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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2CLO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**
2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **07/18/2016** (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 **43** (L18)
13.Total Certified Beds **43** (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
	43			
(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 :
Susanne Reuss, Unit Supervisor 07/18/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 08/15/2016 (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
04/14/1981
(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 08/11/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
07/06/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245237
August 15, 2016

Mr. Marcus Parence, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Dear Mr. Parence:

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 July 12, 2016 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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
August 15, 2016

Mr. Marcus Parence, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

RE: Project Number F5237024

Dear Mr. Parence:

On June 14, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 2, 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 July 18, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 24, 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 June 2, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 12, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 2, 2016, effective July 12, 2016 and therefore remedies outlined in our letter to you dated June 14, 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
245237 Y1	A. Building B. Wing Y2	7/18/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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 F0226	Correction	ID Prefix F0280	Correction	ID Prefix F0282	Correction
Reg. # 483.13(c)	Completed	Reg. # 483.20(d)(3), 483.10(k)(2)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	07/12/2016	LSC	07/12/2016	LSC	07/12/2016
ID Prefix F0309	Correction	ID Prefix F0323	Correction	ID Prefix F0334	Correction
Reg. # 483.25	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.25(n)	Completed
LSC	07/12/2016	LSC	07/12/2016	LSC	07/12/2016
ID Prefix F0441	Correction	ID Prefix F0492	Correction	ID Prefix F0502	Correction
Reg. # 483.65	Completed	Reg. # 483.75(b)	Completed	Reg. # 483.75(j)(1)	Completed
LSC	07/12/2016	LSC	07/12/2016	LSC	07/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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) SR/KJ	DATE 08/15/2016	SIGNATURE OF SURVEYOR 16022	DATE 07/18/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 6/2/2016

☐ 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
245237 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/24/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	07/12/2016	LSC K0029	07/12/2016	LSC K0038	07/12/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0072	07/12/2016	LSC K0144	07/12/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
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) TL/KJ	DATE 08/15/2016	SIGNATURE OF SURVEYOR 35482	DATE 07/24/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
6/2/2016	☐ 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: 2CLO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**

2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **06/02/2016** (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 **43** (L18)

13.Total Certified Beds **43** (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
	43			
(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 :
LoAnn DeGagne, HFE NE II — 06/24/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 07/01/2016 (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
04/14/1981
(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 07/06/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2016

Mr.. Marcus Parence, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, Minnesota 56283

RE: Project Number S5237023

Dear Mr.. Parence:

On June 2, 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.

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:

Susanne Reuss, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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 July 12, 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 July 12, 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 September 2, 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 December 2, 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.

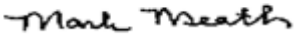
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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.	F 000		
F 226 SS=E	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. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to conduct reference checks and background study for 1 of 5 newly hired employee (nursing assistant (NA)-C) whose position included direct contact with multiple residents. Findings include: The facility Abuse and Neglect policy, revised 9/13, included, "The center will not knowingly employ individuals who have been found quilty of abusing, neglecting or mistreating residents by a	F 226	1.The background study was completed for NA-C on June 12th 2016 and reference checks were completed on June 21, 2016. 2.All new hired employees will be reviewed for completion of background study and reference checks 3.Re-training for all department heads for ensuring that reference checks and background study are completed prior to hire on June 22, 2016 4.Human Resource Director, or her	7/12/16

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

Electronically Signed | 06/23/2016

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F 226	Continued From page 1 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." The facility Background Investigations policy and procedure, revised 4/16, included, "All offers of employment shall be conditioned on the successful completion of the federal exclusion and criminal background check, the results of personal and professional reference checks and any other pre-employment requirements such as physical assessments, state-specific criminal background check or screens for illegal drugs and alcohol." During an interview on 6/2/16, at 2:26 p.m., the office manager stated NA-C was hired on 1/19/16, after observing through a school program and then decided she wanted to work at the facility. On 12/1/15, NA-C signed the authorization for the background check, but the office manager was unable to locate the completed background check and lacked evidence of completing reference checks. During an interview on 6/2/16, at 3:15 p.m., the administrator verified NA-C's background check and reference checks could not be located.	F 226	designee, will audit for need for completion of reference checks and background studies prior to hire weekly x 4 weeks. QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280		7/12/16

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F 280	Continued From page 2 A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan for 1 of 3 residents (R30) who was reviewed for falls. Findings include: R30's quarterly minimum data set (MDS), dated 5/20/16, indicated she had severe cognitive impairment. R30's care care assessment (CAA), dated 11/13/15, indicated she was at risk for falls based on impaired balance, impaired vision and hearing, and the use of antipsychotics. R30 had the following falls: - On 2/7/16, R30 was found lying on the floor next to her wheelchair. Interventions after this fall included placing a personal alarm and increasing R30's toileting schedule. - On 5/19/16, R30 was found lying on the floor next to her wheelchair while propelling herself down the hallway, Interventions after this fall	F 280	1.Care plan reviewed and fall interventions put into place for R30. 2.All other resident□s care plans were reviewed for appropriate fall interventions. 3.All residents are assessed upon admission for fall risk using the Falls Risk Assessment. . Re-training of all licensed staff will be completed on care planning fall interventions on June28, 29 and 30th 2016. 4.Audits of residents at risk for falls care plan to be audited weekly to ensure compliance. DNS, or designee, will be responsible for compliance.QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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F 280	Continued From page 3	F 280		

included placing Dysem in her wheelchair.
- On 5/21/16, R30 was found lying on the floor next to her bed. Interventions after this fall included placing a fall mat on the floor next to her bed.

On 6/1/16, at 6:49 p.m., R30 was observed being transferred into bed and repositioned by nursing assistant (NA)-D. A floor mat was observed lying on the ground beside R30's bed.

Later that night at 6:59 p.m., NA-D stated she was aware that R30 had a history of falling and had a bed alarm to notify staff if R30 was getting out of bed.

During an interview on 6/2/16, at 7:34 a.m., NA-E was unable to state fall interventions for R30, but further stated she would check R30's care plan for fall interventions.

Later that day at 8:15 a.m., R30 was observed being transferred into bed by NA-E and NA-F. During the observation, NA-E was not aware of the reason for the floor mat; however, NA-F stated the fall mat was on the floor because R30 was a "fall risk." NA-F went on to state R30 also had Dysem in her wheelchair to prevent her from slipping out; however, when she went to check on the R30's wheelchair, she stated there wasn't any Dysem in R30's wheelchair.

R30's most current careplan, revised 10/29/15, listed a personal bed alarm as a current intervention, to "remind resident not to stand up or exit building unattended." R30's care plan did not address putting Dysem in her wheelchair to prevent falls.

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F 280	Continued From page 4 On 6/2/16, at 8:20 a.m., register nurse (RN)-B stated the facility had gone alarm free and thought R30 no longer had a bed alarm. During interview, RN-C confirmed that R30 did not have a bed alarm and RN-B stated the intervention should be taken off the care plan. RN-B was unable to find any other interventions related for fall prevention on R30's care plan.	F 280		
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 implement interventions to prevent further falls for 1 of 3 residents (R54) reviewed for accidents. Findings include: R54's admission Minimum Data Set (MDS) dated 2/18/16, indicated R54 had severe memory impairment and needed extensive assistance to transfer. The MDS identified the following diagnoses cancer, hypertension, diabetes mellitus, osteoporosis, fracture, dementia and cataracts. The MDS further indicated R54 had a history of falls prior to admission with a fracture related to a fall prior to admission. R54's care plan dated 5/6/16, directed staff R54	F 282	1.Fall interventions reviewed and put into place for R54. Night light is in room R54 and is in working order. 2.All other resident's care plans were reviewed for fall interventions to ensure they are in place. 3.All residents are assessed upon admission for fall risk using the Falls Risk Assessment. Appropriate interventions are care planned to meet each resident's individual needs. 4.Re-training of all Nursing Staff will be completed on fall interventions and care planning June 28, 29,30th 2016 DNS or designee, will be responsible for compliance. Audits for placement of interventions will be conducted randomly at least 3 x weeks x 1 month. QA&A Committee will provide direction or	7/12/16

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F 282	Continued From page 5 was at risk for falls related to confusion and impulsive behavior and would attempt unsafe self transfers. Interventions included remind the resident to not bend over and pick up dropped items, encourage the use of the grabber or call for assistance, encourage to participate in activities that promote exercise and physical activity, ensure appropriate footwear, night light in room, monitor resident for significant changes in gait and mobility, nursing to check orthostatic blood pressures (lying, sitting, standing blood pressures to check for low blood pressure caused by a change in position) twice a day for three days and then update the physician. R54's medication administration record and blood pressure record were reviewed for twice daily orthostatic blood pressure (BP) documentation starting 5/11/16 on the p.m. shift and ending 5/14/16 on the a.m. shift. -5/11/16 p.m. shift lacked any documentation of orthostatic BP's -5/12/16 a.m. and p.m. shift lacked any documenting of orthostatic BP's. - 5/13/16, at 10:44 a.m. a sitting BP of 126/16 was recorded but lacked a record of lying and standing BP's. The p.m. shift lacked any documentation of orthostatic BP's - 5/14/16, at 4:08 a standing BP of 126/74, lying BP of 122/60 and sitting BP of 94/53 were recorded.	F 282	change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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F 282	Continued From page 6 On 6/2/16, at 8:51 a.m. R54's room was observed and a night light was not observed to be in the room or the bathroom. When interviewed on 6/2/16, at 11:49 a.m. registered nurse (RN)-C verified the orthostatic BP's were not documented as completed. When interviewed on 6/2/16, at 12:22 p.m. the director of nursing services (DNS) stated she expected care planned interventions to be followed. On 6/2/16, at 12:51 p.m. the DNS verified that R54 did not have a night light in his bedroom or bathroom, and it should have been placed in there by maintenance. A policy on care plans was requested and not received.	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 monitor bruises for 1 of 3 residents (R11) who were reviewed for non	F 309	1.Resident R11 had skin assessment completed June 2, 2016. 2.Daily skin assessment audits will be	7/12/16

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F 309	Continued From page 7 pressure related skin conditions. Findings include: R11 was admitted to the facility on 4/13/16 for rehab after being hospitalized. Her admission minimum data set (MDS), dated 4/20/16, had a BIMS of 14 and was cognitively intact. R11's admission care area assessment, dated 4/26/16, listed her as needing extensive assistance with bed mobility causing her to be at risk for pressure related skin conditions. R11's current physician orders, dated 4/20/16, listed coumadin (a blood thinning medication) 1.25 mg (milligrams) once a day every Tuesday and Thursday and coumadin 2.5 mg once a day every Monday and Wednesday related to unspecified atrial fibrillation (a heart condition). During observation on 5/31/16, at 1:02 p.m., three quarter size bruises were noted on R11's right forearm and one quarter size bruise was noted on the top of her left hand. R11 stated no one had hurt her but the bruises, "they just appear." On 6/1/16, at 6:38 p.m., the same bruises were noted on R11 and, in addition, she appeared to have a new bruise to her left inner wrist, approximately the same size as the others. Again, R11 stated no one had hurt her and she didn't have to do anything the bruises, "just come." She went on to state she took a blood thinner and the staff had never mentioned her bruises. R11 was observed wearing a short sleeve night gown making the bruises visible. During an interview later that evening, at 7:14	F 309	completed on designated bath days for all residents 3.All nursing staff will be retrained on June 28,29,30th 2016 on skin assessments 4.Weekly skin assessments will be audited by DNS or designee to prevent reoccurrence of deficiency for one month QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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F 309	Continued From page 8	F 309		

p.m., trained medication aide (TMA)-A stated skin observations were made with the residents' baths. The nurses would fill out the skin observation sheet if there were any skin concerns and scan it into the electronic medical record. She also stated new bruises were reported to the charge nurse, case manager, administrator, and resident's family. Then were investigated. Furthermore, TMA-A stated she was not aware of R11 having any bruises recently.

Later that same evening, 7:29 p.m., registered nurse (RN)-A stated bruises were documented in the progress notes, investigated, and monitored by verbally telling staff member to staff member. She further stated staff could document a progress note if a bruise was healing or getting worse, but mainly would "keep an eye on it" via verbal report. RN-A was unaware of R11's bruises stating she was never informed of them but R11 was on coumadin. She also stated she wouldn't know if the bruises were healing without reporting or documentation.

During an interview on 6/2/16, at 2:05 p.m., RN-B stated the nurses were expected to monitor for bruise and skin conditions on bath days, but further stated there had been a "breakdown" in communication regarding the monitoring. She also stated she was unaware of R11's bruises and, if she had been aware, would have notified the clinic nurse for further instruction.

R11's progress notes were reviewed from admission. The progress notes did not mention any bruises or skin concerns.

R11's "daily skilled notes" were reviewed from admission. The notes did not mention any skin

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F 309	Continued From page 9 concerns and noted R11's skin was normal. R11's "skin observation" assessments were reviewed from admission. The assessments indicated "no skin conditions observed." R11's current care plan, initiated on 4/22/16, did not address any skin related concerns and did not list any current skin interventions.	F 309		
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 fully investigate a fall and/or implement interventions to prevent further falls for 2 of 3 residents (R54, R30) reviewed for accidents. Findings include: R54's admission Minimum Data Set (MDS) dated 2/18/16, indicated R54 had severe memory impairment and needed extensive assistance to transfer. The MDS identified the following diagnoses: cancer, hypertension, diabetes mellitus, osteoporosis, fracture, dementia and cataracts. The MDS further indicated R54 had a	F 323	1.Fall interventions reviewed and put into place for R54 and R30. 2.All other resident□s care plans were reviewed for fall interventions to ensure they are in place. 3.All residents are assessed upon admission for fall risk using the Falls Risk Assessment. Appropriate interventions are care planned to meet each resident□s individual needs. 4.Re-training of all Nursing Staff will be completed on fall interventions and care planning on June 28,29 30th,2016.. DNS, or designee, will be responsible for compliance. Audits for placement of	7/12/16

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F 323	Continued From page 10 history of falls prior to admission with a fracture related to a fall prior to admission. R54's fall Care Area Assessment (CAA) dated 2/24/16, indicated R54 had impaired balance during transitions and was taking antidepressants and diuretics. The CAA identified the following risk factors: osteoporosis, cognitive impairment, depression, loss of leg movement, incontinence and visual impairments. The CAA indicated R54 was at high risk for falls and a care plan would be developed to decrease the risk of falling with the improvement of strength as R54 was working with physical and occupational therapy due to impaired balance. R54's care plan dated 5/6/16, indicated R54 was at risk for falls related to confusion and impulsive behavior and would attempt unsafe self transfers. Interventions included remind the resident to not bend over and pick up dropped items, encourage the use of the grabber or call for assistance, encourage to participate in activities that promote exercise and physical activity, ensure appropriate footwear, night light in room, monitor resident for significant changes in gait and mobility, nursing to check orthostatic blood pressures (lying, sitting, standing blood pressures to check for low blood pressure caused by a change in position) twice a day for three days and then update the physician. R54's Fall Tools were completed on the following dates: - 2/11/16 on admission and indicated a medium fall risk - 3/6/16 following a fall and indicated a medium	F 323	interventions will be conducted randomly at least 3x week x 1 month. QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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F 323	Continued From page 11 fall risk - 3/14/16 following a fall and indicated a medium fall risk - 3/27/16 following a fall and indicated a medium fall risk - 3/29/16 following a fall and indicated a medium fall risk - 4/6/16 following a fall and indicated a medium fall risk - 4/20/16 following a fall and indicated a medium fall risk - 5/6/16 following a fall and indicated a medium fall risk - 5/11/16 following a fall and indicated a low fall risk R54's fall investigation forms indicated R54 had the following falls: - 2/11/16, at 7:50 p.m. R54 was found in the bathroom sitting on the wheelchair foot pedals next to the toilet and the call light was on. R54 stated that the floor was slippery and his foot slid out from under him as he was trying to get to the bathroom. Vital signs and blood sugars were not documented. Bathroom floor noted to not be wet. R54 did not receive an injury. R54 was noted to have a walking boot on his right foot due to a fibula fracture. Intervention added was to encourage R54 to wait for help due to weakness.	F 323		

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F 323	Continued From page 12	F 323		

- 2/19/16, at 8:00 p.m. R54 was found on the floor sitting in the doorway of the bathroom. R54 stated he slipped out of the wheelchair when he was trying to get up. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention added was to encourage R54 to toilet after meals and during the morning and at bedtime, care plan was updated.

- 3/6/16, at 3:50 a.m. R54 was found on the floor in his room. Vital signs and blood sugars were not documented. R54 did not receive an injury. Interventions included remind R54 to use his call light, not to self transfer and added a sign to his walker to remind him to ask for assistance. R54 was on an antibiotic for an urinary tract infection.

- 3/14/16, at 8:45 p.m. R54 was found on the floor next to his recliner, call light within reach. Resident stated he was attempting to transfer from his chair to go to bed. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention added clip call light to resident shirt.

- 3/27/16, at 2:30 p.m. was found sitting on the floor next to his recliner. resident stated he was trying to get to his bed and fell. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention listed was R54 remained in physical and occupational therapy and had memory issues.

- 3/29/16, 2:20 p.m. R54 was found lying on the floor of the TV room and his walker was next to him tipped over. R54 stated he got lost and needed to sit down. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention included was R54 was still

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receiving therapy and his walking boot was to be discontinued on 4/12/16. R54 will continue to work with therapy for strengthening and ambulation.

- 4/6/16, at 9:00 a.m. R54 was found on the floor in the middle of his room. R54 stated he was trying to get to his recliner. Vital signs and blood sugars were not documented. R54 did not receive an injury. Interventions's included R54 was still receiving therapy and continues to wear a cam boot. R54 has a history of unsafe self transfers due to cognitive impairments.

- 4/20/16, at 10:25 p.m. R54 was found on the floor beside his bed, call light was sounding. R54 stated he didn't know what he was doing. Vital signs and blood sugars were not documented. R54 did not receive an injury. Interventions added were resident education, toileting plan reviewed and resident will be toileted after meals and every four hours promptly. MD discontinued hydrochlorothiazide (medication for controlling blood pressure) due to low blood pressures.

- 5/6/16, at 3:15 a.m. R54 was found sitting on the floor with his call light sounding. R54 stated he was coming back from the bathroom. Blood Sugar 125, BP 115/62, pulse 62, respirations 18, temperature 97.7 and oxygen saturation level 96%. No injury was noted. Intervention added was a night light placed in his bedroom.

- 5/10/16, 11:15 p.m. R54 found sitting on the floor. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention added was for nursing to obtain orthostatic blood pressures twice daily for three days and then update the physician.

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R54's medication administration record and blood pressure record were reviewed for twice daily orthostatic blood pressure (BP) documentation starting 5/11/16 on the p.m. shift and ending 5/14/16 on the a.m. shift.

-5/11/16 p.m. shift lacked any documentation of orthostatic BP's

-5/12/16 a.m. and p.m. shift lacked any documenting of orthostatic BP's.

- 5/13/16, at 10:44 a.m. a sitting BP of 126/16 was recorded at but lacked a record of lying and standing BP's. The p.m. shift lacked any documentation of orthostatic BP's

- 5/14/16, at 4:08 a standing BP of 126/74, lying BP of 122/60 and sitting BP of 94/53 were recorded.

The medical record lacked any notification to the physician that orthostatic BP's were not completed or of the orthostatic BP's that were completed on 5/14/16.

On 6/1/16, at 5:49 p.m. nursing assistant (NA)-A was observed transporting R54 via wheelchair to his room. NA-A asked R54 if he needed to use the bathroom and R54 stated no. NA-A then asked R54 if he wanted to sit in his recliner and R54 stated yes. NA-A moved R54 in the wheelchair to the side of the recliner, removed the wheelchair foot pedals, placed a transfer belt around R54's waist and then placed R54's walker in front of him. NA-A assisted R54 to stand and R54 used the walker and pivoted to the recliner and sat down. NA- removed the transfer belt and

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gave R54 his call light and instructed him to use it if he needed assistance.

On 6/1/16, at 5:55 p.m. NA-A stated that R54 has had a lot of falls and that staff needed to bring him back from meals right way, offer to toilet him and then transfer him to the recliner or he would self transfer himself. NA-A stated R54 rarely used his call light and could not remember it ever being on. NA-A further stated that they didn't change anything after each fall other than toileting him after meals.

On 6/2/16, at 7:48 a.m. NA-B stated the aids are informed of fall interventions in report and that R54's fall interventions were to toilet before and after meals and to check on him every hour.

On 6/2/16, at 8:02 a.m. registered nurse (RN)-D stated that after a fall they do a fall huddle with the staff that are working, assess the resident from where they fell, check for range of motion, pain and injury. RN-D further stated that if a resident has care planned interventions they do not make changes unless there is a new reason for a fall. RN-D stated that the fall paperwork is left in the case managers box and they review the paperwork and update the care plan if needed. RN-D stated that R54 is difficult to prevent falls due R54 being able to walk but shouldn't on his own.

On 6/2/16, at 8:51 a.m. R54's room was observed and a night light was not observed to be in the room or the bathroom.

When interviewed on 6/2/16, at 11:49 a.m. occupational therapist (OT) stated the facility has a fall committee but the therapists are not a part

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of the meeting. The OT stated that the facility will communicate if someone is in therapy and has a fall or if they have a referral for someone to be seen due to falls. The OT further stated they tried many interventions with R54 while in therapy and many were not successful due to his cognition and vision. The OT stated that the facility had not approached her regarding fall interventions for R54 since his discharge from therapy.

When interviewed on 6/2/16, at 11:49 a.m. RN-C stated that the next business day following a fall, the fall and possible interventions are reviewed during stand up meeting. RN-C stated that R54's reminders to use his call light and therapy interventions were effective initially, the sign was removed from his walker as it was not effective and that the facility had tried numerous interventions and they didn't work and he would have another fall. RN-C stated that vital signs should be done following each fall and that R54 should have his blood sugar checked following a fall because he was diabetic. RN-C stated it was discussed to move his room closer to the nursing station but his power of attorney declined the room change recommendation. RN-C verified the orthostatic BP's were not documented as completed.

When interviewed on 6/2/16, at 12:22 p.m. the director of nursing services (DNS) stated her expectations following a fall were for the nurses to notify herself and the administrator, do a full assessment, transfer to the emergency room if there is significant possible injury, complete an incident report and fall investigation. The DNS stated that following a fall nursing is to put a new intervention into place and then management is to review the reports and interventions and make

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any needed changes to the interventions. The DNS stated that with each fall the interventions were accurate to the scenario, however expected care planned interventions to be followed. The DNS further stated that absolutely vital signs should be assessed with every fall and a blood sugar level if someone is diabetic.

On 6/2/16, at 12:51 p.m. the DNS verified that R54 did not have a night light in his bedroom or bathroom, and it should have been placed in there by maintenance.

A policy on falls was requested and was not received.

R30's quarterly minimum data set (MDS), dated 5/20/16, indicated she had severe cognitive impairment. R30's care area assessment (CAA), dated 11/13/15, indicated she was at risk for falls based on impaired balance, impaired vision and hearing, and the use of antipsychotics.

R30 had the following falls:
- On 2/7/16, R30 was found lying on the floor next to her wheelchair. Interventions after this fall included placing a personal alarm and increasing R30's toileting schedule.
- On 5/19/16, R30 was found lying on the floor next to her wheelchair while propelling herself down the hallway. Interventions after this fall included placing Dysem in her wheelchair.
- On 5/21/16, R30 was found lying on the floor next to her bed. Interventions after this fall included placing a fall mat on the floor next to her bed.

On 6/1/16, at 6:49 p.m., R30 was observed being

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transferred into bed and repositioned by nursing assistant (NA)-D. A floor mat was observed lying on the ground beside R30's bed.

Later that night at 6:59 p.m., NA-D stated she was aware that R30 had a history of falling and had a bed alarm to notify staff if R30 was getting out of bed.

During an interview on 6/2/16, at 7:34 a.m., NA-E was unable to state fall interventions for R30, but further stated she would check R30's care plan for fall interventions.

Later that day at 8:15 a.m., R30 was observed being transferred into bed by NA-E and NA-F. During the observation, NA-E was not aware of the reason for the floor mat; however, NA-F stated the fall mat was on the floor because R30 was a "fall risk." NA-F went on to state R30 also had Dysem in her wheelchair to prevent her from slipping out; however, when she went to check on the R30's wheelchair, she stated their wasn't any Dysem in R30's wheelchair.

R30's most current careplan listed a personal bed alarm as a current intervention, last revised on 10/29/15, to "remind resident not to stand up or exit building unattended." The care plan did direct for R30 to have a low bed, floor mat, and to offer toileting. R30's care plan did not address putting Dysem in her wheelchair to prevent falls.

On 6/2/16, at 8:20 a.m., register nurse (RN)-B stated the facility had gone alarm free and thought R30 no longer had a bed alarm. During interview, RN-C confirmed that R30 did not have a bed alarm and RN-B stated the intervention should be taken off the care plan. RN-B was

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F 323	Continued From page 19 unable to find any other interventions related for fall prevention on R30's care plan.	F 323		
F 334 SS=D	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the	F 334		7/12/16

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F 334	Continued From page 20 immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to maintain documentation of vaccination status for 2 of 5 residents (R23, R45) who refused the Pneumococcal vaccination and failed to offer the influenza vaccination to 1 of 5 residents (R23) who admitted to the facility during the influenza season.	F 334	1.Resident R23 is no longer in the facility. R45, or their representative, received education regarding pneumococcal vaccine. 2.All residents will be reviewed for current pneumococcal and influenza vaccination. If none exists, education will be given	

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F 334	Continued From page 21 Findings include: R23 was admitted to the facility on 3/18/16. Review of R23's record indicated that he had refused the pneumococcal vaccination; however, there was no date of refusal or consent scanned into his medical record. R45 was admitted to the facility on 2/11/16. Review of R45's record indicated that he had refused the pneumococcal vaccination; however there was no date of refusal or consent scanned into his medical record. During an interview on 6/2/16, at 2:31 p.m., registered nurse (RN)-B could not find any documentation regarding R23 and R45's refusal of the pneumococcal vaccinations. During the interview, RN-C confirmed the facility did not have documentation stating the pneumococcal consents were kept in a binder that the facility no longer had. A facility policy entitled Immunization for Residents, dated 2/15, directed staff to select "refused" in the resident's medical record under the "immunizations tab" and to document the "resident or name of family member/POA (power of attorney)." It did not address where or how to obtain consent for the pneumococcal vaccination. R23 was admitted to the facility on 3/18/16. Review of R23's record indicated that he had not received an influenza vaccination during the 2015-2016 influenza season. In addition, his medical record had no evidence that R23 was offered the influenza vaccination upon admission nor did it indicate that a historical vaccination had	F 334	regarding risks and benefits of pneumococcal and influenza vaccine. If resident consents, medication will be administered. If refuses or vaccination is medically contradicted, documentation of refusal/medical contradiction will be maintained in the medical record. 3.All new residents will be reviewed on admission for current pneumococcal vaccination. If none exists, education will be given regarding risks and benefits of pneumococcal vaccine. If resident consents, medication will be administered. If refuses or vaccination is medically contradicted, documentation of refusal/medical contradiction will be maintained in the medical record. All licensed nurses will be trained on policy and procedures related to pneumococcal vaccines on June 28, 29, 30 2016. 4.Audits of new residents will be completed to prevent reoccurrence of deficiency monthly x 3. DNS, or designee, will be responsible for compliance. QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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F 334	Continued From page 22 been entered upon admission. R23's admission minimum data set (MDS), dated 3/25/16, indicated he had not received the influenza vaccination because he had not been in the facility during the 2015-2016 influenza season. According to the Centers for Disease Control (CDC), the 2015-2016 influenza season began late, peaked in March 2016, and ran into May 2016. During interview on 6/2/16, at 2:31 p.m., RN-B could not find any documentation regarding R23's influenza vaccination status, including whether or not he had been offered the vaccination and if he had refused it. RN-B was unaware as to why there wasn't any documentation. A facility policy titled Immunizations for Residents, dated 2/15, directed staff to obtain written consent upon admission for the resident's annual influenza vaccination and to "assess the resident's current immunization status for annual influenza vaccination." Furthermore, the policy directed that "annual influenza vaccinations will be given for all residents for the current year based on CDC recommendations. Residents admitted through March 31 should be vaccination at the time of admission, if not previously vaccinated for the current influenza season."	F 334		
F 441 SS=F	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and	F 441		7/12/16

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F 441	Continued From page 23 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene while personal cares were performed for	F 441	1.All nursing staff will be retrained on proper hand hygiene. Facility has implemented an infection control program	

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F 441	Continued From page 24 1 of 5 residents (R47) observed during activities of daily living. The facility also failed to develop a comprehensive infection control program that included ongoing surveilance and tracking of infections. This had the potential to affect all 34 residents residing in the facility. Findings include: R47's quarterly Minimum Data Set (MDS) assessment dated 5/2/16, indicated R47 was cognitively intact and required extensive assistance for transfers, toilet use, and personal hygiene. R47's care plan last revised on 5/12/16, indicated that R47 had weakness, used a sit-to-stand lift for all transfers with assistance of one staff, and requred assistance for toileting on the commode in her room. On 6/2/16, at 8:41 a.m., nursing assistant (NA)-E was observed assisting R47 to transfer onto the commode in her room, using the sit-to-stand lift. NA-E gave R47 the call light and instructed her to call when finished. At 8:53 a.m., R47's call light came on. NA-E entered R47's room, donned gloves, and used the sit-to-stand lift to raise R47 up from the commode. While R47 stood, NA-E used several disposable wipes from a package to clean R47's peri area and then threw them into the trash can. NA-E told R47 that she had a, "Large," bowel movement. Without removing her soiled gloves, NA-E picked up a disposable brief from the bed and put it on R47, pulled up R47's pants, adjusted R47's shirt, pushed the commode out of the way using the handles, and then placed both hands on the handles of the sit-to-stand lift to transfer R47 into her motorized wheelchair.	F 441	to monitor and track infections throughout the facility. 2.All nursing staff will be retrained on proper hand hygiene June 28, 29, 30 2016. 3.Weekly audits will be completed to prevent reoccurrence of deficiency x 4. DNS, or designee, will be responsible for compliance. QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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 441	Continued From page 25 NA-E used the sit-to-stand remote to lower R47 into the wheelchair and then used the remote again to raise R47 up to readjust her placement into the wheelchair. Still without removing the soiled gloves, NA-E unhooked the sling from the sit-to-stand lift, put both hands on the handles and moved the lift, placed R47's feet onto the platform of the wheelchair, pulled up her own pants, closed the lid on the package that held the disposable wipes and moved the package, adjusted R47's clothing, latched R47's seat belt, took the bag out of the garbage can, opened the bathroom door by touching the door handle, grabbed a new bag for the garbage and placed it into the can, and then took off the soiled gloves and washed her hands. NA-E then pushed the sit-to-stand lift out of R47's room with both hands on the handles into the storage area across the hall, where two other lifts were stored, and placed the sling that she had used for R47 across the handles. NA-E proceeded to move the commode into the utility room, donned clean gloves, and cleaned the commode. After completion of R47's cares, NA-E was interviewed and stated she should have removed the soiled gloves and washed her hands after cleaning R47's peri area, before touching equipment and other items, and should have cleaned the sit-to-stand lift before putting it into the storage area where it was considered ready for use. During an interview on 6/2/16, at 2:32 p.m., the director of nursing stated her expectation was for the staff to follow the facility's policy and procedure for hand hygiene and glove use. DON stated, "They should change their gloves.There's a possibility of cross contamination. That's my expectaton."	F 441		

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F 441	Continued From page 26 A review of the facility's Hand Hygiene and Handwashing procedure, revised 3/16, did not include directions for hand hygiene with glove use. During review of the facility's Monthly Infection Control Reports from 5/15 to 4/16, the following infections were identified: 25 nosocomial (aquired in facility) urinary tract infections, 2 community acquired urinary tract infections, 15 nosocomial upper/lower respiratory tract infections, 2 community acquired upper/lower respiratory tract infections, 35 nosocomial infections of varying types, and 9 community acquired infections of varying types. The Monthly Report of Resident Infections in Center listed the residents, date of infection, site of infection, whether or not a culture was obtained, a causative agent if known, and the antibiotic treatment used. It did not list any symptoms contributing to the infection. In addition, all infections listed on the monthly report were treated with antibiotics. During an interview on 6/2/16, at 2:31 p.m., registered nurse (RN)-B pulled a report from the computer of all infections in the facility from the first of the month to the end of the month. With that report, RN-B filled out the Monthly Infection Control Reports with the number of infections, type of infections, whether the infections were nosocomial or community aquired, and the infection control rate for that month. She also stated the names of the residents with infections were taken off that report to fill out the Monthly Report of Resident Infections in Center. Furthermore, RN-B acknowledged due to the	F 441		

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F 441	Continued From page 27 timing of the report, the names of the residents with infections were not known until the end of the month and ongoing surveillance could not be completed. RN-B also acknowledged the current infection control program did not have a mechansim for tracking infections to decrease their spread and control outbreaks. A facility policy entitled Infection Control Plan, last revised 3/16, directed that the facility "maintain an infection control plan to provide a safe, sanitary and comfortable environment." It further directed that the plan "will attempt to meet federal and state regulations for infection control where applicable," but did not address surveillance or tracking infections as part of the infection control plan.	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to give proper notice of non-coverage for 1 of 3 residents (R57) whose Medicare Part A benefits were ending. Finding include: R57 was discharged from the facility on 2/4/16 to	F 492	1.Resident R57 is no longer in the facility 2.No other residents are coming off a traditional Medicare (Medicare A and B) stay to issue an non-coverage denial 3.Case managers and business office manager will be re-trained on when to give proper notice on June 22nd 2016 4.Weekly audits of new residents will be	7/12/16

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F 492	Continued From page 28 a different facility. A denial letter titled Notice of Medicare Non-Coverage listed medicare services for R57 would end on 2/4/16. The denial letter was signed by R57's representative on on 2/3/16, indicating the denial had been given to R57's representative less than 48 hours before coverage ended. During interview on 6/2/16, at 12:35 p.m., office manager stated denial notices are usually given to the resident or resident's representative within 48 hours of noncoverage per the facility policy. She further stated the registered nurse case managers were responsible for giving the denial notices to the residents and their representatives. Later that same day, at 3:32 p.m., registered nurse (RN)-C stated that R57's representative had been informed of the denial letter before 2/3/16; however, had requested to sign the denial letter when he came to pick up R57 on that day. RN-C stated R57's representative had been verbally informed of her coverage ending and further stated staff would usually write a progress note in addition. RN-C was unable to find a progress note notifying R57's representative. A facility policy entitled Non-Coverage Notification Requirements, dated 8/12, required the Notice of Medicare Non-Coverage to be give "at least two days prior to the last covered day."	F 492	completed to prevent reoccurrence of deficiency x4. DNS, or designee, will be responsible for compliance. QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	
F 502 SS=D	483.75(j)(1) ADMINISTRATION The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.	F 502		7/12/16

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F 502	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on interview, and document review, the facility failed to provide laboratory services for 1 of 5 residents (R11) who recieved lab monitoring for anticoagulation therapy. Findings include: R11 was admitted to the facility on 4/13/16 for rehab after being hospitalized. Her admission minimum data set (MDS), dated 4/20/16, had a BIMS of 14, was cognitively intact, listed atrial fibrillation (a heart condition) as an active diagnosis, and recieved anticoagulation therapy (blood thinning medications). R11's current physician orders, dated 4/20/16, listed coumadin (a blood thinning medication) 1.25 mg (milligrams) once a day every Tuesday and Thursday and coumadin 2.5 mg once a day every Monday and Wednesday related to unspecified atrial fibrillation (a heart condition). It did not list any laboratory orders. R11's records indicated she was monitored by the anti-coagulation clinic to monitor her INR (lab to deteremine the thickness of the blood). R11 had a goal for her INR tests to range between 1.8 and 2.2. R11's lab work listed INR results for the following dates: - On 4/29/16, INR was 2.9. Coumadin adjusted to "Hold today & resume 1.25 mg (milligrams) Wed (wednesday) and 2.5 mg all other days." Recheck date of 5/6/16.	F 502	1.Resident R11 lab was completed for coagulation therapy. Lab was completed on June 2, 2016. 2.All residents have been reviewed to ensure lab was completed for coagulation therapy. 3.All licensed nurses will be retrained on June 28, 29, 30 2016 on coagulation therapy and lab procedures. All orders received are being double checked by licensed personnel. 4.Weekly audits x 4, then Monthly x 2 will be done by DNS or designee to prevent reoccurrence of deficiency with coagulation therapy and lab procedures for one month. QA&A Committee will provide direction or change, if necessary, and will dictate continuation or completion of audits based on compliance.	

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F 502	Continued From page 30	F 502		

- On 5/6/16, INR was 4.0. Coumadin adjusted to "Hold x2 (for two) day 2.5 mg Sunday." Recheck date of 5/9/16.
- On 5/9/16, INR was 2.5. Coumadin adjusted to "1.25 mg Monday & Thursday 2.5 mg Wed." Recheck 5/12/16.
- On 5/12/16, INR was 1.8. Recheck date 5/19/16. No documentation was provided for this lab work.

No further INR rechecks were found.

On 6/2/16, at 2:07 p.m., RN-B was unable to find any additional INR checks and stated the recheck on 5/19/16 was not completed. RN-B also stated the INR results were faxed to the anticoagulation clinic nurse who determined any dose adjustment and recheck date. She further stated the recheck date was hand written on a calendar; however, there had been some "missed." RN-B verified the INR levels and dates listed above.

During a follow up interview on 6/6/16, at 10:08 a.m., the anticoagulation clinic registered nurse stated R11's last INR check had been on 5/12/16. At that time, R11's INR was 1.8 and the facility had been directed to "continue (coumadin) dosing 2.5 mg Wednesday, 1.25 mg all other days." She went on to state R11's next INR should have been on 5/19/16 and had called the facility on 5/26/16 when the clinic had not recieved R11's recheck INR. On 5/26/16, she stated the facility told her the INR would be drawn that day and would fax the result to the clinic; however, the clinic had never recieved the result that day.

A facility policy entitled, Processing And Auditing Laboratory And Diagnostic Orders, dated 9/13, directed staff to "Audit the medical record to verify

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F 502	Continued From page 31 the results of the tests are in the medical record and documention of physician notification." It further directed "A process should be in place to track when labs are due." Further documentation of INR lab work for 5/12/16 to 5/19/16 was requested, but not recieved.	F 502		

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET** **REDWOOD FALLS, MN 56283**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 02, 2016. At the time of this survey, Good Samaritan Society Redwood Falls was found not to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, 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		06/23/2016

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 000	Continued From page 1 Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Redwood Falls is a one-story building with no basement. The facility is fully fire sprinkler protected, and was determined to be of Type II(000) construction. The original building was constructed in 1962, with building additions in 1966 and 1975. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 35 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD 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	K 025		7/12/16

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K 025	Continued From page 2 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 This STANDARD is not met as evidenced by: 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 FINDINGS INCLUDE: During Facility Inspection on June 2, 2016, between the hours of 10:30 AM and 1:30 PM, observation revealed a penetration around a fire sprinkler pipe above the lay-in ceiling in the smoke barrier between the East Nurses Station and the Ramp. This deficient practice was verfied by the Maintenance Supervisor.	K 025	1. The penetration around the fire sprinkler pipe above the lay-in ceiling between the East Nurses station and the ramp has been sealed with fire rated caulk on 06/21/2016. 2.The safety committee will complete audits of the facility monthly for 90 days. 3.To ensure this doesn't happen again the safety committee will continue to utilize monthly inspections to help identify any safety concerns.	
K 029 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with o 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 are separated from other spaces by smoke resisting partitions and doors. Doors are 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 This STANDARD is not met as evidenced by:	K 029		7/12/16

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K 029	Continued From page 3 One hour fire rated construction (with o 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 are separated from other spaces by smoke resisting partitions and doors. Doors are 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 FINDINGS INCLUDE: During Facility Inspection on June 2, 2016, between 10:30 AM and 1:30 PM, observation during the inspection revealed the following discrepancy with a Hazardous Area: a.) the door on the Oxygen Storage Room (S-14) was observed without a self-closing device. These deficient practices were observed by the Facility Maintenance Director.	K 029	1. A self-closing device was added to the oxygen storage room door on 06/3/2016. 2.The safety committee will complete audits of the facility monthly for 90 days. 3.To ensure this doesn't happen again the safety committee will continue to utilize monthly inspections to help identify any safety concerns.	
K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 FINDINGS INCLUDE: On facility tour between 10:30 AM and 1:30 PM on 06/02/2016, observation revealed:	K 038	1. The exit door from the generator room (153) had a new one action turn device added to the door on 06/16/2016. 2.The safety committee will complete audits of the facility monthly for 90 days. 3.To ensure this doesn't happen again the safety committee will continue to utilize monthly inspections to help identify any safety concerns.	7/12/16

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K 038	Continued From page 4 1.) the exit door from the Generator Room (153) was observed with a "thumb turn device" on the door locking mechanism. Doors need to be operable with no more than one action. This deficient practice was confirmed with the Facility Maintenance Director.	K 038		
K 072 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD 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 This STANDARD is not met as evidenced by: 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. FINDINGS INCLUDE: On 06/02/2016, between the hours of 10:30AM and 1:30PM, observation revealed, several items (floor buffers/carpet cleaners)were observed within the Northeast Exit by the Dining Room. Also, Physical Therapy equipment was observed attached to the exit door from the Physical Therapy Department. This deficient practice was confirmed with the Facility Maintenance Director.	K 072	1. The items within the northeast exit have been removed from this area. The physical therapy equipment that was attached to the door has been removed all on 06/03/2016. 2. The safety committee will complete audits of the facility monthly for 90 days. 3.To ensure this doesn't happen again the safety committee will continue to utilize monthly inspections to help identify any safety concerns.	7/12/16
K 144	NFPA 101 LIFE SAFETY CODE STANDARD	K 144		7/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/02/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

(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 144 SS=D	Continued From page 5 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) This STANDARD is not met as evidenced by: 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) FINDINGS INCLUDE: During documentation review on June 2, 2016, between the hours of 10:30 AM and 1:30 PM, the following was discovered: 1.) It was revealed that there was no assurance letter from the natural gas provider indicating that natural gas would be supplied to the emergency generator at all times. Also, it was observed that the transfer time and cool down time was not being documented during the monthly generator load test. During documentation review, it was revealed that the transfer time from normal to emergency power and cool down time was not documented on the Monthly Emergency Generator Test Report. This deficient practice was verfied by the Maintenance Supervisor.	K 144	1. The assurance letter will be obtained from the natural gas supplier on/or before 07/11/2016. The monthly generator load test will be for 30 minutes with a 10 minute cool down period. Our policy has been updated on 06/03/2016. 2. The safety committee will complete audits of the facility monthly for 90 days. 3.To ensure this doesn't happen again the safety committee will continue to utilize monthly inspections to help identify any safety concerns.	

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
June 14, 2016

Mr.. Marcus Parence, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5237023

Dear Mr.. Parence:

The above facility was surveyed on May 31, 2016 through June 2, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, 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 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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 Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the

statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Susanne Reuss at (651) 201-3793 or email: susanne.reuss@state.mn.us**.

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 if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	06/02/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: 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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GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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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 May 31, June 1, and June 2, 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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GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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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.	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 implement interventions to prevent further falls for 1 of 3 residents (R54) reviewed for accidents. Findings include: R54's admission Minimum Data Set (MDS) dated 2/18/16, indicated R54 had severe memory impairment and needed extensive assistance to transfer. The MDS identified the following diagnoses cancer, hypertension, diabetes mellitus, osteoporosis, fracture, dementia and cataracts. The MDS further indicated R54 had a history of falls prior to admission with a fracture related to a fall prior to admission. R54's care plan dated 5/6/16, directed staff R54 was at risk for falls related to confusion and impulsive behavior and would attempt unsafe self transfers. Interventions included remind the	2 565	Corrected	7/12/16

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2 565	Continued From page 3	2 565		

resident to not bend over and pick up dropped items, encourage the use of the grabber or call for assistance, encourage to participate in activities that promote exercise and physical activity, ensure appropriate footwear, night light in room, monitor resident for significant changes in gait and mobility, nursing to check orthostatic blood pressures (lying, sitting, standing blood pressures to check for low blood pressure caused by a change in position) twice a day for three days and then update the physician.

R54's medication administration record and blood pressure record were reviewed for twice daily orthostatic blood pressure (BP) documentation starting
5/11/16 on the p.m. shift and ending 5/14/16 on the a.m. shift.

-5/11/16 p.m. shift lacked any documentation of orthostatic BP's

-5/12/16 a.m. and p.m. shift lacked any documenting of orthostatic BP's.

- 5/13/16, at 10:44 a.m. a sitting BP of 126/16 was recorded but lacked a record of lying and standing BP's. The p.m. shift lacked any documentation of orthostatic BP's

- 5/14/16, at 4:08 a standing BP of 126/74, lying BP of 122/60 and sitting BP of 94/53 were recorded.

On 6/2/16, at 8:51 a.m. R54's room was observed and a night light was not observed to be in the room or the bathroom.

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2 565	Continued From page 4 When interviewed on 6/2/16, at 11:49 a.m. registered nurse (RN)-C verified the orthostatic BP's were not documented as completed. When interviewed on 6/2/16, at 12:22 p.m. the director of nursing services (DNS) stated she expected care planned interventions to be followed. On 6/2/16, at 12:51 p.m. the DNS verified that R54 did not have a night light in his bedroom or bathroom, and it should have been placed in there by maintenance. A policy on care plans was requested and not received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could monitor to assure the plan of care is followed and interventions implemented to assure residents are provided sufficient care to prevent falls. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least	2 570		7/12/16

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2 570	Continued From page 5 quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to revise the care plan for 1 of 3 residents (R30) who was reviewed for falls. Findings include: R30's quarterly minimum data set (MDS), dated 5/20/16, indicated she had severe cognitive impairment. R30's care care assessment (CAA), dated 11/13/15, indicated she was at risk for falls based on impaired balance, impaired vision and hearing, and the use of antipsychotics. R30 had the following falls: - On 2/7/16, R30 was found lying on the floor next to her wheelchair. Interventions after this fall included placing a personal alarm and increasing R30's toileting schedule. - On 5/19/16, R30 was found lying on the floor next to her wheelchair while propelling herself down the hallway, Interventions after this fall included placing Dysem in her wheelchair. - On 5/21/16, R30 was found lying on the floor next to her bed. Interventions after this fall included placing a fall mat on the floor next to her bed. On 6/1/16, at 6:49 p.m., R30 was observed being transferred into bed and repositioned by nursing assistant (NA)-D. A floor mat was observed lying on the ground beside R30's bed. Later that night at 6:59 p.m., NA-D stated she	2 570	Corrected	

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2 570	Continued From page 6 was aware that R30 had a history of falling and had a bed alarm to notify staff if R30 was getting out of bed. During an interview on 6/2/16, at 7:34 a.m., NA-E was unable to state fall interventions for R30, but further stated she would check R30's care plan for fall interventions. Later that day at 8:15 a.m., R30 was observed being transferred into bed by NA-E and NA-F. During the observation, NA-E was not aware of the reason for the floor mat; however, NA-F stated the fall mat was on the floor because R30 was a "fall risk." NA-F went on to state R30 also had Dysem in her wheelchair to prevent her from slipping out; however, when she went to check on the R30's wheelchair, she stated there wasn't any Dysem in R30's wheelchair. R30's most current careplan, revised 10/29/15, listed a personal bed alarm as a current intervention, to "remind resident not to stand up or exit building unattended." R30's care plan did not address putting Dysem in her wheelchair to prevent falls. On 6/2/16, at 8:20 a.m., register nurse (RN)-B stated the facility had gone alarm free and thought R30 no longer had a bed alarm. During interview, RN-C confirmed that R30 did not have a bed alarm and RN-B stated the intervention should be taken off the care plan. RN-B was unable to find any other interventions related for fall prevention on R30's care plan. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures	2 570		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 570	Continued From page 7 related to care plan revisions. The DON or designee, could provide training for all nursing staff related to the timeliness of care plan revisions. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must 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 fully investigate a fall and/or implement interventions to prevent further falls for 2 of 3 residents (R54, R30) reviewed for accidents and failed to monitor bruises for 1 of 3 residents (R11) who were reviewed for non pressure related skin conditions. Findings include:	2 830	Corrected	7/12/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 830	Continued From page 8 R54's admission Minimum Data Set (MDS) dated 2/18/16, indicated R54 had severe memory impairment and needed extensive assistance to transfer. The MDS identified the following diagnoses: cancer, hypertension, diabetes mellitus, osteoporosis, fracture, dementia and cataracts. The MDS further indicated R54 had a history of falls prior to admission with a fracture related to a fall prior to admission. R54's fall Care Area Assessment (CAA) dated 2/24/16, indicated R54 had impaired balance during transitions and was taking antidepressants and diuretics. The CAA identified the following risk factors: osteoporosis, cognitive impairment, depression, loss of leg movement, incontinence and visual impairments. The CAA indicated R54 was at high risk for falls and a care plan would be developed to decrease the risk of falling with the improvement of strength as R54 was working with physical and occupational therapy due to impaired balance. R54's care plan dated 5/6/16, indicated R54 was at risk for falls related to confusion and impulsive behavior and would attempt unsafe self transfers. Interventions included remind the resident to not bend over and pick up dropped items, encourage the use of the grabber or call for assistance, encourage to participate in activities that promote exercise and physical activity, ensure appropriate footwear, night light in room, monitor resident for significant changes in gait and mobility, nursing to check orthostatic blood pressures (lying, sitting, standing blood pressures to check for low blood pressure caused by a change in position) twice a day for three days and then update the physician.	2 830		

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2 830	Continued From page 9 R54's Fall Tools were completed on the following dates: - 2/11/16 on admission and indicated a medium fall risk - 3/6/16 following a fall and indicated a medium fall risk - 3/14/16 following a fall and indicated a medium fall risk - 3/27/16 following a fall and indicated a medium fall risk - 3/29/16 following a fall and indicated a medium fall risk - 4/6/16 following a fall and indicated a medium fall risk - 4/20/16 following a fall and indicated a medium fall risk - 5/6/16 following a fall and indicated a medium fall risk - 5/11/16 following a fall and indicated a low fall risk R54's fall investigation forms indicated R54 had the following falls: - 2/11/16, at 7:50 p.m. R54 was found in the bathroom sitting on the wheelchair foot pedals next to the toilet and the call light was on. R54 stated that the floor was slippery and his foot slid out from under him as he was trying to get to the bathroom. Vital signs and blood sugars were not	2 830		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 10	2 830		

documented. Bathroom floor noted to not be wet. R54 did not receive an injury. R54 was noted to have a walking boot on his right foot due to a fibula fracture. Intervention added was to encourage R54 to wait for help due to weakness.

- 2/19/16, at 8:00 p.m. R54 was found on the floor sitting in the doorway of the bathroom. R54 stated he slipped out of the wheelchair when he was trying to get up. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention added was to encourage R54 to toilet after meals and during the morning and at bedtime, care plan was updated.

- 3/6/16, at 3:50 a.m. R54 was found on the floor in his room. Vital signs and blood sugars were not documented. R54 did not receive an injury. Interventions included remind R54 to use his call light, not to self transfer and added a sign to his walker to remind him to ask for assistance. R54 was on an antibiotic for an urinary tract infection.

- 3/14/16, at 8:45 p.m. R54 was found on the floor next to his recliner, call light within reach. Resident stated he was attempting to transfer from his chair to go to bed. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention added clip call light to resident shirt.

- 3/27/16, at 2:30 p.m. was found sitting on the floor next to his recliner. resident stated he was trying to get to his bed and fell. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention listed was R54 remained in physical and occupational therapy and had memory issues.

- 3/29/16, 2:20 p.m. R54 was found lying on the

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2 830	Continued From page 11 floor of the TV room and his walker was next to him tipped over. R54 stated he got lost and needed to sit down. Vital signs and blood sugars were not documented. R54 did not receive an injury. Intervention included was R54 was still receiving therapy and his walking boot was to be discontinued on 4/12/16. R54 will continue to work with therapy for strengthening and ambulation. - 4/6/16, at 9:00 a.m. R54 was found on the floor in the middle of his room. R54 stated he was trying to get to his recliner. Vital signs and blood sugars were not documented. R54 did not receive an injury. Interventions's included R54 was still receiving therapy and continues to wear a cam boot. R54 has a history of unsafe self transfers due to cognitive impairments. - 4/20/16, at 10:25 p.m. R54 was found on the floor beside his bed, call light was sounding. R54 stated he didn't know what he was doing. Vital signs and blood sugars were not documented. R54 did not receive an injury. Interventions added were resident education, toileting plan reviewed and resident will be toileted after meals and every four hours promptly. MD discontinued hydrochlorothiazide (medication for controlling blood pressure) due to low blood pressures. - 5/6/16, at 3:15 a.m. R54 was found sitting on the floor with his call light sounding. R54 stated he was coming back from the bathroom. Blood Sugar 125, BP 115/62, pulse 62, respirations 18, temperature 97.7 and oxygen saturation level 96%. No injury was noted. Intervention added was a night light placed in his bedroom. - 5/10/16, 11:15 p.m. R54 found sitting on the floor. Vital signs and blood sugars were not	2 830		

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2 830	Continued From page 12	2 830		

documented. R54 did not receive an injury. Intervention added was for nursing to obtain orthostatic blood pressures twice daily for three days and then update the physician.

R54's medication administration record and blood pressure record were reviewed for twice daily orthostatic blood pressure (BP) documentation starting 5/11/16 on the p.m. shift and ending 5/14/16 on the a.m. shift.

-5/11/16 p.m. shift lacked any documentation of orthostatic BP's

-5/12/16 a.m. and p.m. shift lacked any documenting of orthostatic BP's.

- 5/13/16, at 10:44 a.m. a sitting BP of 126/16 was recorded at but lacked a record of lying and standing BP's. The p.m. shift lacked any documentation of orthostatic BP's

- 5/14/16, at 4:08 a standing BP of 126/74, lying BP of 122/60 and sitting BP of 94/53 were recorded.

The medical record lacked any notification to the physician that orthostatic BP's were not completed or of the orthostatic BP's that were completed on 5/14/16.

On 6/1/16, at 5:49 p.m. nursing assistant (NA)-A was observed transporting R54 via wheelchair to his room. NA-A asked R54 if he needed to use the bathroom and R54 stated no. NA-A then asked R54 if he wanted to sit in his recliner and R54 stated yes. NA-A moved R54 in the wheelchair to the side of the recliner, removed the wheelchair foot pedals, placed a transfer belt around R54's waist and then placed R54's walker

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2 830	Continued From page 13 in front of him. NA-A assisted R54 to stand and R54 used the walker and pivoted to the recliner and sat down. NA- removed the transfer belt and gave R54 his call light and instructed him to use it if he needed assistance. On 6/1/16, at 5:55 p.m. NA-A stated that R54 has had a lot of falls and that staff needed to bring him back from meals right way, offer to toilet him and then transfer him to the recliner or he would self transfer himself. NA-A stated R54 rarely used his call light and could not remember it ever being on. NA-A further stated that they didn't change anything after each fall other than toileting him after meals. On 6/2/16, at 7:48 a.m. NA-B stated the aids are informed of fall interventions in report and that R54's fall interventions were to toilet before and after meals and to check on him every hour. On 6/2/16, at 8:02 a.m. registered nurse (RN)-D stated that after a fall they do a fall huddle with the staff that are working, assess the resident from where they fell, check for range of motion, pain and injury. RN-D further stated that if a resident has care planned interventions they do not make changes unless there is a new reason for a fall. RN-D stated that the fall paperwork is left in the case managers box and they review the paperwork and update the care plan if needed. RN-D stated that R54 is difficult to prevent falls due R54 being able to walk but shouldn't on his own. On 6/2/16, at 8:51 a.m. R54's room was observed and a night light was not observed to be in the room or the bathroom. When interviewed on 6/2/16, at 11:49 a.m.	2 830		

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2 830	Continued From page 14 occupational therapist (OT) stated the facility has a fall committee but the therapists are not a part of the meeting. The OT stated that the facility will communicate if someone is in therapy and has a fall or if they have a referral for someone to be seen due to falls. The OT further stated they tried many interventions with R54 while in therapy and many were not successful due to his cognition and vision. The OT stated that the facility had not approached her regarding fall interventions for R54 since his discharge from therapy. When interviewed on 6/2/16, at 11:49 a.m. RN-C stated that the next business day following a fall, the fall and possible interventions are reviewed during stand up meeting. RN-C stated that R54's reminders to use his call light and therapy interventions were effective initially, the sign was removed from his walker as it was not effective and that the facility had tried numerous interventions and they didn't work and he would have another fall. RN-C stated that vital signs should be done following each fall and that R54 should have his blood sugar checked following a fall because he was diabetic. RN-C stated it was discussed to move his room closer to the nursing station but his power of attorney declined the room change recommendation. RN-C verified the orthostatic BP's were not documented as completed. When interviewed on 6/2/16, at 12:22 p.m. the director of nursing services (DNS) stated her expectations following a fall were for the nurses to notify herself and the administrator, do a full assessment, transfer to the emergency room if there is significant possible injury, complete an incident report and fall investigation. The DNS stated that following a fall nursing is to put a new intervention into place and then management is	2 830		

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2 830	Continued From page 15 to review the reports and interventions and make any needed changes to the interventions. The DNS stated that with each fall the interventions were accurate to the scenario, however expected care planned interventions to be followed. The DNS further stated that absolutely vital signs should be assessed with every fall and a blood sugar level if someone is diabetic. On 6/2/16, at 12:51 p.m. the DNS verified that R54 did not have a night light in his bedroom or bathroom, and it should have been placed in there by maintenance. A policy on falls was requested and was not received. R30's quarterly minimum data set (MDS), dated 5/20/16, indicated she had severe cognitive impairment. R30's care area assessment (CAA), dated 11/13/15, indicated she was at risk for falls based on impaired balance, impaired vision and hearing, and the use of antipsychotics. R30 had the following falls: - On 2/7/16, R30 was found lying on the floor next to her wheelchair. Interventions after this fall included placing a personal alarm and increasing R30's toileting schedule. - On 5/19/16, R30 was found lying on the floor next to her wheelchair while propelling herself down the hallway. Interventions after this fall included placing Dysem in her wheelchair. - On 5/21/16, R30 was found lying on the floor next to her bed. Interventions after this fall included placing a fall mat on the floor next to her bed.	2 830		

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2 830	Continued From page 16 On 6/1/16, at 6:49 p.m., R30 was observed being transferred into bed and repositioned by nursing assistant (NA)-D. A floor mat was observed lying on the ground beside R30's bed. Later that night at 6:59 p.m., NA-D stated she was aware that R30 had a history of falling and had a bed alarm to notify staff if R30 was getting out of bed. During an interview on 6/2/16, at 7:34 a.m., NA-E was unable to state fall interventions for R30, but further stated she would check R30's care plan for fall interventions. Later that day at 8:15 a.m., R30 was observed being transferred into bed by NA-E and NA-F. During the observation, NA-E was not aware of the reason for the floor mat; however, NA-F stated the fall mat was on the floor because R30 was a "fall risk." NA-F went on to state R30 also had Dysem in her wheelchair to prevent her from slipping out; however, when she went to check on the R30's wheelchair, she stated their wasn't any Dysem in R30's wheelchair. R30's most current careplan listed a personal bed alarm as a current intervention, last revised on 10/29/15, to "remind resident not to stand up or exit building unattended." The care plan did direct for R30 to have a low bed, floor mat, and to offer toileting. R30's care plan did not address putting Dysem in her wheelchair to prevent falls. On 6/2/16, at 8:20 a.m., register nurse (RN)-B stated the facility had gone alarm free and thought R30 no longer had a bed alarm. During interview, RN-C confirmed that R30 did not have a bed alarm and RN-B stated the intervention should be taken off the care plan. RN-B was	2 830		

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2 830	Continued From page 17 unable to find any other interventions related for fall prevention on R30's care plan. R11 was admitted to the facility on 4/13/16 for rehab after being hospitalized. Her admission minimum data set (MDS), dated 4/20/16, had a BIMS of 14 and was cognitively intact. R11's admission care area assessment, dated 4/26/16, listed her as needing extensive assistance with bed mobility causing her to be at risk for pressure related skin conditions. R11's current physician orders, dated 4/20/16, listed coumadin (a blood thinning medication) 1.25 mg (milligrams) once a day every Tuesday and Thursday and coumadin 2.5 mg once a day every Monday and Wednesday related unspecified atrial fibrillation (a heart condition). During observation on 5/31/16, at 1:02 p.m., three quarter size bruises were noted on R11's right forearm and one quarter size bruise was noted on the top of her left hand. R11 stated no one had hurt her but the bruises "they just appear." On 6/1/16, at 6:38 p.m., the same bruises were noted on R11 and, in addition, she appeared to have a new bruise to her left inner wrist, approximately the same size as the others. Again, R11 stated no one had hurt her and she didn't have to do anything the bruises "just come." She went on to state she took a blood thinner and the staff had never mentioned her bruises. R11 was observed wearing a short sleeve night gown making the bruises visible. During an interview later that evening, at 7:14 p.m., trained medication aide (TMA)-A stated skin observations were made with the residents'	2 830		

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2 830	Continued From page 18	2 830		

baths. The nurses would fill out the skin observation sheet if there were any skin concerns and scan it into the electronic medical record. She also stated new bruises were reported to the charge nurse, case manager, administrator, and resident's family. Then were investigated. Furthermore, TMA-A stated she was not aware of R11 having any bruises recently.

Later that same evening, 7:29 p.m., registered nurse (RN)-A stated bruises were documented in the progress notes, investigated, and monitored by verbally telling staff member to staff member. She further stated staff could document a progress note if a bruise healing or getting worse, but mainly would "keep an eye on it" via verbal report. RN-A was unaware of R11's bruises stating she was never informed of them but R11 was on coumadin. She also stated she wouldn't know if the bruises were healing without reporting or documentation.

During an interview on 6/2/16, at 2:05 p.m., RN-B stated the nurses were expected to monitor for bruise and skin conditions on bath days, but further stated there had been a "breakdown" in communication regarding the monitoring. She also stated she was unaware of R11's bruises and, if she had been aware, would've notified the coumadin clinic nurse for further instruction.

R11's progress notes were reviewed from admission. The progress notes did not mention any bruises or skin concerns.

R11's "daily skilled notes" were reviewed from admission. The notes did not mention any skin concerns and noted R11's skin was normal.

R11's "skin observation" assessments were

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2 830	Continued From page 19 reviewed from admission. The assessments indicated "no skin conditions observed." R11's current care plan, initiated on 4/22/16, did not address any skin related concerns and did not list any current skin interventions. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop polices and procedures regarding assessing and monitoring non-pressure related skin conditions. The Director of Nursing or her designee could educate staff on the policies and procedures. The Director of Nursing or her designee could develop a monitoring system to ensue residents receive the appropriate care. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a comprehensive infection control program that included ongoing surveilance and tracking of infections. This had the potential to affect all 34 residents residing in the facility.	21375	Corrected	7/12/16

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21375	Continued From page 20 Findings include: During review of the facility's Monthly Infection Control Reports from 5/15 to 4/16, the following infections were identified: 25 nosocomial (aquired in facility) urinary tract infections, 2 community acquired urinary tract infections, 15 nosocomial upper/lower respiratory tract infections, 2 community acquired upper/lower respiratory tract infections, 35 nosocomial infections of varying types, and 9 community acquired infections of varying types. The Monthly Report of Resident Infections in Center listed the residents, date of infection, site of infection, whether or not a culture was obtained, a causative agent if known, and the antibiotic treatment used. It did not list any symptoms contributing to the infection. In addition, all infections listed on the monthly report were treated with antibiotics. During an interview on 6/2/16, at 2:31 p.m., registered nurse (RN)-B a report was pulled from the computer of all infections in the facility from the first of the month to the end of the month. With that report, RN-B filled out the Monthly Infection Control Reports with the number of infections, type of infections, whether the infections were nosocomial or community aquired, and the infection control rate for that month. She also stated the names of the residents with infections were taken off that report to fill out the Monthly Report of Resident Infections in Center. Furthermore, RN-B awknowledged due to the timing of the report, the names of the residents with infections were not known until the end of the month and ongoing surveillance could not be completed. RN-B also awknowledged the current infection control program did not have a mechansim for tracking	21375		

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21375	Continued From page 21 infections to decrease their spread and control outbreaks. A facility policy entitled Infection Control Plan, last revised 3/16, directed that the facility "maintain an infection control plan to provide a safe, sanitary and comfortable environment." It further directed that the plan "will attempt to meet federal and state regulations for infection control where applicable," but did not address surveillance or tracking infections as part of the infection control plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise infection control policies and procedures to ensure adequate tracking and trending of resident infections. The DON could ensure the infection control program analyzed resident infections identifying patterns and trends, symptom tracking, and antibiotic stewardship and provide training to involved staff. The quality assurance team could audit the system to ensure program ongoing compliance with the infection control program. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21385	MN Rule 4658.0800 Subp. 3 Infection Control; Staff assistance Subp. 3. Staff assistance with infection control. Personnel must be assigned to assist with the infection control program, based on the needs of the residents and nursing home, to implement the policies and procedures of the infection control program.	21385		7/12/16

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21385	Continued From page 22 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper hand hygiene while personal cares were performed for 1 of 5 residents (R47) observed during activities of daily living. Findings include: R47's quarterly Minimum Data Set (MDS) assessment dated 5/2/16, indicated R47 was cognitively intact and required extensive assistance for transfers, toilet use, and personal hygiene. R47's care plan last revised on 5/12/16, indicated that R47 had weakness, used a sit-to-stand lift for all transfers with assistance of one staff, and requred assistance for toileting on the commode in her room. On 6/2/16, at 8:41 a.m., nursing assistant (NA)-E was observed assisting R47 to transfer onto the commode in her room, using the sit-to-stand lift. NA-E gave R47 the call light and instructed her to call when finished. At 8:53 a.m., R47's call light came on. NA-E entered R47's room, donned gloves, and used the sit-to-stand lift to raise R47 up from the commode. While R47 stood, NA-E used several disposable wipes from a package to clean R47's peri area and then threw them into the trash can. NA-E told R47 that she had a, "Large," bowel movement. Without removing her soiled gloves, NA-E picked up a disposable brief from the bed and put it on R47, pulled up R47's pants, adjust R47's shirt, pushed the commode out of the way using the handles, and then placed	21385	Corrected	

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both hands on the handles of the sit-to-stand lift to transfer R47 into her motorized wheelchair. NA-E used the sit-to-stand remote to lower R47 into the wheelchair and then used the remote again to raise R47 up to readjust her placement into the wheelchair. Still without removing the soiled gloves, NA-E unhooked the sling from the sit-to-stand lift, put both hands on the handles and moved the lift, placed R47's feet onto the platform of the wheelchair, pulled up her own pants, closed the lid on the package that held the disposable wipes and moved the package, adjusted R47's clothing, latched R47's seat belt, took the bag out of the garbage can, opened the bathroom door by touching the door handle, grabbed a new bag for the garbage and placed it into the can, and then took off the soiled gloves and washed her hands. NA-E then pushed the sit-to-stand lift out of R47's room with both hands on the handles into the storage area across the hall, where two other lifts were stored, and placed the sling that she had used for R47 across the handles. NA-E proceeded to move the commode into the utility room, donned clean gloves, and cleaned the commode. After completion of R47's cares, NA-E was interviewed and stated she should have removed the soiled gloves and washed her hands after cleaning R47's peri area, before touching equipment and other items, and should have cleaned the sit-to-stand lift before putting it into the storage area where it was considered ready for use.

During an interview on 6/2/16, at 2:32 p.m., the director of nursing stated her expectation was for the staff to follow the facility's policy and procedure for hand hygiene and glove use. DON stated, "They should change their gloves.There's a possibility of cross contamination. That's my expectaton."

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21385	Continued From page 24 A review of the facility's Hand Hygiene and Handwashing procedure, revised 3/16, did not include directions for hand hygiene with glove use.	21385		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced	21390		7/12/16

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21390	Continued From page 25 by: Based on interview and document review, the facility failed to develop a comprehensive infection control program that included ongoing surveilance and tracking of infections. This had the potential to affect all 34 residents residing in the facility. Findings include: During review of the facility's Monthly Infection Control Reports from 5/15 to 4/16, the following infections were identified: 25 nosocomial (aquired in facility) urinary tract infections, 2 community acquired urinary tract infections, 15 nosocomial upper/lower respiratory tract infections, 2 community acquired upper/lower respiratory tract infections, 35 nosocomial infections of varying types, and 9 community acquired infections of varying types. The Monthly Report of Resident Infections in Center listed the residents, date of infection, site of infection, whether or not a culture was obtained, a causative agent if known, and the antibiotic treatment used. It did not list any symptoms contributing to the infection. In addition, all infections listed on the monthly report were treated with antibiotics. During an interview on 6/2/16, at 2:31 p.m., registered nurse (RN)-B a report was pulled from the computer of all infections in the facility from the first of the month to the end of the month. With that report, RN-B filled out the Monthly Infection Control Reports with the number of infections, type of infections, whether the infections were nosocomial or community aquired, and the infection control rate for that month. She also stated the names of the residents with infections were taken off that report to fill out the Monthly Report of Resident	21390	Corrected	

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21390	Continued From page 26 Infections in Center. Furthermore, RN-B awknowledged due to the timing of the report, the names of the residents with infections were not known until the end of the month and ongoing surveillance could not be completed. RN-B also awknowledged the current infection control program did not have a mechansim for tracking infections to decrease their spread and control outbreaks. A facility policy entitled Infection Control Plan, last revised 3/16, directed that the facility "maintain an infection control plan to provide a safe, sanitary and comfortable environment." It further directed that the plan "will attempt to meet federal and state regulations for infection control where applicable," but did not address surveillance or tracking infections as part of the infection control plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could develop, review and/or revise policies and procedures to ensure infection control procedures are maintained. The DON or designee could educate all appropriate staff on the policies/procedures, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) Days.	21390		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis	21426		7/12/16

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21426	Continued From page 27 infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to administer the tuberculin skin test within the appropriate timeframe for 1 of 5 employees (NA-C) and 2 or 5 residents (R21, R28) who worked and resided in the facility. Findings include: The Facility Tuberculosis (TB) Risk Assessment Worksheet for Health Care Settings Licensed by the Minnesota Department of Health (MDH), completed 4/4/16, identified the facility as low risk for TB infections. A facility policy entitled Tuberculosis Control Plan and Screening for Employees, reviewed 3/16, indicated that new employees of the facility be	21426	corrected	

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tested and screened for TB upon hire using the two step tuberculin skin test (TST) method. The policy further directed "new employees will have baseline TB screening according to current CDC (Center for Disease Control) recommendations and guideline."

Recommendations from the CDC "Testing Health Care Workers" states baseline testing (two step TST or TB blood test) should be given prior to employment.

Employee files were reviewed for the facility. Nursing assistant (NA)-C file was had a hire date of 1/19/16; however, her Employee/Candidate Mantoux Questionnaire (symptom screen) and first TST were not completed until 3/1/16.

During on interview on 6/2/16, at 12:14 p.m., office manager stated NA-C had been in a school program shadowing the nurses at the facility. Later, NA-C had asked to work as a nursing assistant and had been hired on after the school program was completed. Office manager stated that NA-C had not started working and doing cares with the residents until 3/16; however, she verified that during the shadow experience, NA-C had been in and out of residents' rooms observing cares.

A facility policy entitled: Tuberculosis Control Plan for Residents, reviewed 3/16, indicated that "prior to and upon admission, residents will receive a baseline two-step tuberculin skin test (TST) or a TB blood test." The policy did not indicate any timeframe for tuberculosis screening prior to or after admission for new residents.

Resident medical records were reviewed and contained the following:

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21426	Continued From page 29 R21 was admitted to the facility on 2/5/16. A symptom screen for active TB was completed on 2/8/16. R21's first TST was not administered until 2/9/16 (over 72 hours later). Physician orders for R21 were not provided. R28 was admitted to the facility on 1/7/16. A symptom screen for active TB was completed 1/10/16. R28's first TST was not administered until 1/12/16 (almost a week later) and appeared positive with 4 mm (millimeters) of induration when read. A subsequent chest X-ray was ordered. During interview on 6/2/16, at 2:24 p.m., registered nurse (RN)-B stated the first TST was to be given on the day of admission with the second TST administered approximately two weeks later, but not before the month was up. She further stated that the dates the TST's were given and read were suppose to be placed on the calendar. She verified R21 and R28's baseline screenings had been given late and should have been given their admission date. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) could review and revise policies and procedures for TB surveillance. The DON could educate all appropriate staff on the policies and procedures. The DON could monitor resident and employee TB screening to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21426		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults	22000		7/12/16

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22000	Continued From page 30 Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse. (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives	22000		

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22000	Continued From page 31 such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to conduct reference checks and background study for 1 of 5 newly hired employee (nursing assistant (NA)-C) whose position included direct contact with residents. Findings include: The facility Abuse and Neglect policy, revised 9/13, included, "The center will not knowingly employ individuals who have been found quilty 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." The facility Background Investigations policy and procedure, revised 4/16, included, "All offers of employment shall be conditioned on the successful completion of the federal exclusion and criminal background check, the results of personal and professional reference checks and any other pre-employment requirements such as physical assessments, state-specific criminal background check or screens for illegal drugs and alcohol."	22000	Corrected	

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22000	Continued From page 32 During an interview on 6/2/16, at 2:26 p.m., the office manager stated NA-C was hired on 1/19/16, after observing through a school program and then decided she wanted to work at the facility. On 12/1/15, NA-C signed the authorization for the background check, but the office manager was unable to locate the completed background check and lacked evidence of completing reference checks. During an interview on 6/2/16, at 3:15 p.m., the administrator verified NA-C's background check and reference checks could not be located.	22000		