		

R20's care plan dated 4/9/15, indicated the resident had a ADL self care performance deficit related to cerebral vascular accident (CVA).

A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant) [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath. [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 225	Continued From page 3	F 225		

investigated R20's allegation of mistreatment, it was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident.

During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations need to be reported immediately to the state agency.

R65's quarterly MDS, completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living.
R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.
During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 225	Continued From page 4 and reported it to a nurse. A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency, nor were any other staff interviewed as part of the investigation. When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been reported to the State agency because the other interviewed residents all felt safe.	F 225		
F 226 SS=D	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 226	Continued From page 5	F 226		

This REQUIREMENT is not met as evidenced by:
Based on interview and document review, the facility failed to ensure allegations of mistreatment were thoroughly investigated, reported to the state agency, and immediately reported to the administrator according to the facility abuse and neglect policy for 2 of 2 residents (R20 and R65) who made allegations of staff mistreatment.

Findings include:

A facility Policy titled Abuse And Neglect revised 9/13, indicated "Notify the location administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse, and injury of unknown origin, neglect, financial exploitation or involuntary seclusion. In case absence of the administrator, follow the chain of command for notification (DNS, SW, etc)... Document this notification. "Immediately," in this procedure means "as soon as possible after discovery of the incident, and ought not to exceed the end of the shift, in the absence of a shorter state time frame requirement." The policy also directed staff to notify the designated stated agency immediately, and to interview staff, residents, or other witnesses to the incident.

R20's quarterly Minimum Data Set (MDS) dated 12/22/15, indicated the resident had severe cognitive impairment, and required extensive assistance with activity's of daily living (ADL)'s.

R20's care plan dated 4/9/15, indicated the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 226	Continued From page 6	F 226		

resident had a ADL self care performance deficit related to cerebral vascular accident (CVA).

A Suggestion Or Concern report dated 1/4/16, indicated "[R20] requests that TMA/CNA (trained medical assistant/certified nursing assistant) [NA-D] no longer be in her room. Resident states that TMA/CNA "hollered" at her and swore at her on 1/1/16 while cares were being provided. Resident reports that CNA [NA-E] provided HS (bed time cares) and that during cares [NA-D] swore at her and "muttered" under her breath. [R20] reports that [NA-D] was "mean" to her while in her room with [NA-E] and states that she threatened her by stating, "I'm taking care of you tomorrow." Resident reports that she wants [NA-D] fired and wants something done abut this." The Investigation indicated, "Interviews with [NA-D] and [NA-E] were conducted. [NA-E] reports that he provided all HS cares for [R20] and that [NA-D] was told to stand by the wall and observe only. Both [NA-D and NA-E] report that no inappropriate words or tones were used by [NA-D] during the timeframe reported. [NA-E] reports that [R20] informed him on the day of question that she did not like [NA-D] and was going to "get her fired." The resolution indicated, "Care Plan includes 2 staff members in resident's room when providing cares. Resident has a history of making false allegations against staff and has difficulty adjusting to change. Resident's care plan was being followed at the time of the incident. Resident requests that [NA-D] not come in her room again, request will be respected and accommodated. [NA-D] advised to have the nurse pass medications to [R20] and switch with other team members for care needs. [NA-D] and [R20] agreeable to the plan." Although the facility investigated R20's allegation of mistreatment, it

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 7	F 226		

was not reported the state agency, and the concern form was signed by the administrator on 1/5/16, one day after the incident, and not immediately according to the facility policy.

During interview 2/10/16, at 12:14 p.m. registered nurse (RN)-A stated NA-D does not enter R20's her room per the residents request and the resident was to have two care givers in the room. RN-A stated R20 had a history of making false accusations of staff mistreatment, and RN-A stated after they confirmed with NA-E the allegation did not happen, they did not feel they needed to report it to the state agency. RN-A stated the facility does interview the residents or staff involved before they would make the decision as a team to report the incident to the state agency, and stated she was not aware that allegations needed to be reported immediately to the state agency prior to a full investigation according to the facility policy.

Although R20 made an allegation of abuse the facility investigated the incident, and did not notify the state agency, nor did they notify the administrator immediately according to facility policy.

R65's quarterly MDS completed 11/26/15, indicated R65 was cognitively intact and required extensive assistance of one to complete activities of daily living.
R65's care plan dated 02/09/16, identified R65 had hearing and visual deficits and directed staff to allow him adequate time to respond, and repeat things as necessary.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 226	Continued From page 8	F 226		

During interview on 2/8/16, at 5:15 p.m. R65 stated NA-F, "Picked me up and threw me into bed when I asked to go to bed." R65 stated this incident happened approximately three months prior, but was unable to provide a specific date. R65 stated NA-F, "Hit my head on the metal on the far side of the bed," which caused the resident to say, "Ow." R65 stated he received a sore spot on his head because of the incident, and reported it to a nurse.

A facility Suggestion or Concern form dated 12/29/15, identified R65 had reported a nursing assistant had, "Pick[ed] him up and threw him on the bed," and this had occurred, "Multiple times." The form identified a facility investigation into the incident, which included, "SW [social worker] met with resident who was unable to provide any further description of staff member ... Resident [R65] endorses feeling safe and denies being hurt ... Resident [R65] does have severe vision deficits and severe hearing difficult [sic]." SW interviewed five other residents in the same unit as R65 for potential abuse, however, there was no indication the allegation of mistreatment was reported to the state agency according to the facility policy, nor were any other staff interviewed as part of the investigation.

When interviewed on 2/9/16, at 12:20 p.m. SW stated R65 had reported a staff would wrap his arms around R65's chest and throw him on the bed without waiting for other staff to assist. R65 had been unable to identify a specific staff member, however, R65 reported he felt safe at the facility. SW stated the allegation of abuse identified on the concern form had not been

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	02/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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F 226	Continued From page 9 reported to the State agency according to the facility policy because the other interviewed residents all felt safe.	F 226		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to promote dignity with toileting needs for 2 of 5 residents (R163 and R154) observed for toileting. Findings include: R163's quarterly Minimum Data Set (MDS) dated 12/21/15, indicated the resident was cognitively intact, needed extensive assist with toileting, and was frequently incontinent of urine. R163's care plan dated 10/08/15, indicated he had bladder incontinence and wore briefs. During observation 2/10/16, at 6:51 a.m. R163 was sitting in his recliner chair, and a soiled, white incontinence brief was observed from the hall way sitting on the floor behind his wheelchair. During interview 2/10/16, at 6:52 a.m. R163 stated he was not aware the incontinence pad was on the floor next to him and stated, "I have grand kids I would not want them to see that."	F 241		

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During interview 2/10/16, at 7:00 a.m. registered nurse (RN)-E stated the pad should not be on the floor for people to see, and RN-E then entered the room and removed the pad.

R154's quarterly MDS dated 11/12/15, indicated he was cognitively intact, needed extensive assistance with toileting, and was frequently incontinent of urine.

R154's care plan dated 9/01/15, indicated he had bladder incontinence and preferred a urinal or toilet, and wore a brief.

During interview 2/10/16, at 7:12 a.m. R154 stated at times his call light was left on for over 30 minutes, and stated, "I am in bed wanting to go into the bathroom. It's embarrassing when I have to tell them I peed by pants again, please change me." R154 stated he had incontinence episodes every day because he had to wait so long for staff to answer, especially at night.

A Bowel and Bladder Documentation Survey Report dated from 2/1/16, to 2/11/16, R154 was incontinent of urine five times at 7:00 p.m.

During interview 2/11/16, at 10:58 a.m. RN-A stated the facility does random call light audits, however, they were not able to do a computerized print out to see how long R154's call light was being left on. RN-A was able to provide one call audit on 1/28/16, however, only the morning hours were included, and the facility was unable to provide any evening audits.

A facility policy titled Resident Dignity dated

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F 241	Continued From page 11 February 2013, indicated, "The facility will promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." The policy further indicated "Refraining from practices demeaning to residents such as keeping urinary catheter bags uncovered, refusing to comply with a residents request for toileting."	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure care plan interventions were followed by staff for 1 of 3 residents (R34) reviewed for accidents and for 1 of 3 residents (R37) reviewed for toileting and pressure ulcers. Findings include: R34's admission Minimum Data Set (MDS) dated 1/13/16, indicated R34 had moderate cognitive impairment, had cancer, anemia, and heart failure. The MDS indicated the resident needed extensive assist of two with transfers, toileting, dressing, bed mobility, was incontinent of bowel and bladder, and had no falls in the last month. R34's care plan dated 1/14/16, indicated the	F 282		

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resident had metastic breast cancer with brain mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach.

During observation 2/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor.

During observation 2/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank.

During interview 2/9/16, at 11:39 a.m. registered nurse (RN)-I stated the fall mat should be on the floor and the bed should be in the low position at all times. RN-I entered R34's room and placed the fall mat on the floor next to resident.

During observation 2/10/16, at 8:01 a.m. R34 was observed laying in bed and the bed was in the low position with fall mat on the floor. However, the residents call light was observed laying on the floor out of R34's reach. Director of nursing (DON) was informed of the call light being out of R34's reach, and she entered the residents room and gave her the call light.

During interview 2/10/16, at 12:31 p.m. RN-A stated she didn't know why R34's bed was not in the low position, and stated she had talked to the NA who was working with R34 on 02/9/16, and the NA stated she thought during a physician visit he had left the bed up. RN-A stated R34 was a

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fall risk and should have all the assessed interventions in place according to the care plan, including having the call light available because the resident will use it to call for staff assistance. R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility.

R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift.

During continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes.

During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing. RN-A stated the facility staff should specifically

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F 282	Continued From page 14 ask R37 if she would like to be repositioned to offload her bottom, have her brief changed, and utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. A facility Care Plan Policy dated September 2013, indicated, "Residents will receive and be provided the necessary care and services to maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing physical, functional, spiritual, emotional, psychosocial and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician's orders, any problems, needs and concerns identified will be addressed."	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively	F 309		

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reassess pain to ensure adequate interventions were in place to relieve pain for 1 of 1 residents (R154) with pain.

Findings include:

R154's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated he was cognitively intact and was on a scheduled pain regimen, received prn (as needed) pain medications, and had occasional to moderate pain.

R154's care plan dated 5/28/15, indicated he had chronic pain/discomfort related to osteoarthritis, gout, and neuropathy which was managed with medications. The care plan further instructed staff to, "Report to Nurse any change in usual activity attendance patterns or refusal to attend activities related to s/s (signs and symptoms) or c/o (complaints of) pain or discomfort. Notify health care provider if interventions are unsuccessful or if current complaint is a significant change from residents past experience of pain."

A Care Area Assessment (CAA) Worksheet dated 5/25/15, indicated he had osteoarthritis with worsening right hip pain, rated his pain as 7, and indicated the pain affected his sleep and mood.

R154 Pain Data Collection form dated 11/28/15, indicated R154 had pain in the last 5 days that was frequent on all of his back and whole leg. The form indicated the resident rated his pain at a 6 (on a scale from 1-10, with 10 being the worst pain) and had vocal complaints and facial expressions of pain daily. In addition, the pain was stabbing, pain meds relieved the pain, pain increased with movement, the pain did not disrupt

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his sleep at night or limit his day to day activities, had no changes in appetite/eating ability, and was on a scheduled pain medication regimen. Under Resident/Family Education indicated, "Resident c/o increased pain (nothing new) over a few days. Goal is tolerable pain. PRN's to be offered as needed."

A Pain Data Collection dated 2/7/16, indicated R154 had pain in his entire back and right lower extremity, rated his pain at a 5, made protective body movements or postures due to pain, limited day-to-day activities because of pain, decreased interest pursuits, and had irritability and anger. The Pain Data Collection also indicated he had not received PRN pain medication and the, "Current Treatment plan addresses resident's pain".

R154's current physician orders dated February 2016, indicated he received Oxycodone HCL (hydrochloride) 5 milligrams (mg) (a narcotic analgesic used for moderate to severe pain) one tablet three times a day for pain. The orders indicated the start date of the medication was 8/14/15. R154 also had an order for Oxycodone HCL 5 mg every four hours as needed for pain; do not exceed six tablets per day with a start date of 6/26/15. R154 also had an order for Tylenol 325 mg two tablets by mouth every 4 hours as needed for headache pain with a start date of 5/31/15.

R154's medication administration record (MAR) dated 2/1/16, to 2/10/16, at 2:31 p.m. indicated R154 did not receive any of his PRN pain medications.

A HealthPartners Subsequent Visit dated 11/6/15,

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indicated R154 had gout in his knee and the physician had increased allopurinol (a medication used for gout) and added cholchicine (medication used for gout), and he had been receiving morephine (a pain medication for severe pain), however, his morphine tablets were stopped due to sedation and needing narcan (reverses the effects of opioid).

A HealthPartners Subsequent visit dated 1/4/16, indicated R154 used a scooter for mobility and his "Mobility limited by chronic right lower ext pain."

A Park Nicollet Senior Services Nursing Home Visit Note dated 2/3/16, indicated he was new to Park Nicollet team, and R154 had chronic pain syndrome and had been on narcotics for several years and was receiving oxycodone three times a day as well as prn. There was no indication if the current pain regimen was effective.

During interview on 2/8/16, 6:43 p.m. R154 stated he felt his leg pain was getting worse, he wanted his pain medications increased, and he had told the nurses he wanted more pain medication, however, "I get no answer and they [the nurses] say they will contact the nurse practioner. I never heard back and I ask again and never hear back. The nurse practioner comes and see's me but rarely. I haven't had a chance to talk to her about the pain, she doesn't come and ask me about my pain. They are doing nothing for me." R154 stated his pain was at an 8.

During a follow up interview 2/10/16, at 12:44 p.m. R154 stated he had an order for oxycodone but it didn't help, so he doesn't take the PRN. R154 stated his pain was usually at an 8 and

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sometimes a 10 and that he is very rarely at a level of 5.

During interview 2/10/16, at 1:01 p.m. nursing assistant (NA)-B stated she worked with R154 and he has a lot of pain in his right leg and his back, and because of the pain R154 would refuse to transfer or ambulate, and at times would just stay in bed because of the pain.

During observation 2/10/16, at 2:27 p.m. NA-C was observed to transfer R154 in his room. NA-C situated a chair at a 45 degree angle from the bed and placed a four wheeled walker (4WW) in front of R154 with the brakes applied. R154 briefly repositioned himself in his wheelchair and an audible sigh and vocalization of "Ah" were noted. NA-C asked "Are you hurting today?...Where?" R154 stated "Yes... my hands, my legs." Once all set up to transfer, NA-C said "Take your time" several times as R154 made his first attempt to stand. As he began to bear weight on his legs and feet he yelled out "Ow" and quickly returned to a seated position back in his wheelchair. He was breathing quickly and heavily, and then began the 2nd attempt to transfer, and again was observed to breath heavily with his mouth open and eyes tightly closed, as he took steps to turn his back to the bed. With contact guard assist he stood from his wheelchair and placed his hands on the 4WW. The NA repeated several times "Take your time... do you want me to get a nurse for you?" R154 declined for the aide to get the nurse. Once seated on the bed, R154 stated his pain level was 10/10. During the transfer his right knee was visibly shaking.

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Review of R154's progress notes/orders indicated the following:
-On 2/3/16, 4:26 p.m. Communication/Visit with Physician Note Text: "Labs from today called to NP (nurse practioner). Also questioning tens (Transcutaneous Electrical Nerve Stimulation which is predominately used for nerve related pain conditions) unit for residents pain in his right knee if that was possible per resident request. Awaiting return call."
-A physician order was received 2/11/16, eight days after the request for physical therapy to evaluate right knee pain and appropriateness of tens unit.

-On 2/4/16, at 3:00 p.m. staff approached to walk resident but he refused due to pain.

-On 2/5/16, at 8:58 p.m. resident refused to walk.

-On 2/9/16, at 10:00 p.m. patient did not walk to dinner. He wheeled himself out in his electric wheelchair.

-On 2/10/16, at 3:24 p.m. Communication/Visit with Physician Note Text: NP updated on residents c/o pain in bilateral hands. Resident continues to c/o "sharp pain" in his hands. He denied that it is radiating from anywhere. He has requested PRN pain pills this shift, with little relief. Continue to monitor and update NP.

- On 2/10/16, at 10:01 p.m. resident refused shower, "Stating have been in pain all day." Pain meds were administered.

During interview on 2/10/16, at 1:15 p.m. trained medical assistant (TMA) stated R154 had been

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having increased pain and he asked for a PRN today and had been asking more for his pain medication.

During interview on 2/10/16, at 2:30 p.m. registered nurse (RN)-A stated she was the manager for R154's unit and was not aware R154 was having pain. RN-A stated he had recently switched to a new doctor and his previous nurse practioner and physician were not very receptive to additional pain medication requests from the nurses. In addition RN-A stated she was not aware a request for a tens unit was made and she would call the NP and re-request the order.

During interview on 2/11/16, at 9:31 a.m. RN-F stated she worked the day shift and R154 usually had a pain rating of 7/10, and recently the resident has had increased complaints of pain.

During interview on 2/11/16, at approximelty 1:50 p.m. NA-C stated R154 complained of pain in the morning and afternoons and had been requesting his pain medication more often, and felt in the last three weeks R154's pain has been increasing.

Although R154 reported increased pain, was refusing to ambulate, and was observed to be in the pain, the facility did not reassess to determine if any further interventions could be implemented to decrease the residents pain.

A facility policy titled Pain Management-Resident Assistance policy issued September 2012, indicated the purpose was to provide resident assistance in pain management and, "All residents will receive interdisciplinary consultations on assistance in managing pain." The policy futher indicated "The registered nurse

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F 309	Continued From page 21 will assess current pain levels and develop with the physician and interdisciplinary team interventions that may be non-pharmacological as well as pharmacological. The registered nurse will review response to medication interventions and work closely with the physician to assist in the individualized pain measurement plan."	F 309		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure toileting and repositioning were completed as assessed to prevent pressure ulcers for 1 of 3 residents (R37) reviewed who was identified at risk for pressure ulcer development. Findings include: R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37 had no cognitive impairment, was frequently incontinent of both bladder and bowel, was at risk for the development of pressure ulcers, required extensive assistance from staff for toilet use and	F 314		

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personal hygiene, and was totally dependent on staff for transfers and bed mobility.

R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was weak, de-conditioned, and non-weight bearing on her right, lower extremity. The CAA identified a goal for R37 to remain free from skin breakdown related to incontinence and use of an incontinence brief.

R37's Positioning Assessment & Evaluation dated 1/3/16, identified R37 required total assistance with repositioning and directed staff to offer repositioning every two hours.

R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility, and staff were directed to offer and assist with toileting every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep. The care plan also directed staff to assist R37 with turning and repositioning at least every two hours with use of a mechanical lift.

R37's Braden Scale for Predicting Pressure Sore Risk dated 2/6/16, indicated a score of 16/18, identifying R37 was at mild risk for the development of pressure ulcers.

During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated R37 did not get assisted with toileting timely, and stated she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed.

During continuous observation on 2/10/16, from

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7:23 a.m. to 10:17 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for two hours and 37 minutes.
Observations included the following:
At 7:23 a.m., R37 was lying in bed and nursing assistant (NA)-G was present in the room.
At 7:30 a.m., NA-G checked/ changed R37's incontinence product before assisting R37 to sit in her wheelchair using a mechanical lift and two staff to transfer.
At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal.
At 9:00 a.m., R37 was moved from the dining room after breakfast, to an alcove/ day room area (across from the dining room), where the resident watched television with two of her peers.
At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and R37 stated, "See how late they get?" The resident stated she had not yet received her morning medications, nor had she been assisted with her exercises, and R37 visibly and audibly sighed several times.
At 9:40 a.m. R37 asked the surveyor to find a staff member on her behalf and registered nurse (RN)-G was asked to assist R37. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light, and exited the room. RN-G did not offer toileting, checking/ changing or turning/ repositioning to R37.
At 9:57 a.m., NA-G entered R37's room and offered to assist her into bed. R37 accepted and NA-G got another staff member to assist with transferring R37 into bed.
At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed and proceeded to change R37's incontinence brief, with two hours and 37 minutes between changes. NA-G confirmed R37's incontinence

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brief contained a small void of urine.
R37 was not observed to offload or reposition herself during this observation.
At 10:17 a.m., NA-G stated R37 was to be checked/ changed, and turned/ repositioned every two hours.

Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including turning/ repositioning and checking/ changing her incontinence product.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting, checked/ changed, or turned/ repositioned for three hours and five minutes. Observations included the following:
At 8:23 a.m., R37 was seated at the dining room table, awaiting her breakfast meal.
At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached her, brought her to her room, administered eye drop medication and then returned R37 to the day room. RN-H did not offer to toilet or check/ change, or reposition R37.
At 10:09 a.m., NA-A approached R37 and asked if she wanted to lay down. R37 declined to lay down, however, NA-A did not offer to toilet, check/ change her brief, or offer to reposition or offload R37. No encouragement or education was provided to prevent skin breakdown.
At 10:31 a.m., an activities staff invited R37 to attend an exercise group. R37 declined this offer and remained seated in her wheelchair in the day room.
At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed and turned/ repositioned every two hours, using a mechanical

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lift to transfer her into bed. NA-A stated R37 was last checked/ changed and turned/ repositioned at 8:00 a.m. NA-A stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined to lay down. NA-A stated she interpreted R37's response as a refusal to be checked/ changed and/ or repositioned. NA-A stated she attempted to approach R37 every two hours and ask if she wanted to lay down, and if the resident agreed to lay down staff would check and change her. NA-A then proceeded with assisting other residents, and R37 had still not been offered to toilet and/or checked/ changed or turned/ repositioned.
At 11:05 a.m., the surveyor asked NA-A when staff would expect to offer toileting, checking/ changing and turning/ repositioning to R37, at which time NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought the resident to her room, and asked RN-H to assist. NA-A and RN-H proceeded with transferring R37 to her bed and checked and changed her incontinence brief, with three hours and five minutes between changes and offloading. R37's bottom was observed as slightly pink, but blanchable, which RN-H confirmed.
At 11:29 a.m., NA-A stated when changing R37's brief she had a small bowel movement and a small void of urine in her incontinence brief.

During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be repositioned and toileted every two hours and was usually incontinent. RN-H stated she felt NA-A's offer for R37 to lay down did constitute an offer for turning/ repositioning and toileting or checking/ changing,

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F 314	Continued From page 26 and stated if R37's decline to lay down, that was considered a refusal for toileting and repositioning. During interview on 2/11/16, at 3:01 p.m. RN-A stated R37 was to be turned/ repositioned and toileted every two hours, and offering to lay down in bed was not indicative of an offer for turning/ repositioning, toileting or checking/ changing; and R37's declining to lay down did not equate refusals for these cares. RN-A stated the facility staff should have specifically asked if she would have liked to be repositioned to offload her bottom, have her brief changed, and utilize the bedpan. RN-A stated R37's care planned interventions for repositioning and toileting were not followed during the above observations. The facility's policy titled Skin Assessment, Pressure Ulcer Prevention, and Documentation Requirements dated 12/15, directed, "Residents who are unable to reposition themselves independently should be repositioned as often as directed by the care plan approaches."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	F 315		

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This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review, the facility failed to ensure timely toileting in accordance with assessed needs, in order to maintain as much urinary function as possible, for 1 of 3 residents (R37) reviewed for urinary incontinence.

Findings include:

R37's admission Minimum Data Set (MDS) dated 1/7/16, identified R37's cognition was intact, was frequently incontinent of both bladder and bowel, was not on a toileting program, required extensive assistance from staff for toilet use and personal hygiene, and was totally dependent on staff for transfers and bed mobility.

R37's Care Area Assessment (CAA) dated 1/12/16, indicated R37 had a prosthetic knee fracture, was non-weight bearing on her right, lower extremity, and required a total lift with assistance from two staff to transfer. The CAA identified R37 required maximum assistance with toileting, had functional incontinence, was at an increased risk for urinary incontinence and infection due to a previous UTI, and may have had increased urinary frequency secondary to her use of diuretic medications.

R37's care plan dated 2/2/16, identified R37 had bowel and bladder incontinence related to weakness and impaired mobility. The care plan directed staff to, "Offer and assist with toileting "every two hours (and as needed) while awake, and to check/change every two hours (and as needed) while asleep.

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During a telephone interview on 2/8/16, at 7:36 p.m. family member (FM)-A stated staff did not assist R37 with toileting timely, and she knew of at least one instance where R37 had to wait through the supper meal for her soiled incontinence product to be changed.

During a continuous observation on 2/10/16, from 7:23 a.m. to 10:17 a.m., R37 was not offered toileting or checked/ changed for two hours and 37 minutes. Observations included the following:
At 7:23 a.m., R37 was lying in her bed and nursing assistant (NA)-G was present in the room.
At 7:30 a.m., NA-G checked/ changed R37's incontinence product before she was assisted to sit in her wheelchair, using a mechanical lift and two staff to transfer her.
At 7:45 a.m., NA-G brought R37 to the dining room for the breakfast meal.
At 9:00 a.m., R37 was moved from the dining room, to an alcove/ day room area (across from the dining room), where she watched television with two of her peers.
At 9:20 a.m., R37 remained seated in her wheelchair in the day room area and stated, "See how late they get?" R37 stated she had not yet received her morning medications, nor had she been assisted with her exercises, and was sighing as she was talking.
At 9:40 a.m. R37 asked the surveyor to find a staff member to assist her, and Registered nurse (RN)-G was made aware of R37's request for assistance. R37 stated to RN-G, "Well I'd like to get back to my room." RN-G assisted R37 to her resident room, handed her the call light and exited the room. RN-G did not offer toileting assistance, nor did she check/ change R37.

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At 9:57 a.m., NA-G entered R37's room and offered to assist her into bed. R37 accepted and NA-G sought another staff person to assist with the transfer.
At 10:05 a.m., while NA-G had again stepped out of the room to find another staff person, R37 stated staff did not offer her use of the toilet, commode or bedpan for toileting, and stated she did not believe she could use the toilet or commode because of her leg injury and non-weight bearing status.
At 10:07 a.m., NA-G and licensed practical nurse (LPN)-G used a mechanical lift to transfer R37 to bed, and NA-G then proceeded with changing R37's incontinence brief, with two hours and 37 minutes between changes. R37 was not offered use of a toilet or bedpan.
At 10:17 a.m., NA-G stated R37 was to be checked/ changed every two hours and did not use a bedpan or toilet because she was always incontinent, and NA-G confirmed R37's incontinence brief contained a small void of urine.

Progress Notes from 12/31/15, through 2/10/16, were reviewed and lacked evidence of R37 refusing or declining cares, including toileting/ use of a bedpan and checking/ changing her incontinence product.

During a continuous observation on 2/11/16, from 8:23 a.m. to 11:29 a.m., R37 was not offered toileting or checked/ changed for three hours and five minutes. Observations included the following:
At 8:23 a.m., R37 was seated at the dining room table waiting for breakfast.
At 9:06 a.m., R37 self-propelled her wheelchair to the day room area. RN-H approached the resident, brought her to her room, administered

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eye drop medication, and then returned R37 to the day room. RN-H did not offer to toilet or check/ change R37.
At 10:09 a.m., NA-A approached R37 and asked if she wanted to lay down. R37 declined this offer, however, NA-A did not offer to toilet or check/ change R37.
At 10:31 a.m., an activities staff invited R37 to attend an exercise group, which R37 declined and remained seated in her wheelchair in the day room.
At 10:46 a.m., NA-A was interviewed and stated R37 was to be checked/ changed every two hours, using a mechanical lift to transfer her into bed. NA-A stated R37 was last checked/ changed at 8:00 a.m. and stated she had approached R37 earlier and asked her if she wanted to lay down, but the resident declined. NA-A stated she interpreted R37's response as a refusal to be checked/ changed, and typically she would approach R37 every two hours and ask if she wanted to lay down, which is when she would check and change R37. NA-A stated R37 did not use a toilet or commode because she required a mechanical sling lift for transfers, and stated R37 did not use a bedpan either. NA-A then proceeded with assisting other residents and R37 had still not been offered to toilet or be checked/ changed.
At 11:05 a.m., the surveyor asked NA-A when R37 would be offered toileting again, and NA-A approached R37 and asked if she could take her to her room to check her incontinence brief. R37 accepted and NA-A brought her to her room before seeking a second staff person to help with the transfer. NA-A returned and RN-H entered the room to assist with transferring R37 to bed and checking/ changing her incontinence brief, with three hours and five minutes between

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changes.
At 11:29 a.m., NA-A stated R37 had a small bowel movement and a small void of urine in her incontinence brief. Though staff were not observed offering R37 the use of a bedpan during this observation, NA-A stated she did offer the bedpan and R37 declined.

During interview on 2/11/16, at 2:25 p.m. RN-H stated R37 was to be toileted every two hours and was usually incontinent. RN-H stated that she and NA-A did offer a bedpan to R37 during the above noted observation, but R37 declined. RN-H stated that she felt NA-A's offer for R37 to lay down did constitute an offer for toileting or checking/ changing, and R37's decline to this offer equated a refusal.

During interview on 2/11/16, at 3:01 p.m. RN-A confirmed R37 was to be offered the use of a bedpan every two hours, and should have been offered a bedpan despite identification of urine or bowel in her incontinence brief. RN-A stated an offer to lay down in bed was not indicative of an offer for toileting or checking/ changing, and R37's declining to lay down did not equate a refusal for toileting. RN-A stated staff should have specifically asked if she would have liked to have her brief changed and use the bedpan, and staff were not following R37's care planned interventions for toileting.

The facility's Bowel and Bladder Assessment Evaluation and Retraining policy dated 9/12, directed staff to ensure each resident with bowel or bladder incontinence received appropriate treatment and services to restore as much normal bowel or bladder function as possible.

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F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		

The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to comprehensively assess and implement interventions to reduce the risk of falls for 1 of 3 residents (R34) reviewed for accidents hazards.

Findings include:

R34's admission Minimum Data Set (MDS) dated 1/13/16, indicated R34 had moderate cognitive impairment, had cancer, anemia, and heart failure. The MDS indicated the resident needed extensive assist of two with transfers, toileting, dressing, bed mobility, was incontinent of bowel and bladder, and had no falls in the last month.

R34's Care Area Assessment (CAA) dated 1/13/16, indicated the resident was not steady with transfers, received an antidepressant, had difficulty maintaining balance, and had impaired balance during transitions. The CAA indicated falls would be addressed in the care plan with a goal of preventing falls.

R34's care plan dated 1/14/16, indicated the resident had metastic breast cancer with brain

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mass, was at risk for falls related to impaired mobility, had a history of falls, had low bed, floor mat, concave mattress, and a body pillow. The care plan directed staff to ensure R34 had her call light with in her reach.

An Incident Report dated 1/20/16, at 3:49 a.m. indicated, "Writer was walking down the hall to answer a light, when I heard a resident yelling for help. Resident [R34] was found lying on her left side on the floor by her bed." The report indicated she received a skin tear on her left wrist, and an air overlay mattress was removed and a low bed and concave mattress was provided to resident.

An Incident Report dated 1/25/16, at 2:30 a.m. indicated, "Resident [R34] noted to be lying on floor in resident's room, she was lying on her stomach at foot of bed. Resident is confused to place and time. She states: "I slipped out of bed." The report indicated she had facial bruising on her nose and the center of her forehead, and a raised area on the lower part of the back of her head. The report also indicated she had gripper slippers on and a floor mat was placed on the floor near her bed.

During observation 02/9/15, at 8:21 a.m. R34 was observed laying in her bed. R34's bed was not observed in the low position, nor was there a floor mat on the floor.

During observation 02/9/15, at 9:32 a.m. R34 was observed laying in bed dressed. The bed was in the low position, however, the floor mat was folded up against the wall behind the oxygen tank.

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F 323	Continued From page 34 During interview 02/9/16, at 11:39 a.m. registered nurse (RN)-I stated the fall mat should be on the floor and the bed should be in the low position at all times. RN-I entered R34's room and placed the fall mat on the floor next to resident. During observation 2/10/16, at 8:01 a.m. R34 was observed laying in bed and the bed was in the low position with fall mat on the floor. However, the residents call light was observed laying on the floor out of R34's reach. Director of nursing (DON) was informed of the call light being out of R34's reach, and she entered the residents room and gave her the call light. During interview 2/10/16, at 12:31 p.m. RN-A stated she didn't know why R34's bed was not in the low position, and stated she had talked to the NA who was working with R34 on 02/9/16, and the NA stated she thought during a physician visit he had left the bed up. RN-A stated R34 was a fall risk and should have all the assessed interventions in place, including having the call light available because the resident will use it to call for staff assistance. A facility Fall Prevention And Management policy issued July 2015, indicated to take a "Reactive Approach-requires identifying actual risk factors and taking steps to prevent the fall from occurring again. In a fall prevention program, a reactive approach will include a post-fall investigation to determine the cause of the fall (root cause analysis), identifying risk factors and taking steps (interventions) to prevent the fall from happening again."	F 323		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE	F 325		

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Based on a resident's comprehensive assessment, the facility must ensure that a resident -
(1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and
(2) Receives a therapeutic diet when there is a nutritional problem.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to comprehensively reassess nutritional needs for a significant weight loss for 1 of 4 residents (R72) reviewed for nutritional needs and weight loss.

Findings include:

R72's quarterly Minimum Data Set (MDS) dated 12/08/15, indicated the resident had no cognitive impairment, felt depressed and tired, had dementia and heart failure, needed set up help with eating, and had no swallowing problems.
R72's care plan dated 2/14/14, indicated the resident had obesity related to energy intakes exceeding needs, limited mobility, and choosing high calorie foods at meals/snacks. The care plan goal was for the resident to maintain a weight of 278 lbs (pounds); or a gradual loss of 2-4 lbs a month. The care plan indicated R72 had an amputee of her lower extremity, gastro-esophageal reflux disease, (a chronic condition of mucosal damage caused by stomach

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acid coming up from the stomach) and heart failure.
A Dietary Profile dated 12/07/15, indicated R72 received a regular diet, did not receive supplements, and had an amputation.
A Mini-Nutritional Assessment dated 12/07/15, indicated she had no decrease in her food intake and had weight loss greater than 3 kilograms (6.6 lbs).
A Nutrition Risk Note dated 1/4/16, indicated resident was at nutrition risk, and her oral intake was sporadic and had 11 meal refusals with in the last 14 days. The note further indicated the facility would continue to assess for food preferences, offer substitutions for meals, and would continue to monitor her oral intake and weight.
R72's physician orders dated 2/11/16, indicated the resident received Lasix (diuretic to remove fluid) 20 milligrams (mg) twice a day for edema.
On 2/9/16, at 5:47 p.m. R72 was observed eating a hamburger on a bun, salad, and apple crisp. R72 ate 50% of her meal. R72 was sitting in her wheelchair which had a sticker taped to the back of her wheelchair indicating the foot pedals weighed 51.8 lbs.
On 2/10/16, at 12:22 p.m. R72 was observed eating shrimp scampi and a baked potato, and she ate 75% of her meal.
A facility Percentage Of Meal Eaten form dated 1/13/16, to 2/10/16, indicated R72 refused 19 meals.
R72's Vital Results identified the following weights:

12/2/15 - 260 lbs
12/23/15 - 281 lbs (281-260 lbs weight gain of 21 lbs, no documentation as to why).
12/30/15 - 283 lbs

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1/20/16 - 286 lbs
1/27/16 - 285 lbs
2/03/16 - 263 lbs (285 to 263 lbs weight loss of 22 lbs, no documentation as to why).
2/11/16 - 245 lbs (263- 245 weight loss of 18 lbs, no documentation as to why).

Although R72's weights fluctuated and R72 had a 5.8 % weight loss from 12/02/15, to 2/11/16, there was no indication the facility reassessed R72 to determine why there were significant weight changes.

During interview on 2/10/16, at 12:22 p.m. registered nurse (RN)-A stated R72 was on Lasix, however, after reviewing the weights she stated it looked as if there was some inconsistency with the weights because, "You wouldn't loose 20 lbs in one week," and stated she would have staff reweigh the resident. In a follow-up interview at 2:22 p.m. RN-A stated R72 was weighed and the weight was 242.6 lbs. RN-A stated she felt the weight fluctuation could be from R72 not having her prosthetic leg on, however, RN-A weighed R72's prosthetic leg which weighed 4.4 lbs.

During interview 2/11/16, at 1:27 p.m. registered dietician (RD) stated R72 had a decline in health and felt the weights which were recorded in the 280's were inaccurate. The RD stated she felt the weight from 12/2/15, which was 260 lbs was accurate for R72. The RD stated she had been working with staff to ensure they obtained accurate weights, and RD stated she had staff reweigh the resident and she now weighed 243 lbs. RD stated R72 had a weight loss and indicated it could be due to the resident requiring more staff assistance, and the resident had also

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F 325	Continued From page 38 been eating meals in her room more often. RD stated R72 should have been reassessed and had further interventions put into place when the decline in weight was initially noted, from January to early February. During interview 2/11/6, director of nursing (DON) stated R72 had been refusing to get out of bed more often and seemed to be more confused. The DON stated the nuses used to do weights on paper so they could see a weight loss, however, the weights are now entered electronically and staff are not able to see the previous weight. A facility policy titled Nutritional Risk Policy revised 2/16, indicated Nursing staff members with notify the dietary department with in 24 hours by sending an alert significant weight change, gain or loss, 3 pounds in one week, 5 percent in one month, 7.5 percent in three months, 10 percent in six months. The policy further indicated the director of dietary services (DDS) or designee will review resident weights monthly or more often to identify residents with significant weight loss or gain or insidious weigh loss or gain refers to a gradual unintended, progressive weight loss or gain over time.	F 325		
F 412 SS=D	483.55(b) ROUTINE/EMERGENCY DENTAL SERVICES IN NFS The nursing facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine (to the extent covered under the State plan); and emergency dental services to meet the needs of each resident; must, if necessary, assist the resident in making appointments; and by arranging for	F 412		

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transportation to and from the dentist's office; and must promptly refer residents with lost or damaged dentures to a dentist.

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure dental follow up appointments were completed for 1 of 3 residents (R15) reviewed for dental services.

Findings include:

R15's significant change Minimum Data Set (MDS) dated 1/6/16, indicated the resident had moderate cognitive impairment and need for extensive assistance to complete activities of daily living.

R15's care plan dated 2/10/16, directed staff to provide resident with assistance to complete dressing and grooming, and the resident performed oral care independently.

During interview on 2/9/16, at 10:42 a.m. R15 stated he had missing teeth on the upper right side of his mouth and had been seen for evaluation by the dentist because of the missing teeth and discomfort on the right side of his upper jaw. R15 stated he had understood there was to be a follow up appointment, however, he had heard nothing regarding this since his last visit with the dentist.

During observation on 2/10/16, at 1:03 p.m. R15 was observed eating his meal with no visible problems chewing. During interview at this time, R15 stated he continued to have discomfort on

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F 412	Continued From page 40 the upper right side of his mouth with chewing, and again stated he had broken teeth and, "I was supposed to follow up a long time ago [with the dentist], and I haven't heard anything." Review of the Apple Tree Coon Rapids progress note dated 9/10/15, indicated (R15) was seen on that date for a recall exam. The progress note indicated, "Diagnosis/Assessment: Caries risk: High;rampant decay . See oral exam form. Tooth #12 and 13 had buccal cusps have fractured off; non-restorable, Recommend extractions " Several no [sic] cavities noted since last exam." Treatment recommendations were made for fillings and extractions, in addition to follow up for prophylaxis treatment every three months. Review of R15's medical records indicated the resident had no further follow up dental appointments, nor were there any follow up dental appointments scheduled. During interview on 2/11/16, at 1:55 p.m. registered nurse (RN)-A stated it appeared the dental recommendations were not processed because when a follow up of recommendation of appointments is completed, the nurse will write, "Noted," on the form. A review of R15's record indicated there had been no follow up or communication with Apple Tree dental services since R15's visit of 9/10/15. A review of the policy titled Dental/Oral Health Services and Assessments, issued September 2012, indicated the purpose of dental assessments was for treatment to begin as early as necessary.	F 412		
F 441	483.65 INFECTION CONTROL, PREVENT	F 441		

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F 441 SS=D	Continued From page 41 SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		

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F 441	Continued From page 42	F 441		

This REQUIREMENT is not met as evidenced by:
Based on observation, interview, and document review the facility failed to ensure proper disinfecting procedure of the glucometer after blood glucose monitoring for 2 of 3 residents (R42 and R90) who utilized the facility community glucometer on the Sunny Ridges unit.

Findings include:

R42 was observed for a blood glucose testing on 2/10/16 at 8:23 a.m. by registered nurse (RN)-B who pierced R42's finger using a lancet and placed a large drop of blood on the collection strip of the glucometer to measure the glucose level. After disposing of the lancet and blood collection strip, the glucometer was then wiped down with alcohol prep pads and placed on a paper tissue in the tote. At 8:30 a.m., RN-B proceeded to test blood glucose on R90 with the same glucometer used for R42. Upon completion of blood glucose testing, the glucometer, was cleaned with alcohol wipes and placed on a clean paper tissue in the nurses tote and allowed to air dry.

During an interview on 2/10/16 at 8:35 a.m., RN-B stated that the glucometer is wiped down with alcohol wipes between residents. Residents of Sunny Ridges use a community glucose meter. On 2/11/16, registered nurse (RN)-C identified R42, R90, and R20 all had orders for routine blood glucose monitoring on Sunny Ridges unit.

On 2/11/16 at 9:29 a.m., RN-D stated that the residents have their own glucometer on the short term care units. The long term care units, glucometers are to be wiped with sani cloth plus

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F 441	Continued From page 43 wipes before and after use, taking time to assure the surfaces for remained visibly wet for 3 minutes. RN-D stated "It is not our procedure to wipe glucometer with alcohol wipes." The facility policy of Blood Glucose Monitoring, Disinfecting, and Cleaning, issued September 2012, was reviewed and indicates the process to disinfectant the meter may be completed in one of two ways, either with a process of using a dilute 1 ml of house bleach in 9 ml of water to achieve a 1;10 dilution, using a lint-free cloth or paper towel to wipe down the meter, paying attention to the time the meter must remain wet. The other option that may be used is the use of a germicidal disposable wipe supplied by the Society's preferred vendor. After disinfecting, the meter should be left a few minutes to ensure that it is dry.	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure timely repair of the walk-in cooler to ensure adequate temperatures were maintained. This had the potential to affect all 66 residents who ate in the facility. Findings include:	F 456		

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On 2/8/16, at 1:12 p.m. an initial tour of the facility's kitchen was conducted with certified dietary manager (CDM), and the door of the walk-in cooler was observed resting slightly open and was not sealed shut. CDM stated the door no longer automatically sealed and had to be pressed shut after each entry, and he had already informed the maintenance department of this issue.

On 2/11/16, at 1:23 p.m. a follow-up tour was conducted with CDM and the walk-in cooler was again observed to be resting slightly open/ not sealed shut. CDM stated again he had informed maintenance of the door/seal needing repair approximately two weeks prior, however, the facility had experienced a turn-over of maintenance personnel and he suspected the departments response time to maintenance requests may have been somewhat delayed as a result. CDM was unable to provide any documentation regarding the request for the repair, and stated he did not document the request but just spoke to the maintence department. During this follow-up tour, cook-A entered and exited the walk-in cooler, but failed to press the door shut behind him, leaving the door to rest slightly opened/ unsealed, until CDM noticed and pressed the door closed.

During interview on 2/11/16, at 4:13 p.m. the environmental services director (ESD) reported he had started working at the facility approximately three weeks prior. He stated he was not aware of the facility's walk-in cooler door not sealing. He stated the facility had a maintenance log where staff entered needs or requests for repairs, and stated the walk-in cooler door was not identified in the log as per the

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F 456	Continued From page 45 facility's process. ESD stated though some of the preventative maintenance tasks were slightly back logged, he was on schedule with maintenance/ repair requests, and stated if he had known about the issue, he would have repaired it immediately. The facility's Food Storage policy dated 2/16, directed the CDM was responsible for monitoring refrigerator temperatures. The policy added, repair needs were to be brought to the attention of maintenance staff.	F 456		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 12, 2016. At the time of this survey, Good Samaritan Society Ambassador was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000		

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

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

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GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Ambassador is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 77 beds and had a census of 68 at time of the survey.	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(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 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 012 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for proper separation of multiple construction types. This deficient practice could affect all 68 residents. Findings include: During a tour of the facility between 9:30 AM and 1:30 PM on February 12, 2016, observation revealed that the 2-hour fire separation had fiberglass insulation and no fire caulking around the large penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed. This deficient practice was verified by the administrator at the time of the inspection.	K 012		
K 050 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership.	K 050		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(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 050	Continued From page 3 Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 68 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 12, 2016, the review of the fire drill documentation for the past 12 months revealed that a fire drill was not documented for the evening shift during the second quarter. This deficient practice was confirmed by the Director of Environmental Services at the time of discovery.	K 050		
K 143 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated,	K 143		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/12/2016**

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K 143	Continued From page 4 sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99) This STANDARD is not met as evidenced by: Based on observation and staff interview, this building does not meet the requirements for the proper arrangement of room intended for the transferring of liquid oxygen from one container to another per NFPA 99 8-6.2.5.2. This deficient practice could affect all 44 residents. Findings include: During a tour of the facility between 9:30 AM and 1:30 PM on February 12, 2016, observation revealed that the oxygen transfilling room in 1963 building had vinyl floor tiles. This deficient practice was verified by the Administrator at the time of the inspection.	K 143		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD** **NEW HOPE, MN 55427**

(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 THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENTS ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 12, 2016. At the time of this survey, Good Samaritan Society Ambassador was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000		

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

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
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**02/12/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

F5149025

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245149	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
GOOD SAMARITAN SOCIETY AMBASSADOR	A. BUILDING 1 B. WING C. FLOOR K3	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	A. (•) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	K4 02/12/2016	K6	5. [✓] 2000 EXISTING 6. [ ] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (•) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. (•) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (•) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 77	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 77	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 77	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID_____

7. A. (•) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (•) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) FSES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
WILLIAM ABDERHALDEN SURVEYOR ID K10 37009	DEPUTY STATE FIRE MARSHAL	STATE FIRE MARSHAL	02/12/2016
FIRE AUTHORITY OFFICIAL *(Signature)* Thomas Linhoff 12424	TITLE FIRE SAFETY SUPERVISOR	OFFICE STATE FIRE MARSHAL	DATE 02-18-2016

ID PREFIX		MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES				K12- 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II (000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. 1. It was observed that the two hour separation had fiberglass insulation and no fire caulking around the penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed.
	BUILDING CONSTRUCTION				
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2	◉	○	○	
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1	○	◉	○	
	1 ○ I (443), I (332), II (222) — Any Height				
	2 ○ II (111) — One story only (non-sprinklered).				
	3 ○ II (111) — Not over three stories with complete automatic sprinkler system.				
	4 ○ III (211) — Not over two stories with complete automatic sprinkler system.				
	5 ◉ V (111) — Not over two stories with complete automatic sprinkler system.				
	6 ○ IV (2HH) — Not over two stories with complete automatic sprinkler system.				
	7 ○ II (000) — Not over two stories with complete automatic sprinkler system.				
	8 ○ III (200) — Not over one story with complete automatic sprinkler system.				
	9 ○ V (000) — Not over one story with complete automatic sprinkler system.				
	☐ Building contains fire treated wood.				
	Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.				

ID PREFIX					MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.							
	1		I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2		II (111)	Not over three stories with complete automatic sprinkler system				
	3		III (211)	Not over one story with complete automatic sprinkler system.				
	4		V (111)					
	5		IV (2HH)					
	6		II (000)					
	7		III (200)	Not Permitted				
	8		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)				◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s*_____				
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s* A	◉	○		
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s*_____				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.	◉	○	○	
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 *If the walls have a fire resistance rating, give rating _____ if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*	◉	○		
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 $in.^2$ and the opening is installed in bottom half of the wall (80 $in.^2$ in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: ☐ (a) The required manual fire alarm system and ☐ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☐ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2	◉	○	○	
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2				
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	◉	○	○	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5	◉	○	○	
	2000 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5				
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7	◉	○	○	
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8				
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7	◉	○	○	
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: Provider Type / Swinging Doors / Horizontal Sliding Doors Hospitals and Nursing Facilities: 41.5 inches (105 cm) / 83 inches (211 cm) Psychiatric Hospitals and Limited Care Facilities: 32 inches (81 cm) / 64 inches (163 cm) 18.3.7.7				

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	◉	○	○	
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREAS				
K29	2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✓	✓	
c. Laundries (greater than 100 sq feet)	✓	✓	
d. Repair Shops and Paint Shops	✓	✓	
e. Laboratories (if classified a Severe Hazard - see K31)			✓
f. Combustible Storage Rooms/Spaces (over 50 sq feet)	✓	✓	
g. Trash Collection Rooms	✓	✓	
i. Soiled Linen Rooms	✓	✓	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair, Maintenance and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			
m. Combustible Storage Rooms/Spaces (over 100 sq feet)			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles	☐	☐	☐

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☐ The corridor is at least 6 feet wide ☐ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☐ The dispensers shall have a minimum spacing of 4 ft from each other ☐ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☐ Dispensers are not installed over or adjacent to an ignition source. ☐ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	◉	○	○	
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating “No Exit”. 7.10, 18.2.10.1, 19.2.10.1	◉	○	○	
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	◉	○	○	
K35	The capacity of required mean of egress is based on its width, in accordance with 7.3.	◉	○		
K36	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10	◉	○	○	
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10				
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	◉	○		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4				
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5	◉	○		
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5				
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	◉	○	○	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2	○	○	◉	
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	◉	○		
	ILLUMINATION				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	◉	○		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○		
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).			☑	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○	○	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	○	◉	○	K50- It was observed during document review that a fire drill was not documented for the evening shift during the second quarter.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	◉	○		
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3				
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath	○	○	◉	
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○		
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8	◉	○		
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○		
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13	◉	○	○	
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.				
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 10/28/2015				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. SUMMIT				
	C. Note the source of water supply for the automatic sprinkler system. CITY WATER				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	◉	○	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	◉	○		
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	◉	○	○	
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	◉	○	○	
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	◉	○	○	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	◉	○	○	
K160	2000 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators & Escalators*. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	◉	○	○	
	2000 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
K161	2000 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)	○	○	◉	
	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1, *Safety Code for Elevators and Escalators.* 18.5.3, 9.4.2.1				
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	◉	○	○	
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 ☐ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. ☐ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 ☐ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	◉	○	○	
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○	○	
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)	○	○	◉	
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).	○	○	◉	
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).	○	○	◉	
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).	○	○	◉	
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	○	○	◉	
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	◉	○	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)	○	○	◉	
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	○	◉	○	K143- It was observed that the oxygen transfilling room had vinyl floor tiles.
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	○	○	◉	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	◉	○		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2			☑	
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	◉	○	○	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	◉	○	○	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	◉	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	○	○	○	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date

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

F5149025

2000 CODE

Form Approved
OMB Exempt

FIRE SAFETY SURVEY REPORT 2000 CODE - HEALTH CARE
Medicare – Medicaid

1. (A) PROVIDER NUMBER	1. (B) MEDICAID I.D. NO.
K1 245149	K2

PART I — Life Safety Code, New and Existing
PART IV — Waiver Recommendation Form

Identifying information as shown in applicable records. Enter changes, if any, alongside each item, giving date of change.

2. NAME OF FACILITY	2. (A) MULTIPLE CONSTRUCTION (BLDGS)	2. (B) ADDRESS OF FACILITY (STREET, CITY, STATE, ZIP CODE)	
GOOD SAMARITAN SOCIETY AMBASSADOR	A. BUILDING 02 B. WING C. FLOOR K3	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427	A. (●) Fully Sprinklered (All required areas are sprinklered) B. ( ) Partially Sprinklered (Not all required areas are sprinklered) C. ( ) None (No sprinkler system) K0180

3. SURVEY FOR	4. DATE OF SURVEY	DATE OF PLAN APPROVAL	SURVEY UNDER
[✓] MEDICARE [✓] MEDICAID	02/12/2016 K4	K6	5. [ ] 2000 EXISTING 6. [✓] 2000 NEW K7

5. SURVEY FOR CERTIFICATION OF

1. ( ) HOSPITAL 2. (●) SKILLED/NURSING FACILITY 4. ( ) ICF/MR UNDER HEALTH CARE 5. ( ) HOSPICE

IF "2" OR "5" ABOVE IS MARKED, CHECK APPROPRIATE ITEM(S) BELOW

1. (●) ENTIRE FACILITY 2. ( ) DISTINCT PART OF (SPECIFY)_____

3. [ ] IF DISTINCT PART OF HOSPITAL, IS HOSPITAL ACCREDITED?
a. ( ) YES b. (●) NO

6. BED COMPOSITION				
a. TOTAL NO. OF BEDS IN THE FACILITY 77	b. NUMBER OF HOSPITAL BEDS CERTIFIED FOR MEDICARE ____	c. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICARE 77	d. NUMBER OF SKILLED BEDS CERTIFIED FOR MEDICAID 77	e. NUMBER OF NF or ICF/MR BEDS CERTIFIED FOR MEDICAID_____

7. A. (●) THE FACILITY MEETS, BASED UPON (CHECK ALL APPROPRIATE BOXES)

1. ( ) COMPLIANCE WITH ALL PROVISIONS 2. (●) ACCEPTANCE OF A PLAN OF CORRECTION 3. ( ) RECOMMENDED WAIVERS 4. ( ) FSES 5. ( ) PERFORMANCE BASED DESIGN

B. ( ) THE FACILITY DOES NOT MEET THE STANDARD
K9

SURVEYOR *(Signature)*	TITLE	OFFICE	DATE
WILLIAM ABDERHALDEN SURVEYOR ID 37009 K10	Deputy State Fire Marshal	State Fire Marshal	02/12/2016
FIRE AUTHORITY OFFICIAL *(Signature)* Thomas Linhoff 12424	TITLE Fire Safety Supervisor	OFFICE State Fire Marshal	DATE 02-18-2016

ID PREFIX					MET	NOT MET	N/A	REMARKS
	PART I - LSC REQUIREMENTS - Items in italics relate to the FSES							
	BUILDING CONSTRUCTION							
K11	If the building has a common wall with a nonconforming building, the common wall is a fire barrier having at least a two hour fire resistance rating constructed of materials as required for the addition. Communicating openings occur only in corridors and shall be protected by approved self-closing fire doors with at least 1½ hour fire resistance rating 18.1.1.4.1, 18.1.1.4.2, 18.2.3.2, 19.1.1.4.1, 19.1.1.4.2				○	○	◉	
K12	2000 EXISTING Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1							
	1		I (443), I (332), II (222)	Any Height				
	2		II (111)	One story only (non-sprinklered).				
	3		II (111)	Not over three stories with complete automatic sprinkler system.				
	4		III (211)	Not over two stories with complete automatic sprinkler system.				
	5		V (111)					
	6		IV (2HH)					
	7		II (000)					
	8		III (200)	Not over one story with complete automatic sprinkler system.				
	9		V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*							

ID PREFIX			MET	NOT MET	N/A	REMARKS
K12	2000 NEW Building construction type and height meets one of the following: 18.1.6.2, 18.1.6.3, 18.3.5.1.		○	◉	○	K12- 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1963 and was determined to be of Type II (000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. In 2010, an addition was constructed and was determined to be of Type V (111) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The building is automatic fire sprinkler protected throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. 1. It was observed that the two hour separation had fiberglass insulation and no fire caulking around the penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed.
	1 ○ I (443), I (332), II (222)	Any height with complete automatic sprinkler system				
	2 ○ II (111)	Not over three stories with complete automatic sprinkler system				
	3 ○ III (211)	Not over one story with complete automatic sprinkler system.				
	4 ◉ V (111)					
	5 ○ IV (2HH)					
	6 ○ II (000)					
	7 ○ III (200)	Not Permitted				
	8 ○ V (000)					
	☐ Building contains fire treated wood. *Give a brief description, in REMARKS, of the construction, the number of stories, including basements, floors on which patients are located, location of smoke or fire barriers and dates of approval. Complete sketch or attach small floor plan of the building as appropriate.*					
K103	Interior walls and partitions in buildings of Type I or Type II construction shall be noncombustible or limited-combustible materials. 18.1.6.3, 19.1.6.3 (Indicate N/A for existing buildings using listed fire retardant treated wood studs within non-load bearing one-hour rated partitions.)		○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	INTERIOR FINISH				
K14	2000 EXISTING Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Interior finishes existing before December 17, 2010 that are applied directly to wall and ceilings with a thickness of less than 1/28 inch shall be permitted to remain in use without flame spread rating documentation. 10.2, 19.3.3.1, 19.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* _____				
	2000 NEW Interior finish for means of egress, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. Lower half of corridor walls, not exceeding 4ft in height, may have a Class C flame spread rating. 10.2, 18.3.3.1, 18.3.3.2, NFPA TIA 00-2 *Indicate flame spread rating/s* A	◉	○		
K15	2000 EXISTING Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (In fully-sprinklered buildings, flame spread rating of Class C may be continued in use within rooms separated in accordance with 19.3.6 from the exit access corridors.) 19.3.3.1, 19.3.3.2 *Indicate flame spread rating/s*_____				
	2000 NEW Interior finish for rooms and spaces not used for corridors or exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. (Rooms not over 4 persons in capacity may have a flame spread rating of Class A, Class B, or Class C). 18.3.3.1, 18.3.3.2. *Indicate flame spread rating/s* A	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
K16	2000 EXISTING Newly installed interior floor finish complying with 10.2.7 shall be permitted in corridors and exits if Class I. 19.3.3.3 In smoke compartments protected throughout by an approved, supervised automatic sprinkler system in accordance with 19.3.5.2, no interior floor finish requirements shall apply.				
	CORRIDOR WALLS AND DOORS				
K17	2000 EXISTING Corridors are separated from use areas by walls constructed with at least ½ hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 *If the walls have a fire resistance rating, give rating _____ if the walls terminate at the underside of a ceiling, give a brief description in REMARKS, of the ceiling, describing the ceiling throughout the floor area.*				
	2000 NEW Corridor walls shall form a barrier to limit the transfer of smoke. Such walls shall be permitted to terminate at the ceiling where the ceiling is constructed to limit the transfer of smoke. No fire resistance rating is required for the corridor walls. 18.3.6.1, 18.3.6.2, 18.3.6.4, 18.3.6.5	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
K18	2000 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3				
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
	2000 NEW Doors protecting corridor openings shall be constructed to resist the passage of smoke. Clearance between bottom of door and floor covering is not exceeding 1 inch. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with positive latching hardware. Dutch doors meeting 18.3.6.3.6 are permitted. Roller latches shall be prohibited. 18.3.6.3	◉	○		
	Show in REMARKS, details of doors, such as fire protection ratings, automatic closing devices, etc.				
K19	Vision panels in corridor walls or doors shall be fixed window assemblies in approved frames. (In fully sprinklered smoke compartments, there are no restrictions in the area and fire resistance of glass and frames.) In other than smoke compartments containing patient bedrooms, miscellaneous opening are permitted in vision panels or doors provided the aggregate area of the opening per room does not exceed 20 in.^{2} and the opening is installed in bottom half of the wall (80 in.^{2} in fully sprinklered buildings). 18.3.6.5, 19.3.6.2.3, 19.3.6.3.8, 19.3.6.5	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	VERTICAL OPENINGS				
K20	2000 EXISTING Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
	2000 NEW Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least two hours connecting four stories or more. (One hour for single story building and buildings up to three stories in height.) An atrium may be used in accordance with 8.2.5.6, 8.2.5, 18.3.1.1.	○	○	◉	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K21	Doors in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure are self-closing and kept in the closed position, unless held open by as release device complying with 7.2.1.8.2 that automatically closes all such doors throughout the smoke compartment or entire facility upon activation of: ☑ (a) The required manual fire alarm system and ☑ (b) Local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system and ☑ (c) The automatic sprinkler system, if installed 18.2.2.2.6, 18.3.1.2, 19.2.2.2.6, 19.3.1.2, 7.2.1.8.2 Door assemblies in vertical openings are of an approved type with appropriate fire protection rating. 8.2.3.2.3.1 Boiler rooms, heater rooms, and mechanical equipment rooms doors are kept closed.	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Describe method used in REMARKS				
	SMOKE COMPARTMENTATION AND CONTROL				
K23	2000 EXISTING Smoke barriers shall be provided to form at least two smoke compartments on every sleeping room floor for more than 30 patients. 19.3.7.1, 19.3.7.2				
	2000 NEW Smoke barriers shall be provided to form at least two smoke compartments on every floor used by inpatients for sleeping or treatment, and on every floor with an occupant load of 50 or more persons, regardless of use. Smoke barriers shall also be provided on floors that are usable, but unoccupied. 18.3.7.1, 18.3.7.2	◉	○	○	
K24	The smoke compartments shall not exceed 22,500 square feet and the travel distance to and from any point to reach a door in the required smoke barrier shall not exceed 200 feet. 18.3.7.1, 19.3.7.1	◉	○	○	
	Detail in REMARKS zone dimensions including length of zones and dead end corridors.				
K25	2000 EXISTING Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5				
	2000 NEW Smoke barriers shall be constructed to provide at least a one hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels in approved frames. 8.3, 18.3.7.3, 18.3.7.5	◉	○	○	
K26	Space shall be provided on each side of smoke barriers to adequately accommodate the total number of occupants in adjoining compartments. 18.3.7.4, 19.3.7.4	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K27	2000 EXISTING Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors shall be self-closing or automatic-closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7				
	2000 NEW Doors in smoke barriers have at least a 20 minute fire protection rating or are at least 1¾ inch thick solid bonded core wood. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Swinging doors shall be arranged so that each door swings in an opposite direction. Doors shall be self-closing and rabbets, bevels or astragals are required at the meeting edges. Positive latching is not required. 18.3.7.5, 18.3.7.6, 18.3.7.8	◉	○	○	
K28	2000 EXISTING Door openings in smoke barriers shall provide a minimum clear width of 32 inches (81 cm) for swinging or horizontal doors. 19.3.7.7				
	2000 NEW Door openings in smoke barriers are installed as swinging or horizontal doors shall provide a minimum clear width as follows: 18.3.7.7	◉	○	○	

Provider Type	Swinging Doors	Horizontal Sliding Doors
Hospitals and Nursing Facilities	41.5 inches (105 cm)	83 inches (211 cm)
Psychiatric Hospitals and Limited Care Facilities	32 inches (81 cm)	64 inches (163 cm)

ID PREFIX		MET	NOT MET	N/A	REMARKS
K104	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.5. Dampers are not required in duct penetrations of smoke barriers in fully ducted HVAC systems where a sprinkler system in accordance with 18/19.3.5 is provided for adjacent smoke compartments. 18.3.7.3, 19.3.7.3. Hospitals may apply a 6-year damper testing interval conforming to NFPA 80 & NFPA 105. All other health care facilities must maintain a 4-year damper maintenance interval. 8.3.5	◉	○	○	
	Describe any mechanical smoke control system in REMARKS.				
	HAZARDOUS AREAS				
K29	2000 EXISTING One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors. Doors shall be self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1				

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms			
c. Laundries (greater than 100 sq feet)			
d. Repair Shops and Paint Shops			
e. Laboratories (if classified a Severe Hazard - see K31)			
f. Combustible Storage Rooms/Spaces (over 50 sq feet)			
g. Trash Collection Rooms			
i. Soiled Linen Rooms			

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Hazardous areas are protected in accordance with 8.4. The areas shall be enclosed with a one hour fire-rated barrier, with a ¾ hour fire-rated door, without windows (in accordance with 8.4). Doors shall be self-closing or automatic closing in accordance with 7.2.1.8. Hazardous areas are protected by a sprinkler system in accordance with 9.7, 18.3.2.1, 18.3.5.1.	◉	○	○	

Area	Automatic Sprinkler	Separation	N/A
a. Boiler and Fuel-Fired Heater Rooms	✓	✓	
c. Laundries (greater than 100 sq feet)			✓
d. Repair, Maintenance and Paint Shops			✓
e. Laboratories (if classified a Severe Hazard - see K31)			✓
f. Combustible Storage Rooms/Spaces (over 50 and less than 100 sq feet)	✓	✓	
g. Trash Collection Rooms			✓
i. Soiled Linen Rooms	✓	✓	
m. Combustible Storage Rooms/Spaces (over 100 sq feet)	✓	✓	

Describe the floor and zone locations of hazardous areas that are deficient in REMARKS.

K30	Gift shops shall be protected as hazardous areas when used for storage or display of combustibles in quantities considered hazardous. Non-rated walls may separate gift shops that are not considered hazardous, have separate protected storage and that are completely sprinkled. Gift shops may be open to the corridor if they are not considered hazardous, have separate protected storage, are completely sprinklered and do not exceed 500 square feet. 18.3.2.5, 19.3.2.5	○	○	◉	

Area	Automatic Sprinkler	Separation	N/A
L. Gift Shop storing hazardous quantities of combustibles			

ID PREFIX		MET	NOT MET	N/A	REMARKS
K211	Where Alcohol Based Hand Rub (ABHR) dispensers are installed: ☑ The corridor is at least 6 feet wide ☑ The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms) ☑ The dispensers shall have a minimum spacing of 4 ft from each other ☑ Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet. ☑ Dispensers are not installed over or adjacent to an ignition source. ☑ If the floor is carpeted, the building is fully sprinklered. 18.3.2.7, CFR 403.744, 418.110, 460.72, 482.41, 483.70, 485.623	◉	○	○	
	EXITS AND EGRESS				
K22	Access to exits shall be marked by approved, readily visible signs in all cases where the exit or way to reach exit is not readily apparent to the occupants. Doors, passages or stairways that are not a way of exit that are likely to be mistaken for an exit have a sign designating “No Exit”. 7.10, 18.2.10.1, 19.2.10.1	◉	○	○	
K32	Not less than two exits, remote from each other, are provided for each floor or fire section of the building. Not less than one exit from each floor or fire section shall be a door leading outside, stair, smoke-proof enclosure, ramp, or exit passageway. Only one of these two exits may be a horizontal exit. Egress shall not return through the zone of fire origin. 18.2.4.1, 18.2.4.2, 19.2.4.1, 19.2.4.2	◉	○		
K33	2000 EXISTING Exit enclosures (such as stairways) are enclosed with construction having a fire resistance rating of at least one hour, are arranged to provide a continuous path of escape, and provide protection against fire or smoke from other parts of the building. 7.1.3.2, 8.2.5.2, 8.2.5.4, 19.3.1.1 *If all vertical openings are properly enclosed with construction providing at least a two hour fire resistance rating, also check this box.* ☐				
	If enclosures are less than required, give a brief description and specific location in REMARKS.				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Exit enclosures (such as stairways) in buildings four stories or more are enclosed with construction having a fire resistance rating of at least two hours, are arranged to provide a continuous path of escape, and provide a protection against fire and smoke from other parts of the building. In all buildings less than four stories, the enclosure is at least one hour. 7.1.3.2, 8.2.5.2, 8.2.5.4, 18.3.1.1, 18.2.2.3	◉	○	○	
	If enclosures are less than required, give a brief description and specific location in REMARKS.				
K34	Stairways and smokeproof enclosures used as exits are in accordance with 7.2. 18.2.2.3, 18.2.2.4, 19.2.2.3, 19.2.2.4	○	○	◉	
K35	The capacity of required mean of egress is based on its width, in accordance with 7.3.	◉	○		
K36	Travel distance (exit access) to exits are measured in accordance with 7.6. • Room door to exit ≤ 100 ft (≤ 150 ft sprinklered) • Point in room or suite to exit ≤ 150 ft (≤ 200 ft sprinklered) • Point in room to room door ≤ 50 ft • Point in suite to suite door ≤ 100 ft 18.2.6, 19.2.6	◉	○		
K37	2000 EXISTING Existing dead-end corridors shall be permitted to be continued to be used if it is impractical and unfeasible to alter them so that exists are accessible in not less than two different directions from all points in aisles, passageways, and corridors. 19.2.5.10				
	2000 NEW Every exit and exit access shall be arranged so that no corridor, aisle or passageway has a pocket or dead-end exceeding 30 feet. 18.2.5.10	◉	○	○	
K38	Exit access is so arranged that exits are readily accessible at all times in accordance with 7.1. 18.2.1, 19.2.1	◉	○		
K39	2000 EXISTING Width of aisles or corridors (clear and unobstructed) serving as exit access shall be at least 4 feet. 19.2.3.3				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW Width of aisles or corridors (clear and unobstructed) serving as exit access in hospitals and nursing homes shall be at least 8 feet. In limited care facility and psychiatric hospitals, width of aisles or corridors shall be at least 6 feet. 18.2.3.3, 18.2.3.4	◉	○		
K40	2000 EXISTING Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 32 inches in clear width. An exception is provided for existing 34-inch doors in existing occupancies. 19.2.3.5				
	2000 NEW Exit access doors and exit doors used by health care occupants are of the swinging type and are at least 41.5 inches in clear width. Doors in exit stairway enclosures shall be no less than 32 inches in clear width. In psychiatric hospitals or limited care facilities (e.g.,ICF/MD providing medical treatment) doors are at least 32 inches wide. 18.2.3.5	◉	○		
K41	All sleeping rooms have a door leading to a corridor providing access to an exit or have a door leading directly to grade. One room may intervene in accordance with 18.2.5.1, 19.2.5.1 *If doors lead directly to grade from each room, check this box.* ☐	◉	○		
K42	Any patient sleeping room or suite of rooms of more than 1,000 sq. ft. has at least 2 exit access doors remote from each other. 18.2.5.2, 19.2.5.2	◉	○		
K43	Patient room doors are arranged such that the patients can open the door from inside without using a key. Special door locking arrangements are permitted in facilities. 18.2.2.2.4, 18.2.2.2.5, 19.2.2.2.4, 19.2.2.2.5	◉	○	○	
	If door locking arrangement without delay egress is used indicate in REMARKS 18.2.2.2.2, 19.2.2.2.2	○	○	◉	
K44	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5, 19.2.2.5	◉	○	○	
K47	Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 18.2.10.1, 19.2.10.1 (Indicate N/A in one story existing occupancies with less than 30 occupants where the line of exit travel is obvious.)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K72	Means of egress shall be continuously maintained free of all obstructions or impediments to full instant use in the case of fire or other emergency. No furnishings, decorations, or other objects shall obstruct exits, access thereto, egress there from, or visibility thereof shall be in accordance with 7.1.10. 18.2.1, 19.2.1	◉	○		
	ILLUMINATION				
K45	Illumination of means of egress, including exit discharge, is arranged so that failure of any single lighting fixture will not leave the area in darkness. Lighting system shall be either continuously in operation or capable of automatic operation without manual intervention. 18.2.8, 19.2.8, 7.8	◉	○		
K46	Emergency lighting of at least 1½ hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1.	◉	○		
K105	2000 NEW (INDICATE N/A FOR EXISTING) Buildings equipped with or requiring the use of life support systems (electro-mechanical or inhalation anesthetics) have illumination of means of egress, emergency lighting equipment, exit, and directional signs supplied by the Life Safety Branch of the electrical system described in NFPA 99. 18.2.9.2., 18.2.10.2 (Indicate N/A if life support equipment is for emergency purposes only).	○	○	◉	
	EMERGENCY PLAN AND FIRE DRILLS				
K48	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 18.7.1.1, 19.7.1.1	◉	○	○	
K50	Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2	○	◉	○	K50- It was observed during document review that a fire drill was not documented for the evening shift during the second quarter.

ID PREFIX		MET	NOT MET	N/A	REMARKS
	FIRE ALARM SYSTEMS				
K51	A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6	◉	○		
K52	A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7,	◉	○		
K155	Where a required fire alarm system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch shall be provided for all parties left unprotected by the shutdown until the fire alarm system has been returned to service. 9.6.1.8	◉	○	○	
K53	2000 EXISTING (INDICATE N/A FOR HOSPITAL AND FULLY SPRINKLERED NURSING HOMES) In an existing nursing home, not fully sprinklered, the resident sleeping rooms and public areas (dining rooms, activity rooms, resident meeting rooms, etc) are to be equipped with single station battery-operated smoke detectors. There will be a testing, maintenance and battery replacement program to ensure proper operation. CFR 483.70				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	2000 NEW (NURSING HOME AND EXISTING LIMITED CARE FACILITIES) An automatic smoke detection system is installed in all corridors. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridor.) Such detectors are electrically interconnected to the fire alarm system. 18.3.4.5.3	◉	○	○	
K109	2000 EXISTING LIMITED CARE FACILITIES (INDICATE N/A FOR HOSPITALS OR NURSING HOMES) An automatic smoke detection system is installed in all corridors with detector spacing no further apart than 30 ft on center in accordance with NFPA 72. (As an alternative to the corridor smoke detection system on patient sleeping room floors, smoke detectors may be installed in each patient sleeping room and at smoke barrier or horizontal exit doors in the corridors.) Such detectors are electrically interconnected to the fire alarm system. 19.3.4.5.1 Smoke Detection System ☐ Corridors ☐ Rooms ☐ Bath				
K54	All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3	◉	○		
	Give a brief description, in REMARKS of any smoke detection system which may be installed.				
K55	2000 EXISTING Every patient sleeping room shall have an outside window or outside door. Except for newborn nurseries and rooms intended for occupancy for less than 24 hours. 19.3.8				
	2000 NEW Every patient sleeping room shall have an outside window or outside door. The allowable sill height shall not exceed 36 inches (91 cm) above the floor. Windows are not required for recovery rooms, newborn nurseries, emergency rooms, and similar rooms	◉	○		

ID PREFIX		MET	NOT MET	N/A	REMARKS
	intended for occupancy for less than 24 hours. Window sill height for limited care facilities shall not exceed 44 inches (112 cm) above the floor. 18.3.8				
K60	Initiation of the required fire alarm systems shall be by manual fire alarm initiation, automatic detection, or extinguishing system operation. 18.3.4.2, 19.3.4.2, 9.6.2.1	◉	○		
	AUTOMATIC SPRINKLER SYSTEMS				
K56	2000 EXISTING Where required by section 19.1.6, Health care facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13				
	2000 NEW There is an automatic sprinkler system installed in accordance with NFPA13, Standard for the Installation of Sprinkler Systems, with approved components, device and equipment, to provide complete coverage of all portions of the facility. Systems are equipped with waterflow and tamper switches, which are connected to the fire alarm system. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 18.3.5, 18.3.5.1.	◉	○	○	
K154	Where a required automatic sprinkler system is out of service for more than 4 hours in a 24-hour period, the authority having jurisdiction shall be notified, and the building shall be evacuated or an approved fire watch system be provided for all parties left unprotected by the shutdown until the sprinkler system has been returned to service. 9.7.6.1.	◉	○	○	
	A. Date sprinkler system last checked and necessary maintenance provided. 10/28/2015				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	B. Show who provided the service. SUMMIT				
	C. Note the source of water supply for the automatic sprinkler system. CITY WATER				
	(Provide, in REMARKS, information on coverage for any non-required or partial automatic sprinkler system.)				
K61	Automatic sprinkler system supervisory attachments are installed and monitored for integrity in accordance with NFPA 72, and provide a signal that sounds and is displayed at a continuously attended location or approved remote facility when sprinkler operation is impaired. 9.7.2.1, NFPA 72	◉	○	○	
K62	Automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 18.7.6, 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	◉	○	○	
K63	Required automatic sprinkler systems have an adequate and reliable water supply which provides continuous and automatic pressure. 9.7.1.1, NFPA 13	◉	○	○	
K64	Portable fire extinguishers shall be installed, inspected, and maintained in all health care occupancies in accordance with 9.7.4.1, NFPA 10. 18.3.5.6, 19.3.5.6	◉	○		
	SMOKING REGULATIONS				
K66	Smoking regulations shall be adopted and shall include not less than the following provisions: 18.7.4, 19.7.4, 8-6.4.2 (NFPA 99) (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. Exception: In facilities where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs that prohibit smoking in use areas are not required. (Note: This exception is not applicable to medical gas storage areas.) 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(2) Smoking by patients classified as not responsible shall be prohibited, except when under direct supervision. (3) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (4) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted.	◉	○	○	
	BUILDING SERVICE EQUIPMENT				
K67	Heating, ventilating, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2, NFPA 90A, 18.5.2.2, 19.5.2.2	◉	○	○	
K68	Combustion and ventilation air for boiler, incinerator and heater rooms is taken from and discharged to the outside air. 18.5.2.2, 19.5.2.2.	◉	○	○	
K69	Cooking facilities shall be protected in accordance with 9.2.3. 18.3.2.6, 19.3.2.6, NFPA 96	○	○	◉	
K70	Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212°F (100°C). 18.7.8, 19.7.8	◉	○	○	
K71	Rubbish Chutes, Incinerators and Laundry Chutes. 18.5.4, 19.5.4, 9.5, 8.4, NFPA 82 (1) Any existing linen and trash chute, including pneumatic rubbish and linen systems, that opens directly onto any corridor shall be sealed by fire resistive construction to prevent further use or shall be provided with a fire door assembly having a fire protection rating of 1 hour. All new chutes shall comply with 9.5. (2) Any rubbish chute or linen chute, including pneumatic rubbish and linen systems, shall be provided with automatic extinguishing protection in accordance with 9.7. (3) Any trash chute shall discharge into a trash collection room used for no other purpose and protected in accordance with 8.4.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(4) Existing flue-fed incinerators shall be sealed by fire resistive construction to prevent further use.	○	○	◉	
K160	2000 EXISTING Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. Existing elevators conform to ASME/ANSI A17.3, *Safety Code for Existing Elevators & Escalators*. All existing elevators, having a travel distance of 25 ft or more above or below the level that best serves the needs of emergency personnel for fire fighting purposes, conform with Firefighter's Service Requirements of ASME/ANSI A17.3. 9.4.2, 9.4.3, 19.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)				
	2000 NEW Elevators comply with the provision of 9.4. Elevators are inspected and tested as specified in A17.1, Safety Code for Elevators and Escalators. Fire Fighter's Service is operated monthly with a written record. New elevators conform to ASME/ANSI A17.1, Safety Code for Elevators and Escalators, including Fire Fighter's Service Requirements. 9.4.2, 9.4.3, 18.5.3 (Includes firefighters service **phase I** key recall and smoke detector automatic recall, firefighters service **phase II** emergency in-car key operation, machine room smoke detectors, and elevator lobby smoke detectors.)	○	○	◉	
K161	2000 EXISTING Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All existing escalators, dumbwaiters, and moving walks conform to the requirements of ASME/ANSI A17.3, *Safety Code for Existing Elevators and Escalators.* 19.5.3, 9.4.2.2				

ID PREFIX		MET	NOT MET	N/A	REMARKS
	(Includes escalator emergency stop buttons and automatic skirt obstruction stop. For power dumbwaiters includes hoistway door locking to keep doors closed except for floor where car is being loaded or unloaded.)				
	2000 NEW Escalators, dumbwaiters, and moving walks comply with the provisions of 9.4. All escalators and conveyors comply with ASME/ANSI A17.1, *Safety Code for Elevators and Escalators.* 18.5.3, 9.4.2.1	○	○	◉	
	FURNISHINGS AND DECORATIONS				
K73	Combustible decorations shall be prohibited unless they are flame-retardant or in such limited quantity that hazard of fire development or spread is not present. 18.7.5.4, 19.7.5.4	◉	○	○	
K74	Draperies, curtains, including cubicle curtains, and other loosely hanging fabrics and films serving as furnishings or decorations are flame resistant in accordance with NFPA 701 except for shower curtains. Sprinklers in areas where cubical curtains are installed shall be in accordance with NFPA 13 to avoid obstruction of the sprinkler. 10.3.1, 18.3.5.5, 19.3.5.5, 18.7.5.1, 19.7.5.1, NFPA 13 ☑ Newly introduced upholstered furniture shall meet the char length and heat release criteria specified when tested in accordance with the methods cited in 10.3.2 (2) and 10.3.3, 18.7.5.2, 19.7.5.2. ☑ Newly introduced mattresses shall meet the char length and heat release criteria specified when tested in accordance with the method cited in 10.3.2 (3) and 10.3.4. 18.7.5.3, 19.7.5.3 ☑ Newly introduced upholstered furniture and mattresses means purchased since March, 2003.	◉	○	○	
K75	Soiled linen or trash collection receptacles shall not exceed 32 gal (121 L) in capacity. The average density of container capacity in a room or space shall not exceed .5 gal/ft^2 (20.4 L/m^2). A	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	capacity of 32 gal (121 L) shall not be exceeded within any 64-ft^2 (5.9-m^2) area. Mobile soiled linen or trash collection receptacles with capacities greater than 32 gal (121 L) shall be located in a room protected as a hazardous area when not attended. 18.7.5.5, 19.7.5.5	◉	○	○	
	LABORATORIES				
K31	Laboratories employing quantities of flammable, combustible, or hazardous materials that are considered a severe hazard shall be protected in accordance with NFPA 99. (Laboratories that are not considered to be severe hazard shall meet the provision of K29.) 18.3.2.2, 19.3.2.2, Chapter 10 (NFPA 99)	○	○	◉	
K136	Procedures for laboratory emergencies shall be developed. Such procedures shall include alarm actuation, evacuation, and equipment shutdown procedures, and provisions for control of emergencies that could occur in the laboratory, including specific detailed plans for control operations by an emergency control group within the organization or a public fire department in accordance with 10-2.1.3.1 (NFPA 99), 18.3.2.2., 19.3.2.1	○	○	◉	
K131	Emergency procedures shall be established for controlling chemical spills in accordance with 10-2.1.3.2 (NFPA 99)	○	○	◉	
K132	Continuing safety education and supervision shall be provided, incidents shall be reviewed monthly, and procedures reviewed annually shall be in accordance with 10-2.1.4.2 (NFPA 99).	○	○	◉	
K133	Fume hoods shall be in accordance with 5-4.3, 5-6.2 (NFPA 99).	○	○	◉	
K134	Where the eyes or body of any person can be exposed to injurious corrosive materials, suitable fixed facilities for quick drenching or flushing of the eyes and body shall be provided within the work area for immediate emergency use. Fixed eye baths designed and installed to avoid injurious water pressure shall be in accordance with 10-6 (NFPA 99).	○	○	◉	
K135	Flammable and combustible liquids shall be used from and stored in approved containers in accordance with NFPA 30, Flammable and Combustible Liquids Code, and NFPA 45, Standard on Fire Protection for Laboratories Using Chemicals.	○	○	◉	

ID PREFIX		MET	NOT MET	N/A	REMARKS
	Storage cabinets for flammable and combustible liquids shall be constructed in accordance with NFPA 30, Flammable and Combustible liquids Code, 4-3 (NFPA 99), 10-7.2.1 (NFPA 99)	○	○	◉	
	MEDICAL GASES AND ANESTHETIZING AREAS				
K76	Medical gas storage and administration areas shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. 4-3.1.1.2 (NFPA 99), 8-3.1.11.1 (NFPA 99), 18.3.2.4, 19.3.2.4	◉	○	○	
K77	Piped in medical gas, vacuum and waste anesthetic gas disposal systems comply with NFPA 99, Chapter 4.	○	○	◉	
K78	Anesthetizing locations shall be protected in accordance with NFPA 99, Standard for Health Care Facilities. (a) Shutoff valves are located outside each anesthetizing location and arranged so that shutting off one room or location will not affect others. (b) Relative humidity is maintained equal to or great than 35% 4-3.1.2.3(n) and 5-4.1.1 (NFPA 99), 18.3.2.3, 19.3.2.3	○	○	◉	
K140	Medical gas warning systems shall be in accordance with NFPA 99, Standard for Health Care Facilities. (a) Master alarm panels are in two separate locations and have audible and visible signals. (b) There are high/low alarms for +/- 20% operating pressure. This section shall be in accordance with NFPA 99, 4-3.1.2.2 (c) Where a level 2 gas system is used, one alarm panel that complies with 4-3.1.2.2(b)3a,b,c,d and with 4-3.1.2.2(c)2,5 shall be permitted. 4-4.1 (NFPA 99) exception No. 4. 4-3.1.2.2 (NFPA 99)	○	○	◉	
K141	Medical gas storage areas shall have a precautionary sign, readable from a distance of 5 ft, that is conspicuously displayed on each door or gate of the storage room or enclosure. The sign shall include the following wording as a minimum: CAUSION, OXIDIZING GAS(ES) STORED WITHIN, NO SMOKING. 18.3.2.4, 19.3.2.4, 8-3.1.11.3 (NFPA 99)	◉	○	○	

ID PREFIX		MET	NOT MET	N/A	REMARKS
K142	All occupancies containing hyperbaric facilities shall comply with NFPA 99, Standard for Health Care Facilities, Chapter 19.	○	○	◉	
K143	Transferring of liquid oxygen from one container to another shall be accomplished at a location specifically designated for the transferring that is as follows:: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; and (b) the area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area that is posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and Compressed Gas Association. 8-6.2.5.2 (NFPA 99)	○	◉	○	K143- It was observed that the oxygen transfilling room had vinyl floor tiles.
	ELECTRICAL AND EMERGENCY POWER				
K106	Hospitals and inpatient hospices with life support equipment have an Type I Essential Electric System, and nursing homes have a Type II ESS that are powered by a generator with a transfer switch and separate power supply in accordance with NFPA 99. 12-3.3.2, 13-3.3.2.1, 16-3.3.2 (NFPA 99)	○	○	◉	
K107	Required alarm and detection systems are provided with an alternative power supply in accordance with NFPA 72. 9.6.1.4, 18.3.4.1, 19.3.4.1	◉	○		
K108	2000 NEW (INDICATE N/A FOR EXISTING) Power for Alarms, emergency communication systems, and illumination of generator set locations are in accordance with essential electrical system of NFPA 99. 18.5.1.2	◉	○	○	
K144	Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110)	◉	○	○	
K145	The Type I EES is divided into the critical branch, life safety branch and the emergency system and Type II EES is divided into the emergency and critical systems in accordance with 3-4.2.2.2, 3-5.2.2 (NFPA 99)	○	○	◉	

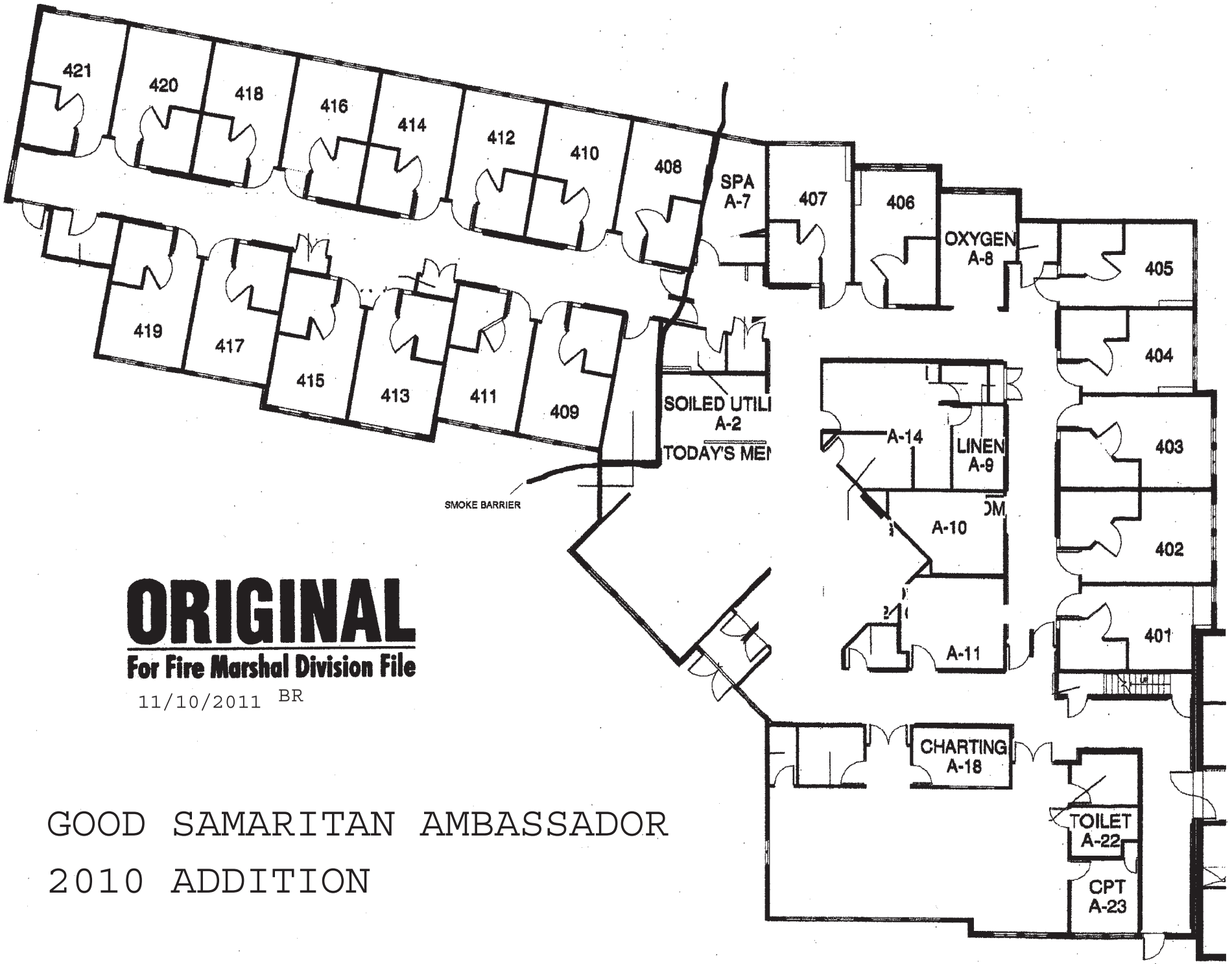
ID PREFIX		MET	NOT MET	N/A	REMARKS
K146	The nursing home/hospice with no life support equipment shall have an alternate source of power separate and independent from the normal source that will be effective for minimum of 1½ hour after loss of the normal source 3-6. (NFPA 99)	◉	○	○	
K147	Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1	◉	○		
K130	Miscellaneous List in the REMARKS sections, any items that are not listed previously, but are deficient. This information, along with the applicable Life Safety Code or NFPA standard citation, should be included on Form CMS-2567.	○	○	◉	

PART IV RECOMMENDATION FOR WAIVER OF SPECIFIC LIFE SAFETY CODE PROVISIONS

For each item of the Life Safety code recommended for waiver, list the survey report form item number and state the reason for the conclusion that: (a) the specific provisions of the code, if rigidly applied, would result in unreasonable hardship on the facility, and (b) the waiver of such unmet provisions will not adversely affect the health and safety of the patients. If additional space is required, attach additional sheet(s).

PROVISION NUMBER(S)	JUSTIFICATION
K84	

Surveyor *(Signature)*	Title	Office	Date
Fire Authority Official *(Signature)*	Title	Office	Date



ORIGINAL

For Fire Marshal Division File

11/10/2011 BR

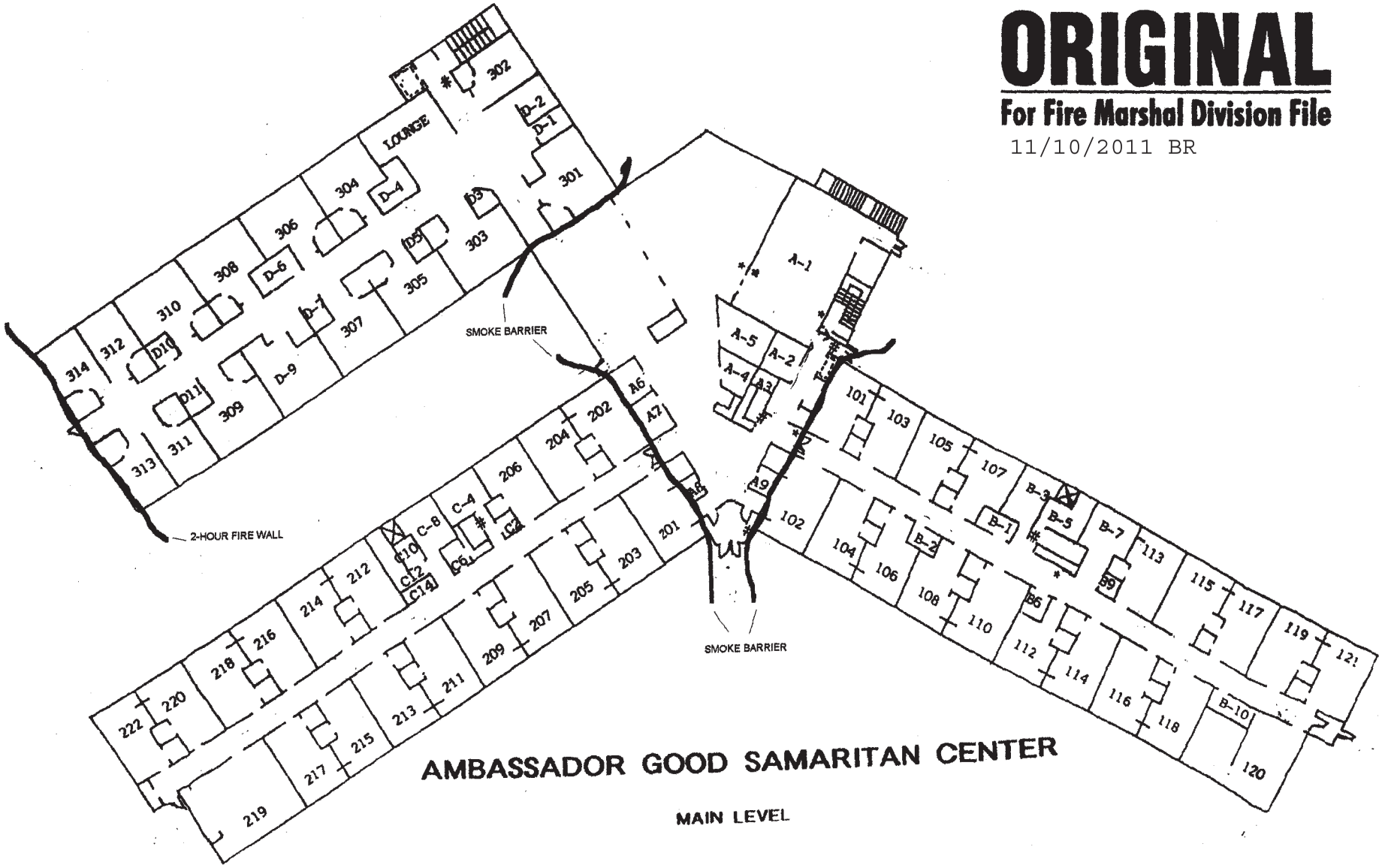
GOOD SAMARITAN AMBASSADOR

2010 ADDITION

ORIGINAL

For Fire Marshal Division File

11/10/2011 BR



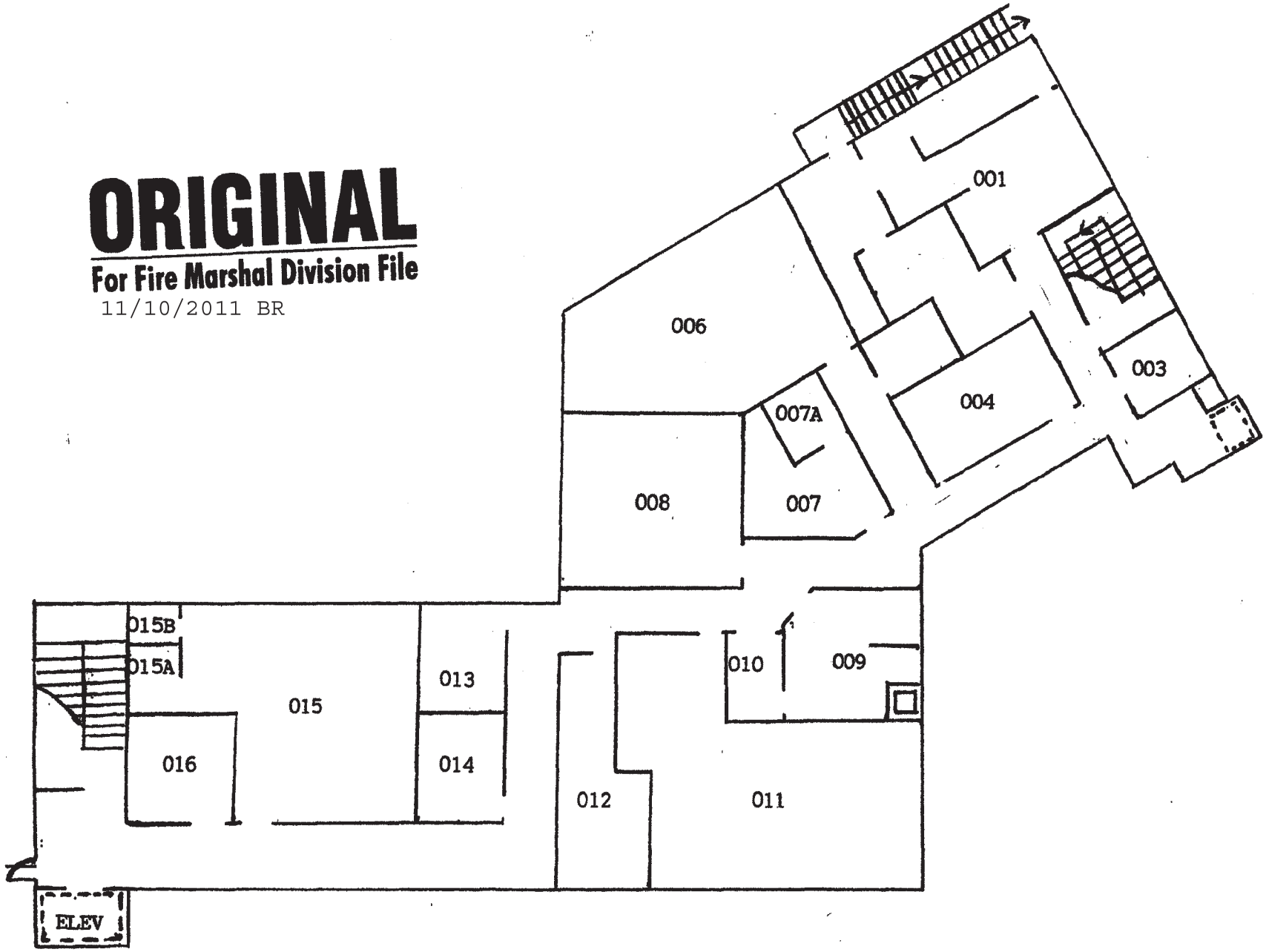
AMBASSADOR GOOD SAMARITAN CENTER

MAIN LEVEL

ORIGINAL

For Fire Marshal Division File

11/10/2011 BR



AMBASSADOR GOOD SAMARITAN CENTER

BASEMENT LEVEL

PROJECT NUMBER:	PROVIDER NAME	SURVEY DATE
F5149025	GOOD SAMARITAN AMBASSADOR	02/12/2016

Administrator: MARIE BARTA | Phone Number: 763/544-4171

Email address: MBARTA@BOOD-SAM.COM

State Fire Inspector: WILLIAM ABDERHALDEN 507-361-6204

These are preliminary findings only. A complete and final Statement of Deficiencies 2567 report will be provided by US Mail.

☐ **At the time of this inspection, this facility was found to comply with the requirements of the 2000 Life Safety Code applicable to:** ☑ **SNF/NF** ☐ **Hospital** ☐ **ICFMR** ☐ **ASC Facilities participating in the Medicare/Medicaid programs.**

☑ **The following fire/life safety deficiencies were found during this inspection:**

K TAG S& S	☑ **Draft Summary of Deficiency(ies)** ☐ **Revisit** ☐ **Clearance**
K12 S&S= F	It was observed that the two hour separation had fiberglass insulation and no fire caulking around the penetrations through the wall between the 1997 building and the 2010 building. Therefore, a 2-hour fire separation cannot be confirmed.
K50 S&S= C	It was observed during document review that a fire drill was not documented for the evening shift during the second quarter.
K143 S&S= E	It was observed that both oxygen transfilling rooms had vinyl floor tiles.