DEPARTMENT OF HEAL	TH AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAL	D CERTIFICA	TION A	AND TRANSMITTAL	ID: 2GLR
	PART I -	TO BE COMPI	LETED BY TH	IE STAT	TE SURVEY AGENCY	Facility ID: 00890
1. MEDICARE/MEDICAID PROV NO.(L1) 245279	IDER	3. NAME AND AL (L3) GOOD SAM			PECIALTY CARE COMMU	4. TYPE OF ACTION: <u>7</u> (L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICA (L2) 138218700	ID NO.	(L4) 3815 WEST BROADWAY (L5) ROBBINSDALE, MN		(L6) 55422	3. Termination4. CHOW5. Validation6. Complaint	
5. EFFECTIVE DATE CHANGE O (L9)	FOWNERSHIP	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD		<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint	
 6. DATE OF SURVEY 05, 8. ACCREDITATION STATUS: 	/26/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct		10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	_	04 SNF	-	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATI	ON	10.THE FACILITY	IS CERTIFIED AS	S:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
10 T-t-1 E iliter D - d-	06 (119)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
12.Total Facility Beds	96 (L18)	V			5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	96 (L17)		pliance with Progra and/or Applied Wa		* Code: A	(L12)
14. LTC CERTIFIED BED BREAKE	DOWN				15. FACILITY MEETS	
18 SNF 18/19 SN	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
96						
(L37) (L38)	(L39)	(L42)	(L43)			
17. SURVEYOR SIGNATURE	E NE II	Date : 0	1/17/2018		18. STATE SURVEY AGENCY	
P	ART II - TO BE	COMPLETED I	BY HCFA REG	(L19) GIONAL	OFFICE OR SINGLE S	(L20)
19. DETERMINATION OF ELIGIE	BILITY	20. COM	IPLIANCE WITH (CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2572)
			ITS ACT:		2. Ownership/Contr	ol Interest Disclosure Stmt (HCFA-1513)
1. Facility is Eligible to 2. Facility is not Eligible	-				3. Both of the Above	e :
2. Facility is not Eligit	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEME	ENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION 04/01/1985	BEGINNINC	G DATE	ENDING DATE	8	<u>VOLUNTARY</u> <u>00</u> 01-Merger, Closure	<u>INVOLUNTARY</u> 05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	•
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	~ /		03-Risk of Involuntary Termination	on OTHER
		n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
	1		(L44)			00-Active
(L27)	B. Rescind Su	uspension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	DATE		
	(L32)			(L33)	DETERMINATION APP	ROVAL

FORM CMS-1539 (7-84) (Destroy Prior Editions)

CENTERS FOR MEDICARE & MEDICARE CERTIFICA



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245279

June 20, 2017

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

Dear Ms. Mattson:

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 May 15, 2017 the above facility is recommended for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 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,

Anne Retension_

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 20, 2017

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

RE: Project Number S5279027

Dear Ms. Mattson:

On April 21, 2017, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective April 25, 2017. (42 CFR 488.422)

Also on April 21, 2017, we recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for a standard survey completed on March 31, 2017. The most serious deficiency was found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On May 26, 2017, the Minnesota Department of Health completed a Post Certification Revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 31, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 15, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 31, 2017, as of May 15, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective May 15, 2017.

In addition, this Department recommended to the CMS Region V Office the following actions:

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

Good Samaritan Society - Specialty Care Community June 20, 2017 Page 2

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

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,

Anne Petenson_

Licensing and Certification Program Health Regulation Division Minnesota Department of Health P.O. Box 64900 St. Paul, MN 55164-0900 Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 2095

July 31, 2017

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

Subject: Good Samaritan Society - Specialty Care Community - IDR Provider # 245279 Project # S5279027

Dear Ms. Mattson:

This is in response to your letter of June 29, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiencies at tag F221 and F356, issued pursuant to the survey event 2GLR11, completed on March 31, 2017.

The information presented with your letter, the CMS 2567 dated March 31, 2017, and corresponding plan of correction, as well as survey documents and discussion with representatives of licensing and certification staff have been carefully considered and the following determination has been made:

F221: §483.10(e) Respect and Dignity.

The resident has a right to be treated with respect and dignity, including:

§483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2).

The facility alleges the bilateral thigh straps used for R40 were a postural positioning device, and not a physical restraint. In addition, R40's condition had deteriorated and the resident was no longer able to transfer or ambulate independently, therefore the device did not restrict R40's free movement.

In review of the information, the thigh straps did not meet the definition of a physical restraint. The thigh straps provided support to allow the resident to propel himself in his wheelchair.

This in not a valid example of a deficient practice under this regulation and will be removed from the CMS 2567 Statement of Deficiencies.

Good Samaritan Society - Specialty Care Community July 31, 2017 Page 2

F356: §483.35(g) Nurse Staffing Information.

(1) Data requirements. The facility must post the following information on a daily basis:

- (i) Facility name.
- (ii) The current date.
- (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:
 - (A) Registered nurses.
 - (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).
 - (C) Certified nurse aides.
- (iv) Resident census.

(2) Posting requirements.

- (i) The facility must post the nurse staffing data specified in paragraph
 - (g)(1) of this section on a daily basis at the beginning of each shift.
- (ii) Data must be posted as follows:
 - (A) Clear and readable format.
 - (B) In a prominent place readily accessible to residents and visitors.

(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater.

The facility alleges the nurse staffing information which is posted daily, included the required information and was posted in a prominent location. The nurse staffing information was posted on the first floor near the front entrance, which is accessible to residents and visitors.

In review of the information, the regulation at F356 does not require the posting to be at wheelchair height. There were no complaints from residents indicating they could not access the nurse staffing information.

This in not a valid example of a deficient practice under this regulation and will be removed from the CMS 2567 Statement of Deficiencies.

Good Samaritan Society - Specialty Care Community July 31, 2017 Page 3

The revised CMS 2567 Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,



Pam Kerssen, Assistant Program Manager Minnesota Department of Health Licensing and Certification Program Health Regulation Division 705 5th Street NW, Suite A Bemidji, MN 56601-2933 Telephone: (218) 308-2129 Pam.Kerssen@state.mn.us

cc: Office of Ombudsman for Long-Term Care Maria King, Assistant Program Manager Licensing and Certification File Susanne Reuss, Metro Team A Unit Supervisor Gloria Derfus, Metro Team C Unit Supervisor

		AND HUMAN SERVICES		FC	ORM APPROVED NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DATE SURVEY COMPLETED
		245279	B. WING _		03/31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E
F 000	INITIAL COMMEN	rs	F 00	00	
	Revised 2567 as a Resolution.	result of an Informal Dispute			
	as your allegation of Department's accept enrolled in ePOC, y at the bottom of the	f correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.			
F 242 SS=D	on-site revisit of you validate that substa regulations has bee your verification. 483.10(f)(1)-(3) SE	acceptable electronic POC, an ur facility may be conducted to untial compliance with the en attained in accordance with LF-DETERMINATION - CHOICES	F 24	12	5/15/17
	schedules (includin health care and pro consistent with his	has a right to choose activities, g sleeping and waking times), oviders of health care services or her interests, assessments, id other applicable provisions			
		has a right to make choices s or her life in the facility that e resident.			
	members of the col community activitie facility. This REQUIREMEN	has a right to interact with mmunity and participate in s both inside and outside the NT is not met as evidenced			
	by: Based on interview	v and document review, the		Resident R246 no longer resides in th	ıe
		DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE	TITLE	(X6) DATE
Electron	ically Signed				05/01/2017

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

		AND HUMAN SERVICES			FORM	07/31/2017 APPROVED 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245279	B. WING		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	v	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242	facility failed to ensibathing preference residents (R246). Findings include: R246 was admitted care unit on 3/22/1 fracture with repair the Admission Face A nursing admit-rea 3/22/17, indicated F showers a week, di A nursing assistant indicated resident r bathing. An initial care plan had a self-care per recent hospitalization (blood between the spinal fracture at the balance and needed An intervention of the not indicate how of shower. On 3/28/17, at 9:26 and stated he had in days after admission showers a week. On 3/30/17, at 8:38 stated R246 was of	A to the facilities post-acute 7, with diagnoses of spinal 7, with diagnoses of spinal 7, insomnia, and recent fall per 8 Sheet. Admit Data Collection dated R246 would like to have two uring the day shift. Care sheet dated 3/22/17, needed assist of one staff with dated 3/22/17, indicated R246 formance deficit related to on, falls, subdural hematoma 8 brain and lining (dura), and ioracic 8. R246 had poor bod for brace when out of bed. Dathing assist of one staff, did ten R246 was to receive a 6 a.m. R246 was interviewed not yet received a shower (six on), and he had asked for two 8 a.m. registered nurse-G in the bath schedule for was not scheduled for a	F 24	facility as of 4/11/2017. Systemic changes were mad that bathing preferences are transferred to bath schedules applicable staff will be retrain process by the Director of Nu Services and/or designee. The GSS Policy and Procedu Resident Dignity will be revie appropriate staff by the Director Nursing Services and/or desi The Director of Nursing Servidesignee will be responsible through routine audits condu- x4, monthly x3. Audit results to the QAPI committee for fu- recommendations.	accurately s. And all led on this ursing ure regarding wed with the stor of gnee. ices and/or to ensure cted weekly will be taken	

If continuation sheet Page 2 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		e survey Ipleted
		245279	B. WING		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CC 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORI X (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 242 F 246 SS=D	verified staff should admission (nursing and R246 should has showers a week. The policy Residem Ideas for maintainin include, but not be residents as they w 483.10(e)(3) REAS OF NEEDS/PREFE 483.10(e) Respect a right to be treated including: (e)(3) The right to re the facility with reas resident needs and do so would endang resident or other re This REQUIREMEN by: Based on observat review, the facility fa within reach for 1 o not have the call lig staff to move in the In addition, the facili	p.m. the director of nursing be transferring data from the admission data collection) ave been scheduled for two t Dignity dated 2/17, indicated: bg a resident's dignity may imited to: "a. Grooming ish to be groomed." ONABLE ACCOMMODATION RENCES and Dignity. The resident has with respect and dignity, eside and receive services in conable accommodation of preferences except when to ger the health or safety of the sidents. NT is not met as evidenced ion, interview, and document ailed to ensure a call light was f 35 residents (R243) who did ht in reach, was dependent on room and was at risk for falls. ity failed to ensure a helmet fit	F 2	Call light for resident R243 within reach on 3/27/17, upor by the surveyor. The helmet R135 was discontinued by the primary physician on 4/25/20	n notification order for le resident s 17.	5/15/17
	reviewed for use of Findings include:			All residents were reviewed f placement on 3/31/2017 and needed. All residents were r 5/1/2017 and there are no ot with helmets in the facility.	adjusted if eviewed on	
	sitting upright in a re	d on 3/27/17, at 4:39 p.m. ecliner situated approximately dge of R243's bed. The call		All staff will be reeducated or procedure by Director of Nur		
	67(02-99) Previous Versions	Obsolete Event ID:2GLB1		Facility ID: 00890	continuation shee	· D 0 (7

Facility ID: 00890

If continuation sheet Page 3 of 73

		& MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY IPLETED
		245279	B. WING _			31/2017
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	CODE	
OOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 246	Continued From pa	ae 3	F 24	46		
	use it when he need R243's admission M dated 3/23/17, indic intact and required mobility, transfers, f room. The Care Are 3/23/17, indicated F to weakness, decor mobility. R243's car 3/27/17, indicated F staff was to encour to ask for assistance During interview on registered nurse (R "capable and does not get up on his ow him. During interview on administrator stated call light would be w that needed it, unle around the room or The facility Call Light	Minimum Data Set (MDS) cated R243 was cognitively assistance of two staff for bed toilet use and walking in the ea Assessment (CAA) dated R243 was at risk for falls due nditioning, and impaired re plan with revision date of R243 was at risk for falls and age R243 to use a grabber or ce. 3/31/17, at 10:44 a.m. N)-A stated R243 was use the call light", but could wn to reach it if it was not near 3/31/17, at 10:50 a.m. the d it was an expectation that the vithin reach for any resident ss they are capable of moving	C	therapy staff that are resp assessment of helmets w by the Rehab Coordinator responsibility to assess fo fit and condition. The Director of Nursing S designee will be responsit compliance through routin conducted weekly x4, mon results will be taken to the committee for further reco	ill be reeducated regarding their r proper helmet ervices and/or ble to ensure he audits nthly x3. Audit e QAPI	
	resident always has assistance and dire room, place call ligh if in bed. If out of be across bed so resid R135 was observed	a method of calling for ected staff "When leaving the nt within easy reach of resident ed, stretch call light cord dent is able to reach it." d on 3/27/17, at 5:27 p.m., nair at the dining room table				

	OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02	/31/2017
NAME OF	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COD		/31/2017
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUN		15 WEST BROADWAY DBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 246	was observed to fit over the resident's push the helmet up movements with he resident was unsuc with eating, trained removed R135's he was complete, TM/ helmet back on R1 again, the helmet of eyes and R135 trie helmet up so it wou resident's eyes. R135 was observe in a Broda chair in helmet was attache chair. R135 was observe and moved her upp her hands were in of try to get out of the R135 was observe 3/29/17 and 3/30/1 the pink helmet ho Broda chair both at her room. R135 did made no attempts R135 was observe her room seated in helmet was hooked R135 was observe	d, 3/29/17, at 7:40 a.m., sitting the dining room. The pink ed to the back of the Broda observed to have multiple ments with her legs and arms ber torso back and forth and constant motion. R135 did not				

	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING		03/:	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	V I	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE C		(X5) COMPLETION DATE
F 246	Continued From pa	ge 5	F 246	5		
	The care plan initial 3/17/15, read R135 and risk for falls rela- gait, and history of the was to apply a soft to wear. The Progress Note wear a soft helmet has been seen seen seems comfortable especially over by the introducing wheel c chair which R135 he comfortable. The MDS and CAA falls that past quarter related to unsteady assist for mobility n had Huntington's ch loss of mobility, had R135 needed assiss mobility, staff were assist of one to two used the Broda cha behaviors symptom physical cares and throwing or smearing The Progress Note "Does wear a soft he R135 had been see floor, seems comfor especially over by the	ted on 1/14/15 and revised on had limited physical mobility ated to Huntington's, unsteady falls. The safety intervention helmet, assist and encourage , 3/6/17, for the MDS, "Does to help protect head." R135 eral times sitting self on floor, and will often do this he couch. Had been hair but changed to Broda as accepted and appears dated 1/26/17, indicated no er, R135 was at risk for falls gait, poor balance, needs eeds. R135 was impulsive, horea was primary reason for d dementia and schizophrefia. t of one to two with bed to ensure safe positioning, with transfers, and R135 air when up walking. R135 had as of care rejection with displayed behaviors of ng of objects. dated 3/6/17, for the MDS, helmet to help protect head." en several times sitting self on rtable and will often do these he couch. The facility had heel chair but changed to				
	to wear. The Progress Note, wear a soft helmet i has been seen seve seems comfortable especially over by th introducing wheel c chair which R135 h comfortable. The MDS and CAA falls that past quarter related to unsteady assist for mobility n had Huntington's ch loss of mobility, had R135 needed assis mobility, staff were assist of one to two used the Broda cha behaviors symptom physical cares and throwing or smearin The Progress Note "Does wear a soft h R135 had been see floor, seems comfo especially over by th been introducing wh	, 3/6/17, for the MDS, "Does to help protect head." R135 eral times sitting self on floor, and will often do this he couch. Had been hair but changed to Broda as accepted and appears dated 1/26/17, indicated no er, R135 was at risk for falls gait, poor balance, needs eeds. R135 was impulsive, norea was primary reason for d dementia and schizophrenia. t of one to two with bed to ensure safe positioning, with transfers, and R135 hir when up walking. R135 had as of care rejection with displayed behaviors of ng of objects. dated 3/6/17, for the MDS, helmet to help protect head." en several times sitting self on rtable and will often do these he couch. The facility had heel chair but changed to				

If continuation sheet Page 6 of 73

		AND HUMAN SERVICES			PRINTED: 07/31/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245279	B. WING		- 03/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STAT 3815 WEST BROADWAY ROBBINSDALE, MN 554	TE, ZIP CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) EACTION SHOULD BE TO THE APPROPRIATE DATE IENCY)
F 246 F 272 SS=D	The RN-D, was intera a.m., and confirmed agreed the helmet of RN-D stated the help product R135 had the part of the helmet winitially but needed The occupational the 3/30/17, at 10:42 a. admitted to the faci Occupational thera that was completed on admission. The 12/18/20 (had year wore a helmet and assessment failed to of the helmet. TMA-C was intervie and confirmed R13 was covering her et helmet touched the will get red. 483.20(b)(1) COMP ASSESSMENTS (b) Comprehensive (1) Resident Assess must make a comp resident's needs, st preferences, using instrument (RAI) sp assessment must in	Arviewed on 3/30/17, at 10:24 d R135 wore a helmet. RN-D did go down over R135's eyes. Imet for R135 was the best o wear. In addition, the front vas originally customized to be reassessed again. Arerapist-A was interviewed on m. and confirmed R135 was lity with a helmet. pist-A shared the assessment I by occupational therapy (OT) OT assessment done on wiped out), indicated R135 was a fall risk. The to indicate the condition and fit ewed on 3/31/17, at 9:52 a.m. 5 can only push it up when it yes. In addition, when the bridge of the nose, the nose PREHENSIVE Assessments asment Instrument. A facility rehensive assessment of a trengths, goals, life history and the resident assessment becified by CMS. The nclude at least the following: and demographic information	C	272	5/15/17

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		AND HUMAN SERVICES & MEDICAID SERVICES				PRINTED: 07/31/2017 FORM APPROVED OMB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTRU		(X3) DATE SURVEY COMPLETED
		245279	B. WING	à	·····	03/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Υ	3815 WEST	DRESS, CITY, STATE, ZIP COI BROADWAY DALE, MN 55422	DE
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX (EA	PROVIDER'S PLAN OF CORR ACH CORRECTIVE ACTION S SS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
F 272	 (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v (viii) Physical ful problems. (ix) Continence. (x) Disease diagno (xi) Dental and nutr (xii) Skin Conditions (xii) Activity pur (xiv) Medications (xvi) Discharge ((xvi) Discharge ((xvi) Discharge ((xvi) Discharge ((xvi) Documenta regarding the addition the care area of the Minimum Dati (xviii) Documenta assessment. The a include direct observati the resident, as well licensed and non-licen on all shifts. The assessment pr observation and co as well as commun non-licensed direct shifts. This REQUIREMENT by: Based on observati 	rns. avior patterns. vell-being. nctioning and structural psis and health conditions. ritional status. s. suit. s. planning. ation of summary information onal assessment performed us triggered by the completion	F	residen	ilization Data Collection t R40 was completed ysical Device and Res	on 4/28/2017

Facility ID: 00890

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		& MEDICAID SERVICES	1			0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245279	B. WING		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIF	P CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	v	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 272	Continued From pa	ge 8	F 27	2		
	² Continued From page 8 positioning device as a potential restraint for 1 of 3 residents (R40) reviewed for restraints; the facility failed to comprehensively assess side rails placed for 1 of 3 residents (R243) reviewed for restraints.			Assessment on 5/1/2017. was picked up on OT cas 5/1/2017. Resident R243 Device and Restraint Asse on 3/29/2017.	e load on had a Physical	
	admission diagnose with behavioral dist (behavioral, cognitiv On 3/29/17, at 7:20 hallway, both legs v chair (tilt and recline (W/C), and he was On 3/29/17, at 8:41 (TMAs)-A and C too readjusted the cloth from the restraint at located in the back not reach the closu himself. Before R40 re-applied the restra R40 was taken to h toileting and clothin was again released R40 left the room th restraint. A Physician's Verba 8/29/13, indicated a with a back latching	to the facility on 10/5/11, with es of schizophrenia, dementia urbances, supranuclear palsy ve, and gait disturbances). a.m. R40 was sitting in the vere restrained in a Broda e positioning wheelchairs leaning forward in the chair. a.m. trained medication aides ok R40 to his room and hing. R40's legs were released is the restraint closure was of the W/C where R40 could re to release the restraint D left the room the TMA aint. On 3/29/17, at 10:48 a.m. is room By TMA-A and C for g adjustment. The restraint I from behind the W/C. Before he TMA re-applied the al Telephone Order dated a pelvic device was approved g for wheelchair The facility was to discontinue		All residents with bilateral be reassessed for restrain and care plans updated a the Nurse Management s with side rails will be revie Nurse Managers to ensur determination and care pl accurate. All staff with responsibility retrained by the Director of Services on 4/25/2017. The Director of Nursing S designee will be responsit compliance through routin conducted weekly x4, mor results will be taken to the committee for further reco	nt determination s appropriate by taff. All residents wed by the e restraint ans are for MDS were of Nursing ervices and/or ole to ensure he audits nthly x3. Audit e QAPI	
	An OT evaluation d					

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		& MEDICAID SERVICES	[). 0938-039
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		03	8/31/2017
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 272	"in Broda chair with support device which sitting position to pro- wheelchair mobility extremities] to prop- flexion with upper to pelvic posture durin thigh pads recomm- pelvis sitting postur promotes upright vi- within environment The Mobilization St dated 2/25/17, indic himself upright from enough torso stren- seated position. R4 transfer between st himself up and rise stand/sit/stand with assistive device to to pull self-up. Was comment indicated standing position w reported his ability inconsistent, and or up or would attemp on them or want the utilize stand aid for A Physical Devices assessment dated for Broda chair - as chair w/out sliding of assessment indicated resident and it rest	bilateral thigh pad postural ch provides a neutral pelvis romote independence with . Uses BLE [bilateral lower bel wheelchair and forward body that results in anterior ing wheelchair mobility. Bilateral rended to provide neutral re when in wheelchair and isual alignment for interaction " upport Data Collection Tool cated R40 was able to pull in lying to sitting. R40 did have gth to maintain an upright, 0 had the leg strength to urfaces, was able to push 1-2 inches. R40 could limited support. "Used transfer, stationary hand hold is unable to ambulate." A R40 was able to pull self to then assessed, however staff to pull self-upright was ften R40 would not pull himself t to grab onto staff and hang em to lift him. "May need to transfers." and Restraint Review 2/25/17, indicated thigh straps sists resident in self-propelling but of it. A bolded note in the ted: "If the device, material or peremoved easily by the ricts freedom of movement or ne's own body, then it is a	C	72		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY IPLETED
		245279	B. WING _		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	•	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	ſY	3815 WEST BROADWAY ROBBINSDALE, MN 55422	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIEI	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE
F 272	then asked "is this of resident?" and the fit the resident was not straps [restaint] him A Good Samaritan Community Progressindicated R40 had activities of daily liv review. He had beet toileting and person assessment dated assessed by physic felt to be appropriat walking program in participate and it wa latching bilateral this positioning in the cl back and forth usin hallway. Those rem A PT evaluation for dated 2/28/17, indic increased difficulty non-ambulatory at I chair in unit. Demotian activity tolerance, s affecting transfers a patient and nursing Recommending us due to decreased E and BLE." The significant chai dated 3/2/17, indica R40 was noted to his	d." The facility assessment device a restraint for this facility checked no. However ot able to remove the thigh nself. Society Specialty Care ss Note dated 2/27/17, declined in three areas of ring (ADL) function since last en dependent with dressing, hal hygiene. A quarterly 3/2/17, indicated R40 was cal therapy (PT), but was not te for therapy. R40 did have a the past but refused to as discontinued. Soft back igh straps to assist with hair due to his forceful rocking ig hand rail to propel himself in				
FORM CMS-25	567(02-99) Previous Versions	S Obsolete Event ID:2GLR	11	Facility ID: 00890	If continuation sheet	Page 11 of 73

		AND HUMAN SERVICES	-		PRINTED: 07/31 FORM APPRO OMB NO. 0938-	OVED
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVE COMPLETED	
		245279	B. WING _		03/31/201	7
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPL D THE APPROPRIATE DAT	ETION
F 272	Continued From pa grabbing, hitting, ar was at risk for falls. The care plan revis indicated R40 was history of striking our risk for falls was im risks. Had impaired and standing balam remote history of fro- strip (mat) next to b An intervention lister thigh straps when u The nursing assista 3/30/17, directed st front, side, and reat positioning device. minutes and "releas load/reposition and On 3/29/17, at 2:10 indicated R40 used the heels and pullin around in his chair chair. The thigh stra- aide, so he can self the chair." RN-F rev wording and stated as a positioning too On 3/29/17, at 2:45 thigh straps for self because he used to forceful movements	ge 11 nd pacing in wheelchair. R40 ed 3/28/17, (during survey), resistive to care and had a ut during cares. R40 was at pulsive and unaware of safety i judgement, impaired sitting ce, gait disturbance. Had a equent falls, laying on landing bed and crawling on the floor. ed of Broda chair with bilateral ip. ant (NA) care sheet printed aff to use the Broda chair with r tip bars, and bilateral thigh Staff were to check every 30 se every two hours" and off offer toileting. p.m. registered nurse (RN)-F, to propel himself by planting ig forward, he was sliding a lot, and kept falling out of aps were considered a mobility i-propel without sliding out of viewed the restraint form "I was told therapy classified it	F 2	DEFICIEN		
	stand up by himself use the thigh straps	f consistently."By having R40 is it afforded him a high level of asked if he could release the		Facility ID: 00800	If continuation shoot Pogo 1	

Facility ID: 00890

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		AND HUMAN SERVICES			FORM	APPROVED
	COF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA				0938-0391 E SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:	. ,			PLETED
		245279	B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 8815 WEST BROADWAY		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	~ .	ROBBINSDALE, MN 55422		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETION DATE
				DEFICIENCY)		
F 070						
F 272	Continued From pa	-	F 272			
thigh straps himself and stated no, "but it was r assessed as a restraint in the facility." On 3/30/17, at 3:00 p.m. the director of nursing						
		wed and stated bilateral thigh				
	straps were conside	ered a positioning device.				
	The Physical Restra	aints Procedure dated 11/16,				
		re appropriate use of				
		Restraints - any manual or mechanical device,				
		ent attached or adjacent to the				
		the individual cannot remove				
		freedom of movement or ne's own body. Physical				
		de, but are not limited to,				
		vests, lap cushions, lap trays				
		he resident cannot remove. straints are location practices				
		tion of a restraint, such as:				
	Using devices in co	njunction with a chair such as				
	trays, tables and be from rising."	elts that prevent a resident				
	nom nsing.					
	Siderails:					
		on 3/16/17, and had				
		cluded lumbar discitis een discs in vertebra of the				
	back), osteomyelitis	and arthritis as indicated on				
		on MDS dated 3/23/17. The				
		3 was cognitively intact and of two staff for bed mobility,				
	transfers, toilet use	and walking in the room. The				
		nent dated 3/23/17, indicated				
		r falls due to weakness, I impaired mobility. R243's				
	medical lacked evic	lence of an assessment for				
	siderails.					

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		AND HUMAN SERVICES			FORM): 07/31/2017 / APPROVED). 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	ſY	3815 WEST BROADWAY ROBBINSDALE, MN 5542	22	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED 1 DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 272	On 3/27/17, at 5:03 were observed to b R243's bed. The si two inches inward bed. R243's record lack assessment for the medical doctor ord bilateral siderails w mobility. During interview or stated occupationa assess for any ass see the siderails w and they are wobb During interview or stated R243 requir grab bar and will us bed was in that roo probably came with RN-A verified the s at least two inches not good, we will g immediately." During interview or environmental assi that shouldn't be lik moving both sidera "large frame" and t been on the bed w EA-A stated he wa nursing that the side	B p.m. the quarter siderails be loose on both upper ends of iderails moved approximately and were not secure to the ed completion of any device e use of side rails and a er indicating the quarter vere to be used for bed n 3/29/17, at 9:38 a.m. OT al therapy would typically istive devices but she did not ere loose, "I see your concern, ly." n 3/29/17, at 9:41 a.m. RN-A ed and was assessed for a se it to sit up. RN-A stated the on when he arrived and in the siderails. At 10:17 a.m. iderails were loose and moved inward, stating "oh my, that's et them switched out n 3/29/2017, at 10:19 a.m. istant (EA)-A stated "oh wow, ke that" when inspecting and ails. EA-A stated the bed had a the siderails shouldn't have ithout an oversized mattress. s not aware nor notified by derails were loose.	F 2			
		n 3/29/17, at 12:06 p.m. the on't consider it a restraint, it's				
ORM CMS-25	67(02-99) Previous Version	s Obsolete Event ID:2GLR	11	Facility ID: 00890	If continuation shee	t Page 14 of 7

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		AND HUMAN SERVICES			FORM	07/31/201 APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY IPLETED
		245279	B. WING		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	v ³⁸	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 272	Continued From pa	-	F 272			
		verified both siderails were e was no siderail assessment.				
F 278 SS=D	483.20(g)-(j) ASSE		F 278			5/15/17
		sessments. The assessment flect the resident's status.				
	(h) Coordination A registered nurse each assessment v participation of hea					
	(i) Certification (1) A registered nur the assessment is	rse must sign and certify that completed.	C			
		who completes a portion of the sign and certify the accuracy of assessment.				
	(j) Penalty for Falsi (1) Under Medicare who willfully and kn	e and Medicaid, an individual				
	(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or					
	and false statemen	r individual to certify a material It in a resident assessment is oney penalty or not more than sessment.				
	(2) Clinical disagree material and falses	ement does not constitute a statement.				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 07/31/2017 APPROVED . 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	· · /	E SURVEY IPLETED
		245279	B. WING			03/	31/2017
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 278	by: Based on interview facility failed to ens Data Set (MDS) wa residents R200 revi Findings include: R200's admission M R200 did not have a greater. A Care Are 12/17/16, indicated ulcers related to de weakness and freq did not identify a cu discharge - return a 12/20/17, indicated entry tracking recor indicated no pressu MDS dated 1/14/17 a pressure ulcer, st A Nursing Admit/ Re 12/4/16, identified a collection tool furthe the following: press surgical wound, art surgical wound or s but did not identify w	NT is not met as evidenced y and document review, the ure an accurate Minimum s completed for 1 of 3 iewed for pressure ulcers. MDS dated 12/11/16, indicated a pressure ulcer stage I or a Assessment (CAA) dated R200 was at risk for pressure pendence on staff for mobility, uent incontinence. The CAA rrent pressure ulcer. A unticipated MDS dated no pressure ulcers and an d MDS dated 12/23/17 also ire ulcers present. A discharge , indicated R200 did not have	F 2	278	Resident R200 was discharged facility on 1/14/2017. The MDS resident R200 was modified on 4 to include pressure ulcer. Documentation for all residents w reviewed to ensure that identified pressure ulcers are appropriately assessed, documented and that information is coded accurately of MDS by the Nurse Managers. All staff with responsibility for wo management will be retrained or protocols for wound assessment documentation by the Director of Services and/or designee. All sta responsibility for completing the were retrained by the Director of Services on 4/25/2017. The Director of Nursing Services designee will be responsible to e compliance through routine audii conducted weekly x4, monthly x3 results will be taken to the QAPI committee for further recomment	for 4/28/2017 will be d y on the t and f Nursing aff with MDS Nursing s and/or ensure ts 3. Audit	
	Specialty Care trea 2016 identified the on 12/10/16: Clean with Mepiles [sic] M foam dressing) dail skin breakdown pre	Good Samaritan Society tment record dated December following treatments initiated se coccyx, pat dry and cover lepilex dressing (an absorbent y in the morning for stage I evention, Cleanse open area al saline, pat dry and apply					

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DEPAR	TMENT OF HEALTH	AND HUMAN SERVICES		P		APPROVED
CENTE	RS FOR MEDICARE	& MEDICAID SERVICES		0		0938-0391
	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING		03/3	31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	Mepilex dressing da A review of R200's Specially Care Com 12/12/16 through 1/ 12/12/16 - Residem nursing care for ma coccyx and open ar wounds (two) are co dressing intact. 12/ coccyx and mid bac dry and intact with r - wounds on mid-bac intact, 1/2/16 - wound with Mepilex and im A physician visit Pro- indicated R200 had mid spine." A Nursing Admit/Ref 12/23/16, indicated wounds: Sacrum; c (cm) x .75 cm, oper closed wound 0.25 During an interview registered nurse (R seen R200's wound finds a wound, the n wound observation RN assessment. Sh also be completing bath day. At 11:36 a unable to locate an R200 and stated, "V not followed." She f should have inform	Good Samaritan Society munity Progress Notes dated (5/16, identified the following: t continued to receive skilled anagement of fragile skin on rea on spine. 12/13/16 - overed with Mepilex and 15/16 - dressing change to ck. 12/25/16 - wounds clean, no signs of infection. 12/27/16 ack and coccyx clean, dry and nd on coccyx was covered	F 27	3		

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		AND HUMAN SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING _		03/	31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	тү	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From pa MDS.	ige 17	F 27	78		
F 279 SS=D	condition should be She stated if a pres admit she would ex and expect a care p R200 had two sepa identified on admis 12/10/16, both doct discharge, the facil four separate times 483.20(d);483.21(b COMPREHENSIVE 483.20 (d) Use. A facility r assessments comp months in the resid results of the asses and revise the resis plan. 483.21 (b) Comprehensive	(1) DEVELOP E CARE PLANS nust maintain all resident bleted within the previous 15 ent's active record and use the ssments to develop, review dent's comprehensive care	t y F 27	79		5/15/17
	each resident, cons set forth at §483.10 includes measurab to meet a resident's	son-centered care plan for sistent with the resident rights D(c)(2) and §483.10(c)(3), that le objectives and timeframes s medical, nursing, and mental eeds that are identified in the				
	comprehensive ass care plan must des	sessment. The comprehensive cribe the following -	9			
	(i) The services that	t are to be furnished to attain				
ORM CMS-2	567(02-99) Previous Versions	Obsolete Event ID:2GLF	R11	Facility ID: 00890	If continuation sheet	Page 18 of 7

		AND HUMAN SERVICES				FORM	: 07/31/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LTIPLE CONSTR			E SURVEY IPLETED
		245279	B. WING	i		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	3815 WEST	DDRESS, CITY, STATE, ZIP (T BROADWAY SDALE, MN 55422	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CO EACH CORRECTIVE ACTION DSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 279	 physical, mental, ar required under §48 (ii) Any services that under §483.24, §48 provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative service provide as a result recommendations. findings of the PAS rationale in the resident's represent (A) The resident's represent (A) The resident's g desired outcomes. (B) The resident's g future discharge. Fawhether the resider community was assolic contact agence entities, for this pur (C) Discharge plane requirements set for section. This REQUIREMENT 	dent's highest practicable nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to ies and/or other appropriate pose. s in the comprehensive care e, in accordance with the orth in paragraph (c) of this NT is not met as evidenced <i>y</i> and document review, the	F		dent R181 is no longe		
		Iement interventions to oment of pressure ulcers			1/23/2017; during the e was amended on 1/		

If continuation sheet Page 19 of 73

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		245279	B. WING			
	PROVIDER OR SUPPLIER	245279		TREET ADDRESS, CITY, STATE, ZIP CODE	03/3	31/2017
		- SPECIALTY CARE COMMUNI	ту 3	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 279	(localized injury to fitissue usually over result of pressure, with shear and/or fit (R181) identified as Findings include: R181's hospice car address pressure u did instruct home hit with lotion on body and arms, observe care and foot care. 3/30/17, was review R181's admission of on 1/23/17. The car identification of pre- development of fou (partial thickness sidermis, or both. The presents clinically a shallow crater). The interventions to pre- R181's admission I dated 12/13/17, inclinated and had not seven days. R181 of one staff for bed toileting and identif bowel and bladder. did not have any pr for developing pres- indicated R181 had	the skin and/or underlying a bony prominence, as a or pressure in combination riction) for 1 of 1 resident s at risk for pressure ulcers. The plan dated 12/28/16, did not ulcer risk or development but lealth aide to, "Assist patient gentle massage to back feet and report skin changes, nail "The Facility care plan printed wed for period of time from on 12/6/16, until R181's death re plan did not include		 include a mepilex dressing, cha 3 days. And on 1/20/2017 to inc following interventions: a low-ai mattress, heel protectors to wea times when in bed, reposition er as resident allows, cover open a small amount of barrier cream a mepilex dressing. Care plans for all residents with for skin integrity issues were re- modified as needed by the Nurs Management staff on 4/28/2017 GSS Care Plan Policy and GSS Procedure for Skin Assessment Ulcer Prevention and Documen Requirements will be reviewed all appropriate staff by the Direct Nursing Services and/or design The Director of Nursing Services designee will be responsible to compliance through routine aud conducted weekly x4, monthly x results will be taken to the QAP committee for further recomme 	lude the r loss ar at all very hour areas with and apply potential viewed and se c. F. Pressure tation by the with ctor of ee. s and/or ensure lits 3. Audit I	

		AND HUMAN SERVICES				FORM APPROVED MB NO. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		245279	B. WING _			03/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNI	Y	STREET ADDRESS, CITY, STATE 3815 WEST BROADWAY ROBBINSDALE, MN 5542		
(X4) ID PREFIX TAG	DD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY ROBBINSDALE, MN 55422 () ID EFIX AG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTIVE (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) 279 Continued From page 20 required continuous oxygen. F 279 The Care Area Assessment (CAA) dated 12/19/16, indicated R181 was at risk for pressure ulcers related to cardiomyopathy shortness of breath, weakness impaired mobility and need for staff assistance with bed mobility. CAA indicated F 279		ACTION SHOULD O THE APPROPF	BE COMPLETION		
F 279	required continuous The Care Area Ass 12/19/16, indicated ulcers related to ca breath, weakness i staff assistance wit R181 did not have indicated pressure developed and R18 participate in theray goal of discharging A Progress Note da "found a stage II of resident's coccy? Mepilex dressing w and protected. Writ Care for seniors to need for tx [treatmen nursing is awaiting A Progress Note da indicated, "writer al open area on coccy of 4 open areas tha [millimeter] in size. [signs/symptoms] careas and applied I cover and keep cle repositioning and w when in bed and fre out of bed. Writer h dietician] of open a air mattress for res this time."	s oxygen. Ressment (CAA) dated I R181 was at risk for pressure ardiomyopathy shortness of mpaired mobility and need for th bed mobility. CAA indicated a pressure ulcer. The CAA ulcer care plan would be B1 would continue to py to become stronger with a	C	9		
FORM CMS-25	567(02-99) Previous Versions	s Obsolete Event ID:2GLR	11 I	acility ID: 00890	If continuation	on sheet Page 21 of 73

TATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /		(X3) DA	0. 0938-039 TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
-	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNI	7V 38	REET ADDRESS, CITY, STATE, ZIP CODE 15 WEST BROADWAY OBBINSDALE, MN 55422	1 00	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 279	an air mattress, he one hour and the a open areas with dra During interview on registered nurse (F pressure ulcer was and that on 1/2017 ulcers were identifie pressure ulcer care admission or when pressure ulcers on stated an initial car opened by the adm of admision. RN-B update the care pla or risks on the Trar Hospice would typie then the facility would asked what is part "The electronic car During interview on of nurses (DON) sar risk for pressure ul- to be developed for there to be a care plan is the ele asked if the care pla of the chart DON s section. If they are care plan to say pro not necessarily to in pressure ulcers. Th During interview on	el protectors, reposition every ddition of barrier cream to				

	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULTI	PLE CONSTRUCTION). 0938-039 TE SURVEY
	FCORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245279	B. WING		03	/31/2017
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF		51/2017
OOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUN	NITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 22	F 27	9		
	"It had started out a she would not get of developed four very were two on either very small. As she expect the wounds encouraged her to she would not." RN the care plan, I was of her." RN-C verifi- care plan. RN-C sa pressure ulcers, the prominences." During interview on DON said, "All of our reducing and it will	get out of bed and to eat but -C said, "I did not think to wri s more focused on taking car ed there should have been a id, "The wounds were	se re ot ite re			
	During interview on medical director sta part of the care pla The facility care pla reviewed for period	n printed 3/30/17, was of time from R181's 16, until R181's death on				
F 282 SS=D	identification of pre development of fou care plan lacked an treat pressure ulce	ssure ulcer risk or Ir stage II pressure ulcers. Th iy interventions to prevent or rs. RVICES BY QUALIFIED		2		5/15/17
	(b)(3) Comprehens		1.			

Facility ID: 00890

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 245279 B. WING 03/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422 3815 WEST BROADWAY ROBBINSDALE, MN 55422 03/31/2017						FORM	: 07/31/201 APPROVEI		
NAME OF PROVIDER OR SUPPLIER Image: Control of Supplier STREET ADDRESS, CITY, STATE, ZIP CODE Street ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY Image: Control of Contr	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			(X3) DAT			
NAME OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES STREET ADDRESS, CITY, STREE, JP CODE (M) ID SUMMARY STATEMENT OF DEFICIENCIES BIS WEST BROADECOMEY BIS WEST BROADECOMEY (M) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAND OF CORRECTION DIECTO CORRECTION (M) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAND OF CORRECTION DIECTO CORRECTION (M) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAND OF CORRECTION DIECTO CORRECTION (M) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S FLAND OF CORRECTION DIECTO THE APPROPHARE (M) ID SUMMARY STATEMENT OF DEFICIENCIES PREIX TAC DEFICIENCIES (M) ID SUMMARY STATEMENT OF DEFICIENCIES PREIX TAC DEFICIENCIES			245279	B. WING _		03/	03/31/2017		
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY ROBBINSDALE, MN 55422 (X4) ID PRETX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEISED BY FULL REQUATORY OR LSC IDENTIFYING INFORMATION) ID PRETX PAG PROVIDERS FUND OF CORRECTION (EACH DEFICIENCY MUST BE RECEISED BY FULL REQUITED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEISED BY FULL REQUITED SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE RECEISED BY FULL REQUITED SUMMARY STATEMENT OF DEFICIENCIES (F282 PROVIDERS FUND OF CORRECTION (EACH DEPICTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY MUST BE RECEISED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDERS FUND ACLO BE (EACH DEPICTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY MUST BE RECEISED BY FULL REGULATORY OF DEFICIENCIES (F382 F 282 Continued From page 23 as outlined by the comprehensive care plan, must- F 282 F 282 F 188 Deprovide by qualified persons in action of the care plan transition review the facility failed to follow the care plan for dementia interventions are infective. F 282 Escient R59 care plan was modified on 4/28/2017, Appropriate staff will be resident R55 who had identified pressure ulcers. F 282 Escient R59 care plan was modified on 4/28/2017, Appropriate staff will be resident R55 who had identified pressure ulcers. F 282 Escient R50 care plan interventions are ineffective. F 282 F indings include: Dementia residents (R55) who had identified pressure ulcers. F 282 Escient R40 has seasonal allery inte	NAME OF F	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CO	-	• = •		
PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) Continued From page 23 as outlined by the comprehensive care plan, must- F 282 F 282 Continued From page 23 as outlined by the comprehensive care plan, must- F 282 (ii) 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 follow the care plan for dementia interventions for1 of 1 resident (R59). In addition, the facility failed to ensure 1 of 3 residents (R55) who had identified pressoure ulcers. F 282 Findings include: Findings include: Findings include: Dementia: R59's Admission Record Resident Information sheet indicated a diagnosif of demental with behavioral symptoms. R59 care plan dided 1/2017. Nake and NA-C were reducated regarding apropriate hand and face hygiene for resident R40 on 3/29/2017. Resident R40 on 3/29/2017. Resident R40 on 3/29/2017. The care plan of all residents with dementia were reeducated by the Nurse Manager: Staff caring for patients with dementia were reeducated by the Nurse Manager regarding for patients with dementia were reeducated by the Nurse Manager regarding their obligation to following. The care plan directed staff to minimize behaviors directed loward others and verbal behaviors directed loward others and verbal behaviors directed loward others and verbal behaviors and sold was available, go to another unit if needed. The care plan directed staff to minterventions: # awas eavily, give R59 breaktat as soon as food was available, go to another unit if needed. The care plan directed staff to minterventions as a lo The care plan interven	GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	гү					
 as outlined by the comprehensive care plan, must. (ii) 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 follow the care plan for dementia interventions for 1 of 1 resident (R59). In addition, the facility failed to ensure 1 of 3 residents (R40) was kept free of nasal discharge and had his hands cleaned after personal addition, the facility failed to ensure pericare and skin protocol was followed for 1 of 3 residents (R55) who had identified pressure ulcers. Findings include: Dementia: R59's Admission Record Resident Information sheet indicated a diagnosis of domenta with behavioral symptoms. H5 usuarienty Minimum Data Set (MDS) dated 12/29/15, indicated he was severely cognitived as slep/wake cycle disturbance, and behaviors that included physical aggression, hitting, pushing and loud disruptive singing. The care plan direct distaft to minimize behavior problems with the following interventions: and the following interventions and the following interventions and to follow care plan interventions and the following interventions and shade and discource and behaviors and verbal behaviors and pushing and loud disruptive singing. The care plan directed staft to minimize behavior problems with the following interventions: a first adve early, give R59 breakfast as soon as food was available, go to another unit if needed. The care plan further directed staft to minimize behavior applane interventions are ineffective. NA-B and NA-C were reeducated specifically on 5/1/2017 regarding public black the foreskin to wash the penis when performing male pericare. 	PRÉFIX	(EACH DEFICIENC)	YMUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A	HOULD BE	COMPLETION		
offer music and the use of head phones as a	F 282	as outlined by the or must- (ii) Be provided by or accordance with ear care. This REQUIREMED by: Based on observar review the facility far dementia interventia addition, the facility residents (R40) wa and had his hands self-touch and the far and skin protocol w residents (R55) wh ulcers. Findings include: Dementia: R59's Admission R sheet indicated a d behavioral symptor Data Set (MDS) da severely cognitively behaviors directed behavioral symptor 1/20/17, identified a disturbance, and be aggression, hitting, singing. The care p behavior problems interventions: If awa as soon as food wa	ecord Resident Information is had identified pressure as followed for 1 of 3 skept free of nasal discharge cleaned after personal facility failed to ensure pericare as followed for 1 of 3 o had identified pressure ecord Resident Information iagnosis of dementia with ns. His quarterly Minimum ted 12/29/16, indicated he was rimpaired and displayed toward others and verbal ns. R59 care plan dated a sleep/wake cycle ehaviors that included physical pushing and loud disruptive lan directed staff to minimize with the following ake early, give R59 breakfast as available, go to another unit		Besident R59 care plan was 4/28/2017. Appropriate staff reeducated by the Director of Services and/or designee reg following resident R59 care p interventions and their respon inform the Nurse Manager if those interventions are ineffe Resident R40 has seasonal a rhinitis; his medication for all changed to a more effective on 4/1/2017. NA-B and NA-C reeducated regarding approp and face hygiene for resident 3/29/2017. Resident R55 no resides in the facility as of 4/7 The care plans of all resident dementia were reviewed by t Manager. Staff caring for pa dementia were reeducated b Manager regarding their oblig follow care plan interventions inform the her if and when th interventions are ineffective. NA-C were reeducated speci 5/1/2017 regarding pulling ba foreskin to wash the penis with	will be Nursing garding lan nsibility to and when ctive. allergic ergies was medication C were wriate hand covere riate hand longer 12/2017. Is with he Nurse tients with y the Nurse gation to and to ose NA-B and fically on uck the			
					All staff will be reeducated or	the GSS			

Facility ID: 00890

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TEMENT OF DEFICIENCIES	E & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI	TIDI	E CONSTRUCTION	MB NO.		
) PLAN OF CORRECTION	IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245279	B. WING			03/	31/2017	
AME OF PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
OOD SAMARITAN SOCIET	(- SPECIALTY CARE COMMUNIT	Y		815 WEST BROADWAY OBBINSDALE, MN 55422			
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE	
F 282 Continued From p	age 24	F 2	282				
R59 was seated in intermittent non-se returned to the din dressed. He had a was clapping his h repeatedly. At 7:59 ambulated past R5 staff member did r swore. At 3/29/17, the table singing, y 8:33 a.m., staff be residents, howeve food. At 8:39 a.m., clap his hands. Sta 8:43 a.m., one hou was seated at the quietly, calling out 8:56 a.m., staff es where he was yelli continued to yell u observation on 3/2 his room with the o loudly. R59 was si music playing in his	hs on 3/29/17, at 7:26 a.m., a the dining room making ensical noises. At 7:57, R59 ing room table after getting a coffee cup in front of him, he ands and calling out, swearing 9 a.m., a staff member 59. R59 called out "hey," the not acknowledge R59 who then at 8:18 a.m., R59 remained at velling out and swearing. At gan serving breakfast to other r, R59 had not yet received any R59 continued to yell out and aff served R59 his breakfast at ur and 27 minutes after R59 table. R59 ate his breakfast once for scrambled eggs. At corted R59 back to his room ng with the door shut. He ntil 9:33 a.m. During a second 19/17, at 1:19 p.m., R59 was in door open. He was calling out tting on his bed, there was no s room and he was not wearing irected in his plan of care.	C		Care Plan Policy, staff obligation t respond appropriately to nasal dis and the GSS Policy and Procedur Perineal Care by the Director of N Services and/or designee. The Director of Nursing Services a designee will be responsible to en compliance through routine audits conducted weekly x4, monthly x3. results will be taken to the QAPI committee for further recommend	charge e for ursing and/or sure Audit		

If continuation sheet Page 25 of 73

DEPARTMENT OF HEALTH AND HUMAN SERVICES						
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES	-	OI		APPROVED 0938-0391
			. ,	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
245279			B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	YI	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG PREFIX TAG PREFIX CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		BE	(X5) COMPLETION DATE
F 282	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F 282			
	R59 was agitated s headphones or mus	taff should offer his sic in his room. She stated				

If continuation sheet Page 26 of 73

		I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	· · /	E SURVEY IPLETED
		245279	B. WING _		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 282	Continued From pa	age 26	F 28	82		
	helped to cancel ou	ut excess noise.				
	director of nursing using the interventi care. A facility policy was Hygiene: R40 was observed in the hallway, he w chair, clear thick m nose, and R40 pus mouth. At 7:35 a.m across the unit. Mu his nose. At 7:38 a. he continued to hav nose. At 8:41 a.m. his room, and releat the chair, assisted R40 was able to put assist of the EZ stat his right hand from pushed mucous int receiving peri-care his penis, and then he put his hand into was taken to his ro and NA-C. Cares w scratched his penis pull mucous from h into his mouth. NA- hands when they g had his hands was R40 had touched h mouth, and that mu	a on 3/30/17, at 2:46 a.m., the (DON) stated staff should be ons in place on the plan of a requested but not received. on 3/29/17, at 7:20 a.m. sitting vas leaning forward in the ucus was running out of his hed the mucous into his bed the mucous from his bed the mucous drain from .m. staff assisted R40 to eat, we mucous drain from his NA-B and NA-C took R40 to ased the restraint from behind with brief using the EZ stand. All himself upright without the and. R40 repeatedly removed the EZ lift assist handle and to his mouth. When he was R40 touched and scratched pulling mucous from his nose on his mouth. At 10:48 a.m. R40 om to change brief by NA-B were provided, R40 again as, and then lifted his hand to his nose and put his right hand and and they would wash his et him back in the chair. R40 hed, NA-B and NA-C verified is penis, put his hand in his ucous draining was also being NA-B and NA-C also verified				
	he had done that in	the cares provided at 8:41 then washed his face.				
	67(02-00) Previous Versions	Chsolete Event ID:2GI B1		Eacility ID: 00890	ntinuation choot	

Facility ID: 00890

If continuation sheet Page 27 of 73

Trag REGULATORY ORLSCIDENTIFYING INFORMATION) Trag CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 27 F 282 The care plan revised 3/28/17 (during survey), indicated R40 had a self-care deficit and needed assist for dressing, grooming, bathing, eating, bed mobility and transfers. R40 was not provided with appropriate hand and face hygiene with the 8:41 a.m. cares. F 282 On 3/29/17, at 2:10 p.m. RN-F stated she would have expected staff to wash his face and hands, and clean away mucous. F 282 On 3/29/17, at 2:45 p.m. RN-E stated she would have expected the staff to clean the mucous away from his face and wash his hands after he touched his penis. F On 3/30/17, at 3:00 p.m. the DON stated she would have expected staff to provide cares wash face and hands. Percare: R55 was observed during moming cares done by two nursing assistants (NAS on 3/29/17) at 3:40 a.m. NA-B and NA-C entered P65 to room to turn and reposition the resident. NA-B cayshing thery were going to lower the bed. The bed was lowered and both NAs gloved affer washing their hands in R55 b abthroom. NA-C washend R55's face. NA-B next removed pillows from between R55's legs. R55 had heel protectors on over skid socks. The two NAs worked together in turning			AND HUMAN SERVICES			FORM): 07/31/2017 / APPROVED). 0938-0391	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY STREET ADDRESS, CITY, STATE, ZIP CODE Bit WEST BROADWAY ROBBINSDALE, MN 55422 CMU ID ESUMMARY STATEMENT OF DEFICIENCIES PREDUX TORY OF DEFICIENCY MIST BE PRECEIPED BY TULL PROVIDER'S PLAN OF CORRECTION TAG BUD MARY STATEMENT OF DEFICIENCIES PREDUX TORY OF LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION TAG PROVIDER'S PLAN OF CORRECTION TAG PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION CONSIDERTIFYING INFORMATION) F 282 Continued From page 27 The care plan revised 3/28/17 (during survey), indicated FA0 had a self-care deficit and needed assist for dressing, grooming, bathing, eating, and clean away mucous. On 3/29/17, at 2:10 p.m. RN-F stated she would have expected staff to and wash his hads after he touched his penis. On 3/30/17, at 3:00 p.m. the DON stated she would have expected staff to provide cares, wash face and hands. Pericare: R55 was observed during moming cares doneby two nursing assistants (NAB) on b/29/17, at 2:45 p.m. The bON stated she would have expected staff to provide cares, wash face and hands. Pericare: R55 was observed during moming cares doneby two nursing assista								
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY 3815 WEST BROADWAY ROBINSDALE, MN 55422 Image: Comparison of the comparison of the precision of the pr	245279			B. WING		03/31/2017		
ROBBINSDALE, MN 55422 PROBEINS PLANOF CORRECTION (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D PROFINE ACTOR SHOLD BE CROSS REFERENCED TO THE APPROPRIATE DEFICIENCY OF LSC IDENTIFYING INFORMATION) F 282 Continued From page 27 The care plan revised 3/28/17 (during survey), indicated R40 had a self-care deficit and needed assist for dressing, grooming, bathing, eating, bed mobility and transfers. R40 was not provided with appropriate hand and face hygiene with the 8:41 a.m. cares. F 282 On 3/29/17, at 2:10 p.m. RN-F stated she would have expected staff to clean the mucous away from his face and wash his face and hands, and clean away mucous. F 282 On 3/29/17, at 2:45 p.m. RN-E stated she would have expected the staff to clean the mucous away from his face and wash his hands after he touched his penis. On 3/30/17, at 3:00 p.m. the DON stated she would have expected staff to provide cares wash face and hands. Pericare: R55 was observed during moming cares dong by two nursing assistants (MAE) on 3/29/17, at 9:40 a.m. NA-B and NA-C entend B55's face. NA-B next removed pillows from between R55's lace. NA-B next removed pillows from between	NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP	ZIP CODE		
Preferix TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG (EACH DOBRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 282 Continued From page 27 F 282 The care plan revised 3/28/17 (during survey), indicated R40 hd a self-care deficit and needed assist for dressing, grooming, bathing, eating, bed mobility and transfers. R40 was not provided with appropriate hand and face hygiene with the 8:41 a.m. cares. F 282 On 3/29/17, at 2:10 p.m. RN-F stated she would have expected staff to clean the mucous away from his face and wash his hands after he buched his penis. On 3/29/17, at 2:45 p.m. RN-E stated she would have expected the staff to clean the mucous away from his face and wash his hands after he buched his penis. On 3/30/17, at 3:00 p.m. the DON stated she would have expected staff to provide cares wash face and hands. Pericare: R55 was observed during morning cares done by two nursing assistants (NIAS) on 3/29/17, at 9/240 a.m. NA-B and NA-C entered P55 is: croom to turn and reposition the resident. NA-B explained they were going to lower the bed. The bed was lowered and both NAs gloved after washing their hands in R55 b abthroom. NA-C washed R55's face. NA-B next removed pillows from between R55's legs. R55 had heel protectors on over skid socks. The two NAs worked together in turning	GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			Υ				
The care plan revised 3/28/17 (during survey), indicated R40 had a self-care deficit and needed assist for dressing, grooming, bathing, eating, bed mobility and transfers. R40 was not provided with appropriate hand and face hygiene with the 8:41 a.m. cares. On 3/29/17, at 2:10 p.m. RN-F stated she would have expected staff to wash his face and hands, and clean away mucous. On 3/29/17, at 2:45 p.m. RN-E stated she would have expected the staff to clean the mucous away from his face and wash his hands after he touched his penis. On 3/30/17, at 3:00 p.m. the DON stated she would have expected staff to provide cares, wash face and hands. Pericare: R55 was observed during moming cares dong by two nursing assistants (NAS) on 3/29/17, at 9:40 a.m. NA-B and NA-C entered R55's room to turn and reposition the resident. NA-B explained they were going to lower the bed. The bed was lowered and both NAs gloved after washing their hands in R55's bathroom. NA-C washed R55's face. NA-B next removed pillows from between R55's legs. R55 had heel protectors on over skid socks. The two NAs worked together in turning	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE	COMPLETION	
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The back dressing was checked, dry and intact, dated 3/28/17. The suprapubic catheter dressing was checked and found to be saturated with urine. The incontinent product under the resident		The care plan revised 3/28/17 (during survey), indicated R40 had a self-care deficit and needed assist for dressing, grooming, bathing, eating, bed mobility and transfers. R40 was not provided with appropriate hand and face hygiene with the 8:41 a.m. cares. On 3/29/17, at 2:10 p.m. RN-F stated she would have expected staff to wash his face and hands, and clean away mucous. On 3/29/17, at 2:45 p.m. RN-E stated she would have expected the staff to clean the mucous away from his face and wash his hands after he touched his penis. On 3/30/17, at 3:00 p.m. the DON stated she would have expected staff to provide cares, wash face and hands. Pericare: R55 was observed during morning cares done by two nursing assistants (NAs) on 3/29/17, at 9:40 a.m. NA-B and NA-C entered R55's room to turn and reposition the resident. NA-B explained they were going to lower the bed. The bed was lowered and both NAs gloved after washing their hands in R55's bathroom. NA-C washed R55's face. NA-B next removed pillows from between R55's legs. R55 had heel protectors on over skid socks. The two NAs worked together in turning resident using draw sheet from left to right side. The back dressing was checked, dry and intact, dated 3/28/17. The suprapubic catheter dressing						
was also wet and but absent of stool. NA-C ungloved and left the room to inform the nurse If continuation sheet Page 28 or FORM CMS-2567(02-99) Previous Versions Obsolete Event ID:2GLR11 Facility ID: 00890 If continuation sheet Page 28 or		ungloved and left th	ne room to inform the nurse					

If continuation sheet Page 28 of 73

	MENT OF HEALTH						FORM A	07/31/2017 PPROVED 0938-0391	
			LIER/CLIA (X2)	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245279) B. V	WING			03/31/2017		
NAME OF I	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIF	CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE	E COMMUNITY		3815 WEST BROADWAY ROBBINSDALE, MN 55422				
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD	BE	(X5) COMPLETION DATE	
F 282	DF PROVIDER OR SUPPLIER SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ed. NAR-B and buttock the penis ck the served for there was over the had been). NA-B t on before ea. The two ent's brief cated R55 17, indicated ion in the eassistant rememory nentia and wed e 3/29/17, at ould have eanse male erviewed on the aides perineal of the aides that was e patient.	F 282		<u>}</u>			
FORM CMS-25	567(02-99) Previous Versions	Obsolete	Event ID:2GLR11	F	acility ID: 00890	If continuation	on sheet Pa	age 29 of 73	

		AND HUMAN SERVICES			-	APPROVEI . 0938-039
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING _		03/	31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 282	indicated the purpo keep the perineal a and odors in the per perineal hygiene, a The procedure for r 'Grasp penis gently Begin at meatus ar toward the base of circumcised, draw f penis is washed. F replace the foreskin scrotum. Lift scrotu new wash cloth, ren washed; Pat dry with necessary; Turn res on side to wash, rin removing soiled glo wash with soap and on clean gloves to p clothing." R55 was pericare as directed Pressure injury care R55 was observed two nursing assista 3/29/17, at 9:40 a.m room to turn and re explained they were bed was lowered all washing their hand next removed pillow The right ankle had closed area which w protectors on over s worked together in sheet from left to rig was hecked, dry a left hip area was re	ise of the procedure was to: irea clean, to prevent infection erineal area, to promote good nd to observe perineal area. male care read as follows: with one hand and wash. nd wash in a circular motion the penis; If resident is not foreskin back. Be sure entire Rinse thoroughly. Be careful to n to normal position; Wash im and wash perineum; With a make mitt and rinse area just th towel. Reposition foreskin if sident (both male and female) use and dry anal area. After poves, use hand sanitizer to d water to cleanse hands. Put put on clean pad and/or a not assisted with total d by the plan of care.	F 28	32		

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING		03/3	31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y I	8815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 282	on (from 7:30 a.m. positioned between were not floating but NAs did not float the which was in the reader of the second s	till 9:40 a.m. A pillow was the resident's legs, heels it resting on the pillow. The e resident's heels off a pillow sident's care plan. s Note, 3/29/17, Late Entry the following: Dressing or suspicious areas of skin of concern were 1. 2.2 cm ack; appears to be larger, ansed, Mepilex applied. 2. 2.0 area on coccyx. Cleansed, . Area to lateral right ankle	F 282			

If continuation sheet Page 31 of 73

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA				. 0938-0391
		IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT		STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309 F 309 SS=E	483.24, 483.25(k)(I FOR HIGHEST WE 483.24 Quality of life Quality of life is a fu applies to all care a residents. Each res facility must provide services to attain of practicable physica well-being, consiste comprehensive ass 483.25 Quality of care Quality of care is a applies to all treatm facility residents. Ba assessment of a re that residents recei accordance with pro- practice, the compre- care plan, and the re but not limited to th (k) Pain Management The facility must em- provided to residen consistent with pro- the comprehensive	PROVIDE CARE/SERVICES ELL BEING e undamental principle that and services provided to facility sident must receive and the e the necessary care and r maintain the highest l, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of ehensive person-centered residents' choices, including e following:	F 309			5/15/17
	residents who requ services, consisten of practice, the com care plan, and the r preferences.	cility must ensure that ire dialysis receive such t with professional standards prehensive person-centered residents' goals and NT is not met as evidenced				

If continuation sheet Page 32 of 73

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	X3) DATE SURVEY COMPLETED
		BENTI IOMIONIBEN.	A. BUILDING	i	
		245279			03/31/2017
NAME OF I	PROVIDER OR SUPPLIER		S	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	TV I	3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE COMPLETI
F 309	Continued From pa	ae 32	F 309		
	review, the facility f related skin condition R245, R116) with or bruising reviewed f pressure conditions to implement care p resident (R59) revie displayed behaviors Findings include: R244 head laceration assessed nor monit R244 was admitted that included toxic of and dementia obtain Record dated 3/30/ On 3/28/17, at 8:22 was observed to have one inch in length a how he had sustain that he fell and hit h bathroom. R244 state days ago, maybe y R244's Nursing Addidated 3/24/17, indice person, place and the and did not have an	I on 3/24/17, with diagnoses encephalopathy, pneumonia ined from the Admission 17. 2 a.m. during interview, R244 ave a laceration approximately above his left eye. When asked hed the laceration, R244 stated his head going into the ated it happened a "couple esterday." mit Re-Admit Data Collection cated R244 was oriented to time, had normal skin integrity hy pressure, venous, arterial or ns, deep tissue injury, and/or		An incident report was created for resident R244 on 3/29/2017 an RI assessed the laceration on 3/29/2 again on 3/30/2017. The care pla resident R244 was modified on 3/ The laceration was assessed aga following week on 4/3/2017. The left the facility on 4/5/2017. On 3/2 weekly skin observation and moni UDA began for resident R245. Pe policy and procedure, an incident for resident R245 was not needed situation; the resident is alert and and the bruise was not suspicious nature. Resident R116 right foreau tear was assessed and observed RN on 3/29/2017 and again on 3/3 and 4/8/2017. Resident R59 care was modified on 4/28/2017. Appro- staff will be reeducated by the Dire Nursing Services and/or designee regarding following resident R59 of interventions and their responsibil inform the Nurse Manager if and we those interventions are ineffective Documentation for all residents we reviewed by Nurse Managers to e that any bruises/contusions/skin to abrasions are appropriately assess documented. RN-A was reeducated her obligation to observe, report a monitor skin issues for all resident Appropriate staff will be reeducated Nurse Manager, regarding following	N 017 and n for 31/2017. in the resident 29/2017 toring r our report in this oriented in m skin by an 30/2017 plan opriate ector of care plan ity to when Il be nsure ears and sed and ion on nd ts. ed by the
	3/25/17, indicated I	plan with revision date R244 had impaired cognitive processes due to dementia,		resident R59 care plan interventio their responsibility to inform the N Manager if and when those intervention	ns and urse

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY IPLETED
		245279	B. WING			31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From pa	ge 33	F 3	09		
	and deconditioning one for ambulation did not indicate any Review of nursing p through 3/28/17, re documentation on t During interview on registered nurse (R transfer and has so asked if she was av RN-A stated "I've ol caregiver," further s report that he had f was no monitoring During interview on director of nursing (tell anyone that he laceration. DON sta have been started, R245 bruise of unk nor monitored. R245 was admitted that included celluli atrial fibrillation and from the Admission On 3/28/17, at 12:0 was observed to ha approximate 2" X 4	brogress notes dated 3/24/17 vealed there was no he head laceration. 3/29/17, at 1:56 p.m. N)-A stated R244 does self one erratic behaviors. When ware of the head laceration, bserved it, but am not his stating they did not have a allen. RN-A verified that there of the laceration. 3/30/17, at 2:36 p.m. the (DON) stated that R244 did not fell and staff didn't notice the ated an incident report should "the nurses missed it." nown cause was not assessed on 3/15/17, with diagnoses tis of left lower limb, chronic l venous insufficiency obtained Record dated 3/30/17. 0 p.m. during interview, R245 twe a large, purple, " bruise on his upper left arm. not know where it came from,		All licensed staff will be re GSS Procedure for Skin A Pressure Ulcer Prevention Documentation Requirem Director of Nursing Servic designee. All nursing staf reeducated on daily skin of reporting procedures by th Nursing Services and/or d The Director of Nursing Se designee will be responsite compliance through routin conducted weekly x4, mor results will be taken to the committee for further reco	assessment, and ents by the es and/or f will be observation and he Director of esignee. ervices and/or oble to ensure e audits hthly x3. Audit QAPI	

If continuation sheet Page 34 of 73

		AND HUMAN SERVICES): 07/31/20 ⁻ 1 APPROVE 0. 0938-039
TATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DA	TE SURVEY
		245279	B. WING		03	/31/2017
NAME OF	PROVIDER OR SUPPLIER		ST	REET ADDRESS, CITY, STATE, ZIP		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI		15 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIC DATE
F 309	dated 3/15/17, indic oriented to person, left lower leg ulcers body, however did i Review of the Orde 3/30/17, indicated a ratio (INR-laborator takes blood to form Friday until 3/31/17 measured high at 4 1.0 - 1.2). Review of the care 3/30/17, indicated F skin integrity due to anticoagulant use, to observe for majo plan directed staff t treatment of skin in the health care pro- skin observation by did not indicate any monitoring. Review of nursing p through 3/28/17, re documentation on t On 3/29/17, at 2:48 bruising was noted investigate, and if a necessary, nurses progress notes and not." RN-B stated s	mit Re-Admit Data Collection cated R245 was alert and place and time, had right and a and rashes on the upper not indicate any bruising. An INR result dated 3/29/17, a clot) was to be drawn every An INR result dated 3/29/17, a clot) was to be drawn every An INR result dated 3/29/17, a clot was to be drawn every and international normalized plan with revision date R245 had actual impairment to cellulitis of left lower limb, increased risk for bruising and or or fatal bleeding. The care o monitor location, size and jury, to report abnormalities to vider, and to conduct weekly clicensed nurse. The care plan or upper arm bruising or corogress notes dated 3/24/17 vealed there was no the upper arm bruise. a p.m. RN-B stated if unknown for a resident, nursing would an incident report wasn't would document in the l monitor if "it got bigger or the was aware of the bruise, and it and verified that	C			

		AND HUMAN SERVICES			FORM	: 07/31/2017 APPROVED : 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	IPLE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING _		03/	31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 309	have expected if so would tell a nurse w report and if a nurse should have docum R116's skin tear of assessed nor moni R116 was admitted that included sepsis lower limb and peri cellulitis obtained fr dated 3/30/17. The (MDS) dated 1/31/1 cognitively intact ar rashes, cuts or skin On 3/28/17, at 10:5 was observed to ha discoloration/bruisin above the area. During observation R116 showed surve bandage on it and s stated he bruises e During observation R116's bandage on removed and replac Review of the Orde 3/30/17, indicated F sodium tablet (bloo one time a day. Review of the care	a.m. DON stated she would omeone saw the bruise they who would fill out an incident e did know about it, "they nented and monitored it" unknown cause was not tored. I on 1/24/17, with diagnoses s, atrial fibrillation, cellulitis of pheral vascular disease om the Admission Record Admission Minimum Data Set 17 indicated R116 was nd had no open lesions, n tears. if a.m. during interview, R116 ave mid forearm ng with a 2" X 4" bandage on 3/29/17, at 10:13 a.m. eyor his right arm with the stated "my skin opened." R116	F3			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING		03/3	31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	v 1	815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	cellulitis with open a anticoagulant thera staff to monitor loca skin injury, report al provider. The care p directing staff to pro facility standing ord high risk for skin inj during transfers and R116's Nursing Adr dated 1/24/17, indic oriented to person a redness, ulcer and Review of Wound F 1/24/17, 1/31/17 an forearm injury and b Review of Wound E 2/15/17 addressed and did not address bandage. Review of nursing p through 3/28/17, re documentation on t bandage. During interview on stated she was awa discolored, but was issue on his forearm	 integrity due to lower extremity areas and was on py. The care plan directed ation, size and treatment of bonormalities to the health care bolan was updated on 3/30/17, ovide skin tear wound care per ers and indicated R116 was at ury and to use extra caution d bed mobility. int Re-Admit Data Collection eated R116 was alert and and time, had lower extremity scab. RN Assessments dated d 2/14/17, did not address any bondage. Data Collection forms dated lower extremity skin injuries any forearm injury and orogress notes dated 1/24/17 vealed there was no he right forearm injury and 3/29/17, at 2:46 p.m. RN-B are R116's skin is fragile and not aware there was a skin n. 3/30/17, at 2:36 p.m. DON nave documented and 	F 309			

If continuation sheet Page 37 of 73

TATEMENT	RS FOR MEDICARE	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA	D. 0938-039 TE SURVEY MPLETED
		245279	B. WING		05	0/01/0017
NAME OF I	PROVIDER OR SUPPLIER	210210		REET ADDRESS, CITY, STATE, ZIP (8/31/2017
	E OF PROVIDER OR SUPPLIER OD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY U) ID SUMMARY STATEMENT OF DEFICIENCIES EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CI					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	N SHOULD BE	(X5) COMPLETIC DATE
F 309	Review of the facili Ulcer Prevention a Requirements polic indicated all reside	ty Skin Assessment, Pressure nd Documentation cy with revision date of 4/16, nts will have a comprehensive				
	admission/readmis present including, t ulcers, and the res (computer program	sion to identify any skin issues out not limited to, pressure ults will be documented in PCC n). Under the "Assessment and				
	Tears/Abrasions" s contusion, abrasior resident, this shoul immediately, shoul	ection of the policy, if a bruise, n or skin tear is observed on a d be reported to the nurse d be monitored weekly and an				
	be documented on and on the residen	the Skin Observation sheet t's care plan.				
	sheet indicated a d behavioral symptor 12/29/16, indicated	liagnosis of dementia with ns. His quarterly MDS dated I he was severely cognitively	d			
	others and verbal b plan dated 1/20/17 disturbance, and b aggression, hitting,	pehavioral symptoms. R59 care, identified a sleep/wake cycle ehaviors that included physica pushing and loud disruptive	e			
	behavior problems interventions: If aw as soon as food is	ake early, give R59 breakfast available, go to another unit if				
	offer music and the	blan further directed staff to buse of head phones as a inister medications as ordered				
		s on 3/29/17, at 7:26 a.m., the dining room making nsical poises At 7:57 B59				

		AND HUMAN SERVIC					FORM A	07/31/2017 PPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	CLIA (X2) MU	ILTIPLE CON	ISTRUCTION		(X3) DATE S COMPL	SURVEY
		245279	B. WIN	G			03/31	1/2017
NAME OF I	PROVIDER OR SUPPLIER			STREE	TADDRESS, CITY, STATE, Z	ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE CO	MMUNITY		VEST BROADWAY			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIC		IX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD	BE	(X5) COMPLETION DATE
F 309	was clapping his hare repeatedly. At 7:59 ambulated past R5 staff member did no swore. At 3/29/17, at the table singing, ye 8:33 a.m., staff beg residents, however food. At 8:39 a.m., clap his hands. Sta 8:43 a.m., one hour was seated at the taguietly, calling out of 8:56 a.m., staff esc where he was yellir continued to yell un observation on 3/20 his room with the d loudly. R59 was sitt music playing in his head phones as dir During observation R59 sat at a table in and clapping his harmeal, however R59 residents on the ad breakfast. At 9:09 a meal and started ye staff escorted R59 continued to yell ou observed lying in be blinds were open. N phones were prese During an interview nursing assistant (N	Ige 38 coffee cup in front of him ands and calling out, sw a.m., a staff member 9. R59 called out "hey," of acknowledge R59 wh at 8:18 a.m., R59 remain elling out and swearing. yan serving breakfast to , R59 had not yet receive R59 continued to yell of ff served R59 his break r and 27 minutes after F able. R59 ate his break once for scrambled egg orted R59 back to his re ag with the door shut. H til 9:33 a.m. During a se or open. He was calling ing on his bed, there was rected in his plan of card s on 3/30/17, at 8:53 a.m. the dining room yelling ands. Staff was setting u did not have any food. joining unit had already a.m., R59 finished eating elling out, "hey." At 9:12 to his room where he it. At 9:19 a.m., R59 wa ed. The lights were on a No music was on and no nt. He continued to yell or on 3/30/17, at 9:23 a.m. NA)-A stated R59 can bu a. She stated he gets ve	m, he rearing the no then ined at At other ved any ut and fast at R59 fast s. At oom e econd was in g out as no wearing e. m., g out up the The reaten g his a.m., s and the o head out. n., e very	309				
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event	t ID:2GLR11	Facility ID	: 00890	If continuation	on sheet Pa	age 39 of 73

		& MEDICAID SERVICES	· ·				<u>). 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		ATE SURVEY
		245279	B. WIN	G		03	3/31/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STF	REET ADDRESS, CITY, STATE, ZIF		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMM	IUNITY		5 WEST BROADWAY BBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREI TAI	FIX	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 39	F	309			
	R59 to his room, bu She stated he had a are supposed to pu it calmed him down offered him any mu During an interview RN-F stated R59 m he wandered a lot a RN-F stated R59 w wanted breakfast ri usually up at 6:30 a stated she brought granola bars left ov would offer him one aware staff were su as soon as it was a music and sometim him. RN-F stated sl phones were workin During an observat R59 was in the dini headphones and hu his lunch. R59 disp During an interview RN-E stated R59 w morning and stated when he was up ea R59 was agitated s	y on 3/30/17, at 9:43 a.m., hakes a lot of noise. She si and was difficult to re-direct yould wake up too early an ight away. She stated he wa a.m., when she got there a him coffee and if they hav yer from the night before sl e. She stated she was not upposed to offer him break yould be be the stated R59 like hes staff would put it on for he did not think R59 head	tated tated				
	helped to cancel ou	ut excess noise.					

If continuation sheet Page 40 of 73

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES	1		OMB NC	1 APPROVE). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZI	P CODE	
				ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIOI DATE
F 309	Continued From pa	ge 40	F3	809		
F 312 SS=D		requested but not received. CARE PROVIDED FOR IDENTS	F3	312		5/15/17
	activities of daily liv services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fi- perineal hygiene wa (R55) observed to r personal hygiene ca Findings include: R55 was observed two nursing assista a.m. NA-B and NA- and reposition the r were going to lower lowered and both N hands in R55's bath face. NA-B next rer R55's legs. R55 ha socks. The two NA resident using draw The back dressing dated 3/28/17. The was checked and fourine. The incontine was also wet and b ungloved and left th that the suprapubic	NT is not met as evidenced tion, interview and document ailed to ensure appropriate as provided for 1 of 3 residents receive assistance with	C	Resident R55 no longer of facility as of 4/12/2017. NA-B and NA-C were ree specifically on 5/1/2017 results will be foreskin to wash performing male pericare All staff will be reeducated and Procedure for Perine 5/15/2017. The Director of Nursing S designee will be responsi compliance through routin conducted weekly x4, mo results will be taken to the committee for further recommittee for further fo	ducated egarding pulling the penis when d on the Policy al Care by services and/or ble to ensure ne audits nthly x3. Audit e QAPI	

Facility ID: 00890

If continuation sheet Page 41 of 73

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED
		245279	B. WING			01/0017
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP CC		/31/2017
		- SPECIALTY CARE COMMUNI	ту ³⁸	15 WEST BROADWAY DBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 312		•	F 312			
	area. NA-B only slig and perineal area, foreskin to wash. F reddened areas an none. The left hip a bony prominence w laying on (from 7:3 removed her glove applying a barrier of NAs worked togeth put on.	clean the perineal and buttock ghtly washed over the penis she did not pull back the 855's penis was observed for id open areas and there was area was reddened over the which the resident had been 0 a.m. till 9:40 a.m.). NA-B s and put a new set on before cream to scrotal area. The two her to put the resident's brief				
	R55's plan of care was a total assist w	dated 2/16/17, indicated R55 vith hygiene.				
	R55 recently had a last thirty days and with hygiene. R55	ta Set dated 2/22/17, indicated urinary tract infection in the required extensive assistant was also had severe memory d diagnoses of dementia and erplasia.				
	immediately after the 10:58 a.m. and cor	RN)-C was interviewed he dressing change 3/29/17, a nfirmed the NAs should have kin to completely cleanse male				
	3/30/17, at 10:00 a are supposed to wa area according to t are just washing ov	sing (DON) was interviewed or .m. and confirmed the aides ash the penis and perineal he facility's policy. If the aides ver the area quickly that was of washing a male patient.	n			
	indicated the purpo	on Perineal Care, revised 5/10 ose of the procedure was to: area clean, to prevent infection				

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM): 07/31/2017 // APPROVEI). 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
	ROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 312 F 314 SS=G	perineal hygiene, an The procedure for r 'Grasp penis gently Begin at meatus an toward the base of circumcised, draw f penis is washed. R replace the foreskin scrotum. Lift scrotu new wash cloth, rer washed; Pat dry wit necessary; Turn res on side to wash, rin removing soiled glo wash with soap and on clean gloves to p clothing." 483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that t (ii) A resident with p necessary treatmer professional standa	rineal area, to promote good and to observe perineal area. male care read as follows: with one hand and wash. d wash in a circular motion the penis; If resident is not foreskin back. Be sure entire tinse thoroughly. Be careful to n to normal position; Wash m and wash perineum; With a make mitt and rinse area just th towel. Reposition foreskin if sident (both male and female) se and dry anal area. After wes, use hand sanitizer to a water to cleanse hands. Put but on clean pad and/or TMENT/SVCS TO RESSURE SORES	F3			5/15/17

If continuation sheet Page 43 of 73

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
	of connection	IDENTIFICATION NOMBER.	A. BUILDI	ING _		COM	
		245279	B. WING	B. WING		03/31/2017	
IAME OF I	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUN	ΙΤΥ		315 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 314	Continued From pa	ane 43	F 3	14			
		NT is not met as evidenced					
	Based on observative interventions to prepressure ulcers (locurderlying tissue us as a result of press combination with stresidents (R55, R12 at risk for pressure responsive care restrictions to pressure responsive care restrictions) addition, the facility include: stage, size bed, surrounding tis healing for 1 of 3 references include: R55 was observed two nursing assistat 3/29/17, at 9:40 a.m room to turn and references and they were bed was lowered at the stage of th	event the development of calized injury to the skin and/o sually over a bony prominence aure, or pressure in hear and/or friction.), for 2 of 3 81) who had been identified a ulcers. Lack of timely sulted in actual harm for R55 pressure ulcer on the heel. In failed to assess wounds to a, characteristics of the wound ssue, or progress toward esidents (R200). during morning cares done by ants (NAs)-B and NA-C on n. The NAs entered R55's eposition the resident. NA-B e going to lower the bed. The nd both NA gloved after	e, 3 5		The facility has pressure redistribut mattresses as a standard intervent all residents and was already in pla- resident R55; then a low air loss m was put in place on 4/7/2017. Care for resident R55 was amended 3/2 Wound RN Assessments began for resident R55 on 3/30/2017. Reside R181 no longer resided in the facili 1/23/2017. Resident R200 no long resided in the facility as of 1/14/20 Documentation for all residents will reviewed by the Nurse Managers t ensure that identified pressure ulco- were appropriately assessed, documented and monitored by. Ca- plans for all residents with potential skin integrity issues were reviewed modified as needed. GSS Care Plan Policy and the GSS Procedure for Skin Assessment, P Ulcer Prevention and Documentati	tion for ace for attress plan 9/2017. r ent ity as of er 17. I be o ers I for I and S ressure on	
	next removed pillow The right ankle had closed area which w protectors on over worked together in	s in R55's bathroom. NA-B ws from between R55's legs. I a loose dressing over a was pea size. R55 had heel skid socks. The two NAs turning resident using draw ght side. The back dressing			Requirements will be reviewed with appropriate staff. The Director of Nursing Services a designee will be responsible to ens compliance through routine audits conducted weekly x4, monthly x3. results will be taken to the QAPI	nd/or sure	

ATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:		G	СО	MPLETED
		245279	B. WING		03	/31/2017
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUN	ΙТΥ	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
F 314	Continued From pa	age 44	F 31	4		
		e resident's heels off a pillow				
	which was in the re	sident's care plan. RN-C cam	е			
		n with a rolling computer on n. RN-C explained to R55 that	•			
		heck the resident's back				
	dressing first.					
	The admission Min	imum Data Set (MDS) dated				
		R55 had no open areas. The				
	Care Area Assessn	nent (CAA) indicated R55 was	5			
	at risk for developir prostate cancer, pa	ng pressure ulcers related to				
		5 had impaired mobility and				
	balance and neede	d assistance with transfers				
		ne CAA also indicated R55 was services for additional care	s			
		fe process. R55 required				
	extensive assist with	th bed mobility and incontinen	t N	_		
	care. R55 was on a	antipsychotics and addition, R55 had diagnoses				
		c end stage liver, heart				
	disease, and deme	entia. R55 had a suprapubic				
		ecently admitted to the facility				
	for inpatient care a	nu nospice cale.				
		ary of the hospice visit				
		s a small red open area mid				
		visit notes indicated the nurse ut a Mediplex dressing on it,				
	and would leave a	message for case manager				
		o documented measurements	5.			
		es indicated that on 3/17/17, ben area on right ankle (no				
		ated 3/20/17, indicated the				
	TOUONNOON LIFE bod		1			1
		a mid-back open area 1 cm abbed over. Covered with				

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ND PLAN C	RS FOR MEDICARE OF DEFICIENCIES	(X1) PROVIDER/SUP	PLIER/CLIA (>	(2) MULTIPLE	CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY	
	OF CORRECTION	IDENTIFICATION	I NUMBER: A	. BUILDING _		CO	MPLETED	
		2452	79 в	. WING		03	03/31/2017	
NAME OF	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIF	P CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CAI	RE COMMUNITY		15 WEST BROADWAY OBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIEI Y MUST BE PRECEDEI SC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 314	Continued From pa area but scabbed of X .5 cm width, had cm circle open, cov over, and had a ne non-blanching, dar 0.3 cm around non protectors applied. On 3/27/17, a hosp change times for for the heel. R55 had a Progres as a Late Entry whi Dressing changes of skin on 3/28/17. cm open area on m dark open are. Clea cm x .5 cm open are Mediplex applied. 3 bone healed. 4.) 2 dark circular area of dressing and sheep note the facility wor R55's care plan rev	over 2 centimeters a right lateral and vered with Band- w left heel "mush k colored area ap opened. Mepilex bice note indicated our areas on R55" as Note dated 3/2 ich documented t to all open or sus Areas of concern hid back; appears ansed, Mepilex ap rea on coccyx. C B.) Area to lateral cm unopened, no on right heel. Foa pskin heel protect uld continue to me vised on 2/26/17,	Aid, scabbed y", proximately and heel d dressing s back and 9/17, entered he following: picious areas were 1.) 2.2 to be larger, oplied. 2.) 2 leansed, right ankle in blanchable, m island ors on. The pinior.	F 314				
	resident had limited terminal illness (ca deconditioning, pai	ncer) evidenced k n, impaired mobil staff assistance v	by weakness, ity and					

		& MEDICAID SERVICES	1			<u>). 0938-039</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		TE SURVEY
		245279	B. WING _		03	8/31/2017
NAME OF	PROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	ſY	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIC DATE
F 314	following: R55 was extra caution during prevent striking arm any sharp or hard s dry, use lotion on d injury, and resident i.e. sheepskin boots not indicate the res heels floated. During an interview a.m., R55 was on h neoplasm of prosta neoplasm of prosta neoplasm of bone. facility for palliative medications were a hospice. R55 did no had a dressing to a over a kyphotic are and on the right hee R55's dressings we there was an order three days and prn. LPN-A was intervie and indicated R55 last week. When as resident's heels, LF not want his feet to liked to sit in the rea The NP-A was inter p.m. and indicated increased pain so s NP-A was asked if or non-avoidable ar	at high risk for skin injury, use g transfers and bed mobility to ns, legs, and hands against surface, keep skin clean and ry skin, do not apply on site of needs protection for the feet s, float heels. The Kardex did ident refused to have the with RN-C on 3/29/17, at 7:14 nospice care for malignant te and secondary malignant R55 was admitted to the care on 2/15/17. R55's pain adjusted one week ago by ot verbalize any longer. R55 n open wound on his mid back a, one dressing on the coccyx, el which was dark in color. ere changed on 3/28/17, and for dressing changes every wed on 3/30/17, at 2:02 p.m. was more alert that week than sked about floating the PN-A stated the resident did float and that the resident cliner a lot. viewed on 3/30/17, at 2:50 she had seen R55 for she did know the resident. The the open areas were avoidable nd the NP indicated the decline on or about 3/15/17,				

If continuation sheet Page 47 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245279	B. WING		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 314	areas. The facility's policy Pressure Ulcers, Pre- requirements was ro- of this policy were to assess residents words are assess residents words and assessments of appropriately use poly- pressure redistributered are assessed at risk for- pressure redistributered are assessed at risk for- pressure redistributered are assessed at risk for- pressure ulcer is pre- accompanying docu- or change is identified following: - An evaluation of to- present (whether it if present, is or is no- - The status of the (that can be observed the distributered are assessed to assessed and the or- assigns of increasing) - The pressure ulcer- assessed/evaluated documented on the sheet. If the resided daily on the Wound every treatment char- assessed at the sheet of the sheet. If the resided daily on the Wound every treatment char- assessed at the sheet of the sheet. If the resided daily on the Wound every treatment char- assessed at the sheet of the sheet. If the resided daily on the Wound every treatment char- assessed at the sheet of the sheet. If the resided daily on the Wound every treatment char- the pressure ulcer assessed at the sheet of the sheet o	o the facility with no open on Skin Assessment, revention and Documentation evised on 4/16. The purpose he following: to systematically ith regard to risk of skin irrately document observations of residents, and to revention techniques and ion surfaces on those pressure ulcers. "When a esent, daily monitoring (with umentation when complication ded) should include the the ulcer, if no dressing is the status of the dressing; if is intact and whether draining, ot leaking) area surrounding the ulcer ed without removing the possible complications, such ng area of ulceration of soft example, increased redness the wound or increased yound)."	F 3			
		should include at least the				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING		03/:	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	Characteristics of u undermining and tu skin, etc.; Presence treatments. Progress toward he the plan of care/trea and evaluated by th failed to implement potential developme worsening of the rig R181's significant c indicated R181 was rejected cares durir required extensive a mobility, transfers a R181 was continent MDS indicated R18 ulcers but was at ris ulcers. R181's MDS diagnosis of depress cardiomyopathy and pulmonary disease oxygen. R181's MDS hospice. Progress Note date "found a stage II p thickness skin loss or both. The ulcer is clinically as an abra on the left side of re cleansed and Mepil keep area clean and placed call to Total open area and need	ments - length, width, depth; lcer - including wound bed, nneling, exudate, surrounding of pain; and Current aling and any modifications to atments should be assessed be registered nurse. The facility interventions to prevent the ent of pressure ulcers or ght ankle ulcer for R55. hange MDS dated 1/2/17, cognitively intact and had not ng previous seven days. R181 assistance of one staff for bed and toileting and identified t of bowel and bladder. R181's 1 did not have any pressure sk for developing pressure 5 indicated R181 had	F 314			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM APPROVED IB NO. 0938-0391
STATEMENT OF DEFIC AND PLAN OF CORRE	CIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
		245279	B. WING _			03/31/2017
NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
GOOD SAMARIT	AN SOCIETY	- SPECIALTY CARE COMMUNI	ΓY	3815 WEST BROADWAY ROBBINSDALE, MN 5542	2	
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPR	BE COMPLETION
The Ca indicat related weakn assista health have a procee compli ulcers. A Prog indicat open a of four [millim [signs/ areas cover a reposit when i out of dieticia air ma this tim A Prog indicat open a of pour [millim [signs/ areas cover a reposit when i out of dieticia air ma this tim A Prog indicat air ma this tim	ed R181 was to cardiomy ess, impaire unce with become condition. C. pressure und d to care plat cations and ress Note da ed, "Writer a rea on coccy open areas eter] in size. symptoms] of and applied la and keep cle ioning and with the clear of the construction of the construction of the construction of the mattress for ress ne." ress Note da ed new orde mattress, he ur and the a reas with dru- cility care plat ed for period sion on 12/6/ 7. The care plat	age 49 eessment (CAA) dated 1/16/17, s at risk for pressure ulcers vopathy shortness of breath, d mobility, and need for staff d mobility due to declining AA indicated R181 did not cer. CAA indicated staff would anning with goal to avoid minimize risks of pressure ated 1/20/17, at 12:42 p.m. diso needs to update on new yx. At this time there are a tota that are 0.25 x 0.25mm Areas are free of s/sx of infection. Writer has cleaned Mepilex dressing to area to ean. Resident is resistant to vill turn herself onto her back equently does not wish to get has notified RD [registered treas. Writer will request and ident. Awaiting return call at ated 1/20/17, at 1:50 p.m. rs received from hospice for el protectors, reposition every ddition of barrier cream to essing changes. an printed 3/30/17, was d of time from R181's (16, until R181's death on olan did not include essure ulcer risk or	C		ENCY)	
FORM CMS-2567(02-99)		s Obsolete Event ID:2GLR		Facility ID: 00890	If continuatio	on sheet Page 50 of 73

	PROVIDER/SUPPLIER/CLIA				0938-0391
	IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY IPLETED
	245279	B. WING _		03/	31/2017
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SP	ECIALTY CARE COMMUNITY	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
PREFIX (EACH DEFICIENCY MUS	INT OF DEFICIENCIES IT BE PRECEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
treat pressure ulcers. During interview on 3/30 registered nurse (RN)-B pressure ulcer was first and that on 1/20/17, the ulcers were identified. R pressure ulcer care plan admission or when the s pressure ulcers on 1/15 stated an initial care plan opened by the admission of admission. RN-B said update the care plan wh or risks on the Transition Hospice would typically then the facility would so asked what is part of the "The electronic care pla RN-B said, "I would exp be completed to at least done." During interview on 3/30 of nurses (DON) said, "I assessment to be comp pressure ulcer. I would exp to reflect wound until he patient is identified at ris would expect a care pla prevention. I would expet for a pressure ulcer. The electronic one in PCC (a record-PointClick Care), plan includes any other said, "No just the care p hospice I would expect a	20/17, at 3:10 p.m. 8 verified a stage II documented on 1/15/17, ee new stage II pressure RN-B verified there was no in developed upon staff identified the /17, or 1/20/17. RN-B in would have been ons nurse within 24 hours d the floor nurses were to nen they found open areas nal Care unit. RN-B stated do a paper care plan and can it into the chart. When e care plan? RN-B said, in is the only care plan." bect a Wound Data tool to t get the assessment 20/17, at 3:35 p.m. director I would expect wound bleted for a patient with a expect the daily skill notes saled." DON said, "If a sk for pressure ulcers in to be developed for ect there to be a care plan	F 31			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION		E SURVEY PLETED
		245279	B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	hospice. I would expressure ulcers are indicate goal is to h goal is individualize During interview on said, "I found the pr was a stage II. She "It had started out a she would not get o developed four very were two on either s very small. As she g expect the wounds encouraged her to g she would not." RN- the care plan, I was of her." RN-C verifie care plan. RN-C sai pressure ulcers, the prominences." RN- notes but said, "I did During interview on DON said, "All of ou reducing and it will someone is at risk f skin care plan." Re documentation of in pressure ulcers During interview on medical director sta of the care plan. Th wound rounds on a weekly. It is unusua	pect the care plan to say present but not necessarily to eal the pressure ulcers. The d." 3/31/17, at 8:51 a.m. RN-C essure ulcer on January 15. It was not eating." RN-C said, s a reddened bottom because ut of bed. Then she small open areas. There side of her coccyx. They were got closer to death we did not to heal. I know we get out of bed and to eat but -C said, "I did not think to write more focused on taking care ed there should have been a id, "The wounds were ey were over bony C verified writing the progress d not do a wound sheet." 3/31/17, at 11:23 a.m. the ur mattress are pressure not be on the care plan. If for pressure ulcers we do a quested DON to find any terventions to prevent or to R181's development of 3/31/17, at 11:54 a.m. the ted physician orders are part e medical director said, "I do monthly basis and am there I for me to be asked to look at cause we do a good job	F 314			

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		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING		03/:	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y I	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 52	F 314	ł		
	ulcers but was iden development of pre- plan of care with int not developed. The identified on 1/15/1 [°] prevention of press prevention of additional u R200's admission M he required extensi bed mobility, transfe R200 was frequent bladder. A CAA date was at risk for press dependence on sta frequent incontinen- current pressure uld limited physical mod living (ADL) self-car stooling and a need care plan did not ad A Nursing Admit/ Re 12/4/16, identified a include a measuren area was blanchabl further indicated R2 pressure ulcer, ven arterial ulcer, diabe suspected deep tiss which wound R200's Specialty Care treat	ssure ulcers. An individualized terventions for prevention was first pressure ulcer was 7, but interventions for the ure ulcers worsening or onal pressure ulcers were not /20/17, after the development ulcers. MDS dated 12/11/16, indicated ve assistance of two staff for ers and toileting and identified ly incontinent of bowel and ed 12/17/16, indicated R200 sure ulcers related to ff for mobility, weakness and ce. The CAA did not identify a cer. R200's care plan identified bility and an activity of daily re deficit and frequent loose d for staff assistance. R200's ddress skin condition.				
	on 12/10/16: Cleans	se coccyx, pat dry and cover				

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		AND HUMAN SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
-	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING _		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 314	with Mepiles [sic] M dressing) daily in th breakdown prevent spine with normal s Mepilex dressing da A review of R200's Specially Care Con 12/12/16 through 1, 12/12/16 - Residen nursing care for ma coccyx and open at 12/13/16 - wounds and dressing intact 12/15/16 - dressing back. 12/25/16 - wounds signs of infection. 12/27/16 - wounds clean, dry and intact 1/2/16 - wound on c and intact. A physician visit Pro- indicated R200 hac mid spine." A Nursing Admit/Re- 12/23/16, indicated wounds: Sacrum; c	lepilex dressing (an absorbent e morning for stage I skin ion, Cleanse open area on aline, pat dry and apply aily. Good Samaritan Society munity Progress Notes dated /5/16, identified the following: t continued to receive skilled anagement of fragile skin on rea on spine. (two) are covered with Mepilex change to coccyx and mid clean, dry and intact with no on mid-back and coccyx et coccyx is covered with Mepilex by ress Note dated 12/13/16, I a "pressure ulcer along the e-admit Data Collection dated R200 had a the following losed wound 0.5 cm x .75 cm, er; mid back closed wound open to air.				Page 54 of 73

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		03/	31/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	r	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 314	RN-E stated resider check each week of there was a skin co assessment on the During an interview RN-B stated she has She stated when a nurse should initiate which would trigger stated the nurses sl skin check each we RN-B stated she was assessments for R2 process, but it was stated the nurses sl skin condition beca coding the MDS. The DON stated resise be documented at le pressure ulcer was expect the staff to fe care plan to be deve While R200 had two there was no evider wounds to include: the wound bed, sur-	on 3/29/17, at 1:37 p.m., nts receive a weekly skin n their bath day. She stated if ncern, it would show up in an electronic record. on 3/30/17, at 10:33 a.m., id never seen R200's wounds. nurse finds a wound, the e the wound observation tool an RN assessment. She hould also be completing a ek on bath day. At 11:36 a.m., as unable to locate any wound 200 and stated, "We have a not followed." She further hould have informed her of his use she was responsible for sident's skin condition should east weekly. She stated if a present on admit she would oblow up on it and expect a eloped.	F 31			
F 323 SS=D	of existing ulcers or		F 32	3		5/15/17

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		& MEDICAID SERVICES				0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING _			31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNI	тү	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 323	Continued From pa	ge 55	F 32	23		
		vironment remains as free rds as is possible; and				
		eceives adequate supervision ices to prevent accidents.				
	(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.					
	(1) Assess the resid from bed rails prior	dent for risk of entrapment to installation.		2		
		s and benefits of bed rails with dent representative and obtain rior to installation.				
	appropriate for the	bed's dimensions are resident's size and weight. NT is not met as evidenced				
	Based on observat review, the facility fa assessed for use a	tion, interview, and document ailed to ensure side rails were nd maintained in a safe and or 1 of 3 residents (R243)		On 3/29/2017 the siderail resident R243 were remove replaced with a bed with seassist bar.	ved and	
	Findings include:			All side rails and pivot ass attached to resident beds on 3/29/2017.		
		ssed for the safe use of oserved to be loose on the		Procedures for reporting e issues and completion of v be reviewed with all staff.		
	On 3/27/17. at 5:03	p.m. the quarter siderails				

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		AND HUMAN SERVICES	-			FORM	07/31/2017 APPROVED 0938-0391
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		NSTRUCTION		E SURVEY PLETED
		245279	B. WING _			03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	3815 V	T ADDRESS, CITY, STATE, ZIP CODE NEST BROADWAY BINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 323	R243's bed. The significated inches inward and the second lacked compassessment for the medical doctor order bilateral siderails with mobility. R243 was admitted diagnoses which in (inflammation betwist), osteomyelitist the R243's Admissi dated 3/23/17. The cognitively intact ar staff for bed mobility walking in the room dated 3/23/17, indice due to weakness, or mobility. R243's care plan with a sisting the R243's are plan with a sisting and the room dated R243 was limited physical moon the care plan direct instruct resident an assistive devices, roover to pick up drop R243 to use a grab. During interview on stated he used the "but they're wobbly.	derails moved approximately 2 were not secure to the bed. Tool assessment dated 3/16/17, is at low risk for falls. R243's obletion of any device is use of side rails and a er indicating the quarter ere to be used for bed I on 3/16/17, and had cluded lumbar discitis een discs in vertebra of the s and arthritis as indicated on ion Minimum Data Set (MDS) MDS indicated R243 was nd required assistance of two ty, transfers, toilet use and n. The Care Area Assessment cated R243 was at risk for falls deconditioning, and impaired with revision date of 3/27/17, is at risk for falls and had bility due to deconditioning. ted staff to educate and d family on safe use of emind resident not to bend oped items and to encourage ober or to ask for assistance. a)/29/17, at 9:29 a.m. R243 siderails to help sit up in bed, ."	F 32	de co co res	signee will be responsible to e mpliance through routine audit nducted weekly x4, monthly x3 sults will be taken to the QAPI mmittee for further recomment.	s Audit dations.	

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		& MEDICAID SERVICES). 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING		03	8/31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	ГҮ	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE
F 323	Continued From pa	ge 57	F 3	23		
	therapy would typic devices but she did	ally assess for any assistive not see the siderails were oncern, and they are wobbly."				
	registered nurse (R was assessed for a up. RN-A stated the he arrived and prob At 10:17 a.m. RN-A loose and moved a	3/29/17, at 9:41 a.m. N)-A stated R243 requires and grab bar and will use it to sit bed was in that room when bably came with the siderails. A verified the siderails were t least two inches inward, t's not good, we will get them diately."				
	environmental assist that shouldn't be lik moving both sidera "large frame" and the been on the bed wi	03/29/2017, at 10:19 a.m. stant (EA)-A stated "Oh wow, e that" when inspecting and ils. EA-A stated the bed had a ne siderails shouldn't have thout an oversized mattress. s not aware nor notified by erails were loose.				
	director of nursing	3/29/17, at 12:06 p.m. the (DON) stated "We don't nt, its an assist bar" and ils were loose.				
	rails/Side Rails/Ass date of 11/16, indica assessed for the ap rails/specialty mattr only when medical that annual inspect	ty Bed Safety - Including Bed ist Bars policy with revision ated residents were to be popropriateness of side ress/overlays, usage will occur necessity is documented and ions will be conducted of all page and bod rolls (olde rolls)				
	assist bars and trar eliminate any poter	esses and bed rails (side rails, nsfer devices) to identify and ntial entrapment issues and to a re compatible with the bed				

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		AND HUMAN SERVICES			FORM	: 07/31/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 323	Continued From pa	-	F 3	23		
F 371 SS=E	frame and mattress 483.60(i)(1)-(3) FO STORE/PREPARE		F 3	71		5/15/17
		d from sources approved or story by federal, state or local				
		e food items obtained directly rs, subject to applicable State gulations.				
	facilities from using gardens, subject to	oes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices.	C			
		loes not preclude residents ods not procured by the facility.				
		re, distribute and serve food in ofessional standards for food				
	foods brought to re- visitors to ensure sa handling, and const	regarding use and storage of sidents by family and other afe and sanitary storage, umption. NT is not met as evidenced				
	by: Based on observat review, the facility f sanitary manner for	tion, interview, and document ailed to serve food in a ^r 2 of 6 dining rooms		Dietary DA-A was reeducate responsibility for proper food hand washing on 3/30/2017.	handling and On	
	safety procedures t borne illness which of 88 residents who	oodlands), failed to follow food o minimize the risk of food had the potential to affect 84 o were served food out of the a system for checking expired		3/27/2017 the uncovered dish peaches were disposed of. T fan was thrown out on 3/27/2 facility had no residents that we the Two Cal HN, it was in our	he drying 017. The were using	
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		AND HUMAN SERVICES				FORM	07/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED
		245279	B. WING _			03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		15 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 371	Arrowhead unit on a aide (DA)-A reached buns with his right, opened a cabinet wareached into the baset it on a plate. At sweat off his forehed hand, placed the rawashing his hands a resident's plate. During an interview DA-A stated, he har years and had not be gloves while serving and vegetable. He what I'm touching." On 3/29/17, at 8:22 observed on Arrow observed to be weat his hands prior to the but during service be stomach and pushed (both with left hand out foam bowls usin up food again, place food surface. A diet hands after touchin opening cupboards prior to serving and be prior to serving and be prior to serving add During an observation of the serving and be prior to serving add burner of the serving and be prior to serving add burner of the serving and be prior to serving add burner of the serving and be prior to serving add burner of the serving and be prior to serving add burner of the serving and be prior to serving add burner of the service of the serving add burner of the service	of a meal service on the 3/27/17, at 5:19 p.m., dietary d into a bag of hamburger un-gloved hand. He then vith the same hand and again g of buns, pulled one out and 5:28 p.m., DA-A wiped the ead with a rag, using his right g on a counter and without touched a hamburger bun on a con 3/27/17, at 5:40 p.m., d been at the facility for two been told he needed to wear g unless he was serving fruits then stated, "L'II keep in mind a stocking cap, washed he start of the meal service, he touched his apron over his ed his glasses up on his face), opened the cabinet to get ng both hands and then dished ing his thumb on the plate tary aide did not wash his g his apron, his glasses, or and getting out foam bowls litional food.	F 3	71	storage awaiting disposal. It was disposed of on 3/30/2017. All Dietary staff will be reeducated b Director of Dietary Services on the G Food Handling Policy and Procedur GSS Policy and Procedure for Dieta Services Handwashing Techniques, Dining Service Standards Procedure procedure for Enteral Storage will b reviewed by the Director of Dietary Services with applicable staff. The Director of Dietary Services and designee will be responsible to ensu- compliance through routine audits conducted weekly x4, monthly x3. A results will be taken to the QAPI committee for further recommendat	GSS e, ary GSS e and . The e d/or ure Audit	
FORM CMS-25	unit on 3/29/17, at 8 67(02-99) Previous Versions	3:27 a.m., DA-A prepared to Obsolete Event ID:2GLR1	1	Faci	ility ID: 00890 If continuatio	n sheet l	Page 60 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03/3	31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	v	8815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 371	serve the breakfast with soap and wate towel, then used the the sweat off his for area through a doo returned, and witho up a plate and bega cabinet and pulled of into another cabine He then wiped the s the back of his hand cabinet to get a whi DA-A sneezed into with his left hand, d continued plating for bowels and holding During an interview director of food and conducted a training contamination and hands prior to servi re-wash hands if the back, if they touch of drawers. The direct stated staff should themselves and pla and if they sneeze i wash their hands and A facility policy titled Handwashing Tech indicated staff will w safeguard the healt on their service. Wa work, after touching (face, hair, body or sneezing or blowing	meal. He washed his hands r, dried his hands on a paper e same paper towel to wipe rehead. DA-A left the serving r leading to an adjoining unit, ut washing his hands, picked an serving. He reached into a but a tray, he then reached t and took out a yellow pate. sweat off of his forehead with d and reached into another te basket out. At 8:43 a.m., his apron, holding the apron id not wash his hands, and od, touching the inside of onto plates with his left hand. on 3/30/17, at 11:00 a.m., the nutrition stated he recently g on handwashing and cross stated staff should wash their ng. He stated staff should ey leave the unit and come objects such as doors or or of food and nutrition further not be wiping the sweat off cing the rag on the counter nto their apron, staff should nd change their apron. d Good Samaritan Society nique, dated February 2013, vash their hands as needed to h of those who are dependent ash hands: when reporting to g any contaminated object clothing), after coughing,	F 371			

If continuation sheet Page 61 of 73

		AND HUMAN SERVICES				FORM APPROVE MB NO. 0938-039	ED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	<u></u>
		245279	B. WING _			03/31/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD	BE COMPLETIC	N
F 371	During initial kitche a.m. the following w by the foodservice A four tier food rack next to the cook's p four racks containe second tier from the dishes of peaches. heavily soiled with of matter was position away on the floor, f the exposed tray of not seen the dryer I came from." FD ver dryer should not ha the food rack, statin with parchment par before going up to During followup kite a.m. with the FD, th In the dry storage of the kitchen area ele observed to have a 2016. At the time o fed residents in the responsible for the "I think nursing is." During interview on registered nurse (R orders the product, responsible for it, fut takes in delivery sh	g not properly disposed. In tour on 3/27/17, at 11:45 vas observed and confirmed director (FD): A was positioned in the kitchen preparation table. Three of the d dishes of desserts, the e bottom contained uncovered A commercial speed dryer, dirt, dust and dark particulate ned approximately four feet acing and blowing directly on peaches. FD stated he had before, "I don't know where it rified the heavily soiled floor we been blowing directly on ng "all food should be covered ber, a pan or plastic wrap the floor, its policy." Chen tour on 3/30/17, at 10:11 he following was observed: sentral supply room outside of even cans of Two Cal HN were in expiration date of December f survey, there were four tube facility. FD stated he was not enteral feedings in the facility, 13/30/17, at 1:20 p.m. N)-D stated administration she was not sure who was urther stating "I think whoever ould rotate it." RN-D verified ents on the unit did not use the	F 37	71	If continuatio	on sheet Page 62 of	73

	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION	(X3) DAT	TE SURVEY MPLETED
		245279	B. WING _		03	/31/2017
	ROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNI	тү	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETION DATE
	stated she stocks h orders the product a put it away. RN-E s was responsible, but check the expiration off the shelf and ge both tube fed reside did not use the prod During interview on registered dietitian resident on a tube f storeroom to look a products and look a would go up to the checks and balance managers", further told about the expir Review of the facilit dated February 201 to ensure food is ke staff would practice preparation that pro- illness. Review of the facilit revision date of 2/1 ensure safe practic fluids. The policy in covered, labeled ar	3/30/17, at 1:39 p.m. RN-E ler own floors, administration and thought maintenance may tated she was not sure who ut "if I am getting the formula, n date, if it's expired I take it t it destroyed." RN-E verified ents on Boundary Waters unit duct. 3/30/17, at 1:56 p.m. (RD) stated if she had a eeding she would go to the t the available tube feeding at the expiration dates before it floor. RD stated "we have es between myself and nursing stating "I understand" when ed formula. by Food Preparation policy 3 indicated the purpose was ept free of contamination and techniques in food otect against food-borne	t g	71		

	DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES								
STATEMEN	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245279	B. WING		03/3	31/2017			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422					
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE			
F 431 SS=E	LABEL/STORE DR The facility must prodrugs and biological them under an agre §483.70(g) of this p unlicensed personn law permits, but onli- supervision of a lice (a) Procedures. A fipharmaceutical ser- that assure the acci- dispensing, and adr biologicals) to meet (b) Service Consult employ or obtain the pharmacist who (2) Establishes a sy disposition of all con- detail to enable and (3) Determines that that an account of a maintained and per (g) Labeling of Drug Drugs and biological labeled in accordan professional princip appropriate access- instructions, and the applicable. (h) Storage of Drug	UGS & BIOLOGICALS ovide routine and emergency ls to its residents, or obtain beenent described in art. The facility may permit el to administer drugs if State y under the general ensed nurse. acility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and the needs of each resident. ation. The facility must e services of a licensed estem of records of receipt and htrolled drugs in sufficient accurate reconciliation; and drug records are in order and all controlled drugs is iodically reconciled. gs and Biologicals. als used in the facility must be ce with currently accepted les, and include the ory and cautionary e expiration date when	F 43						

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM /	APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE	1	
		245279	B. WING		03/3	81/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE	
F 431	locked compartmer controls, and permi have access to the (2) The facility musi permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa personal were super rooms. This had the residents residing of Findings include: During an observati registered nurse (R Waters medication environmental assis RN-A left the EA un room, with the door An observation of th medication room or revealed medication counter and unlock residents residing of accessible to the Affi medication room was	re all drugs and biologicals in the under proper temperature t only authorized personnel to keys. t provide separately locked, compartments for storage of ed in Schedule II of the ug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced ion, interview and document ailed to ensure unauthorized rvised in 1 of 6 medication e potential to affect all 16 in the unit. on on 3/29/17, at 9:09 a.m., N)-F unlocked the Boundary	F 43	1 RN-F was reeducated regarding h obligation to ensure the medication storage room is secure and ensure unauthorized people do not have a on 3/29/2017. All applicable staff will be reeducate GSS Procedure for Acquisition, Re Dispensing and Storage of Medicat Environmental Services staff will be reeducated that they are only to ha access to the medication storage a the presence of authorized staff. The Director of Nursing Services a designee will be responsible to ensist compliance through routine audits conducted weekly x4, monthly x3. results will be taken to the QAPI committee for further recommenda	e that ccess ed the ceiving, tions. ve reas in nd/or ure Audit		

If continuation sheet Page 65 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING		03/:	31/2017
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	v 1	815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	(an anti-psychotic n and mood disorders seizure disorders at conditions), Effexor medication) and lor medication used tree During an interview RN-F stated only nu aides (TMAs) have rooms. She stated of be going in and out unattended. RN-F sc check the regulation was allowed to be in During an interview RN-E stated, only n in the medication ro stated if a houseker she be supervising supervised by a nur alone in the medicat A facility policy titled Acquisition, Receive of Medications, date reviewed and indicat medications are del the appropriate stor stored in a locked n cupboard. Only the medications and the	al antipsychotic), haloperidol nedicine used to treat mental s), Depakote (used to treat nd certain psychiatric (an anti-depressant azepam (a benzodiazepine eat anxiety disorders). on 3/29/17, at 1:11 p.m., urses and trained medication access to the medication non-medical staff should not of med rooms or left stated she would have to n on whether or not the EA n the medication rooms. on 3/29/17, at 1:24 p.m., urses and TMA's are allowed ooms unsupervised. She eper goes in the room, nursing them. RN-E stated unless se, the EA should not be left tion rooms. d Good Samaritan Society ng, Dispensing and Storage ed September 2016 was ated the following: Once livered, they will be secured in age area. Medications will be nedication cart, drawer or	F 431			
F 441 SS=D		e)(f) INFECTION CONTROL, D, LINENS	F 441			5/15/17

If continuation sheet Page 66 of 73

	-	AND HUMAN SERVICES			FORM	APPROVED
		& MEDICAID SERVICES				0938-0391
-	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	V I	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	Continued From pa	ge 66	F 44 ⁻	1		
	(a) Infection preven	tion and control program.				
		tablish an infection prevention n (IPCP) that must include, at owing elements:				
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	I upon the facility assessment ig to §483.70(e) and following tandards (facility assessment	C			
		ds, policies, and procedures hich must include, but are not				
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the				
		om possible incidents of ase or infections should be				
		ansmission-based precautions event spread of infections;				
	(iv) When and how resident; including b	isolation should be used for a out not limited to:				
		uration of the isolation, e infectious agent or organism				
L						l

If continuation sheet Page 67 of 73

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING _		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 441	 least restrictive posicircumstances. (v) The circumstance must prohibit emploid disease or infected contact with resider contact with resider contact will transmited with resider the facility's last of the facility's last of infection. (4) A system for required the facility's last of infection. (e) Linens. Person process, and transported of infection. (f) Annual review. (f) Annual review. (f) Annual review of its program, as necess This REQUIREMENDED by: Based on observation review, the facility fund washing and of the dressing change from clean barrier during This practice had the resident (R55) who dressing change. In ensure that resident facility is that the distribution of the distribution. 	hat the isolation should be the sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct the disease; and ne procedures to be followed direct resident contact. cording incidents identified PCP and the corrective e facility. nel must handle, store, bort linens so as to prevent the The facility will conduct an IPCP and update their	F 4		proper hand and Wound 3/29/2017. ectrical tape for ed on d on 3/30/2017	
	potential infection for	tor 1 of 1 resident (R116) that tape on the siderails.		All staff will be reeducated	on the policies	
	67(02-99) Previous Versions	•			continuation sheet	

Facility ID: 00890

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		AND HUMAN SERVICES				FORM	07/31/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING			03/3	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	38	TREET ADDRESS, CITY, STATE, ZIP CODE B15 WEST BROADWAY OBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 441	room with a rolling a.m. RN-C explaine to check the reside back dressing local dry and intact, date left, no gloves used into bathroom got of to the dressing star dressings (gauge) a counter. RN-C ther on the resident's bl (NA)-C cleaned our discarded gloves a used hand sanitized to the resident that dressing change to RN-C touched the and tape after remo dressing which was remove gloves afte dressing. RN-C use to wipe around ope gauge. No redness dressing she remov checked tubing, uri removed and place container. RN-C the solution and place RN-C then left R55 dressing cart with t for R55.	RN)-C came into resident's computer on 3/29/17, at 9:53 ed to R55 that she was going nt's back dressing first. The ted over a kyphotic area was ed 3/28. RN-C checked heel d. No open areas. RN-C went one set of gloves. RN-C went on wheels and got out and tape placed on the n placed the wound cleanser anket. Nursing assistant t garbage bag that had nd an incontinent brief. RN-C d and gloved. RN-C explained she was going to do a the suprapubic catheter. outside of dressing package oving suprapubic catheter s urine soaked. RN-C did not or removing the soiled ed sterile saline wound cleaner ming for catheter using a noted. RN-C applied the cut ved from the package, ne started to flow. Gloves ed in plastic lined garbage en took the wound cleansing d it on the rolling dressing cart. 's room with the rolling he wound cleanser she used	F 4	41	for Hand Washing and Wound Dre Changes by the Director of Nursing Services and/or designee. All staff reeducated that black electrical tap allowed by the Director of Nursing Services and/or designee. The Director of Nursing Services a designee will be responsible to ens compliance through routine audits conducted weekly x4, monthly x3. results will be taken to the QAPI committee for further recommenda	y will be be is not nd/or sure Audit	
		rapubic catheter every night		_	ility ID: 00890 If continuat		Page 69 of 73

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	OF DEFICIENCIES	& MEDICAID SERVICES	(X2) MULT	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245279	B. WING _		03	8/31/2017
IAME OF F	PROVIDER OR SUPPLIER	• •		STREET ADDRESS, CITY, STATE, ZI	P CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	тү	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 441	Continued From pa	age 69	F 44	11		
	shift for Prostate ca	ancer.				
	RN-C was interviewed immediately after the dressing change 3/29/17, at 10:58 a.m. and confirmed gloves should have been changed after removing a soiled dressing and apply a clean dressing. RN-C did not remove gloves or wash their hands after removing the urine soak dressing before applying a new dressing around the suprapubic catheter. The facility's policy on Wound Dressing Change revised 5/16, indicated the purpose of the policy	3				
	was to promote wo wound would rema procedure was as f Check physician's of assessment and no comfort and to acco Put on gloves; Loos dressing or press of gently and carefully	und healing and that the in free of infection. The ollows: order; review previous otes; Position resident for ommodate dressing change; sen tape from resident's lown on surrounding skin v lift one edge of the dressing		2		
	the dressing from t around the ulcer m Remove slowly, fol pulling it in the direc dressing is difficult a warm, wet cloth;	inue to carefully lift the edge o he skin by moving slowly argins until edges are free; ding dressing over itself and ction of the hair growth. If the to remove, loosen edges with Remove soiled dressing and	T			
	contamination of ot and discard in sam hygiene; Create fie wrappers. Use ster all supplies and por	ag, avoiding contact and thus ther surfaces. Remove gloves e plastic bag. Perform hand ld with equipment/dressing ile technique if required; Open ur solutions if ordered; Put on und and surrounding area to				
	ensure the selectio dressing; Cleanse	n of the appropriate-sized the skin and wound thoroughly using gauze wipes, wound	,			

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		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		NG		MPLETED
		245279	B. WING		03	8/31/2017
AME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	IP CODE	
OOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	тү	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 441	Continued From pa	ge 70	F4	41		
	excess hair at sites completely before a resident's skin is fra to go beyond the wa a skin protection pro Remove dressing fr finger contact with t dressing over the w on the skin. Firmer depending upon ski rolling motion is hel stretching of the dra items in plastic bag discard according to date, and initials on change and wound Data Collection. Eye drops: On 3/29/17, at 10:0 that she was going RN-C applied drops	a antiseptic solution. Clip needed; Allow the skin to dry applying the dressing. If the agile, or drainage is expected ound edge, consider applying eparation around the wound; rom the inner wrapper; avoid the dressing. Position the yound and press down gently pressure be used on edges in condition. Sometimes a pful. Avoid unnecessary essing; Place all disposable with dressings, seal and o procedure. Identify time, dressing; Chart dressing observation on the Wound				
	was reddened and substance. On 3/29	os times two to right eye that had a buildup of a yellow 0/17, at 10:02 a.m. artificial tered to R55 for eye moisture.				
	dressing change or confirmed RN-C dic utilize hand sanitize	ved immediately after the n 3/29/17, at 10:58 a.m. and d not wash their hands or er after the wound care and os were administered.				
	computer on 3/29/1	sident's room with a rolling 7, at 9:53 a.m. RN-C at she was going to check the				

Facility ID: 00890

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DA). 0938-039 TE SURVEY MPLETED		
		245279	B. WING		03/31/2017			
NAME OF I	PROVIDER OR SUPPLIER			REET ADDRESS, CITY, STATE, ZIP COI		31/2017		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUN	IITY 3815 WEST BROADWAY ROBBINSDALE, MN 55422					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE		
F 441	Continued From pa	age 71	F 441					
	dated 3/28. RN-C of used. No open area got one set of glove stand on wheels ar and tape placed or	notic area was dry and intact, checked heel left, no gloves as. RN-C went into bathroom es. RN-C went to the dressing nd got out dressings (gauge) in the counter. RN-C then cleanser on the resident's						
	and confirmed that room a rolling dres top shelf was set u shelf was used to p the shelf before en carts are not room but only two of the RN had a cart and during a shift. RN-0 cleanser she used another resident be on the shelf for dre wound cleanser wa put the wound clean	wed on 3/29/17, at 1:13 p.m. she had brought into R55's sing cart. RN-C said that the p for a computer and the lowe but dressing and supplies on tering the resident's room. The specific. There are three carts carts are used because each there are only two RNs on C confirmed the same wound on R55 could be used on ecause the skin cleanser was ssing change on the cart. The as not disinfected as RN-C had nser on R55's bed and then thout disinfecting the outside						
	R116's room was of p.m. R116's bed ha wrapped fully arour which are a highly rendered the surfac uncleanable.	observed on 3/30/17, at 2:00 ad black electrical tape nd the bilateral grab bars, touched surface. The tape ce to be hygienically						
	the facility administ	ironmental services (EVS) and trator was along on the tour aware of the black electrical	d					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	07/31/2017 APPROVED 0938-0391
STATEMENT OF I	DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
AND FLAN OF CC	ORRECTION	IDENTIFICATION NOWBER.	A. BUILDIN	G	COM	FLETED
		245279	B. WING _		03/3	31/2017
NAME OF PROV	VIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY		
GOOD SAMA	ARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
sui EV use	/S the stated he h	ge 72 ger a cleanable surface. The had not been notified of the tape on the bilateral grab	F 44			

Facility ID: 00890

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DEPARTMENT OF HEALTH	AND HUMA	N SERVICES			CENTERS FOR MEI	DICARE & MEDICAID SERVICES
	MEDICA	ARE/MEDICAI	D CERTIFI	CATION A	AND TRANSMITTAL	ID: 2GLR
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00890
1. MEDICARE/MEDICAID PROVIDE NO.(L1) 245279	R	3. NAME AND AL (L3) GOOD SAM			PECIALTY CARE COMMU	4. TYPE OF ACTION: <u>2</u> (L8)
2. STATE VENDOR OR MEDICAID N (L2) 138218700	NO.	(L4) 3815 WEST (L5) ROBBINSD		7	(L6) 55422	3. Termination4. CHOW5. Validation6. Complaint
5. EFFECTIVE DATE CHANGE OF O (L9)	WNERSHIP	7. PROVIDER/SU 01 Hospital	UPPLIER CATEC	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
 bate of survey 03/31 accreditation status: 	/2017 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF 07 X-Ray	10 NF 11 ICF/IID	14 CORF 0 15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other	(210)	04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATION		10.THE FACILITY	IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of	The Following Requirements:
To (b):			equirements		2. Technical Personnel	6. Scope of Services Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	96 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) 8. Patient Room Size
•	96 (L18) 96 (L17)	X D. Notin Com			5. Life Safety Code	9. Beds/Room
13.Total Certified Beds	90 (L17)	X B. Not in Con Requirements	and/or Applied		* Code: B *	(L12)
14. LTC CERTIFIED BED BREAKDOV	VN	1			15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
96	19 51 1	101	iib			
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REMA	RKS (IF APPLICA	BLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL Date:
Rebecca Wong, HFE N	NE II	0	5/17/2017	(L19)	Kamala Fiske-Downing,	Enforcement Specialist 05/22/2017
PAR	T II - TO BE	COMPLETED I	BY HCFA RI		OFFICE OR SINGLE S	(L20)
19. DETERMINATION OF ELIGIBILI	ГҮ	20. COM	IPLIANCE WIT	H CIVIL	21. 1. Statement of Fina	ncial Solvency (HCFA-2572)
 Facility is Eligible to Pa 	rticipate	RIGH	ITS ACT:		 Ownership/Contr Both of the Above 	ol Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible					5. Dour of the Abov	
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE	MENT	26. TERMINATION ACTION	: (L30)
OF PARTICIPATION	BEGINNING	J DATE	ENDING DA	TE	VOLUNTARY 0	<u>INVOLUNTARY</u>
04/01/1985					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	· · · · · · · · · · · · · · · · · · ·
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	OTHER
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)			(L44)			00-Active
(L27)	B. Rescind Su	spension Date:				
			(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	30	. DETERMINATION		LDATE		
5 NO RECENT OF CMID-1557				_		
	(L32)			(L33)	DETERMINATION APP	ROVAL



PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

April 20, 2017

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

RE: Project Number S5279027

Dear Ms. Mattson:

On March 31, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.

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

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

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

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

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

<u>Informal Dispute Resolution</u> - 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:

Gloria Derfus, Unit Supervisor Minnesota Department of Health P.O. Box 64900 St. Paul, Minnesota 55164-0900 gloria.derfus@state.mn.us Telephone: (651) 201-3792 Fax: (651) 215-9697

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

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

- Immediate jeopardy (IJ) (scope and severity levels J, K, and L) is identified on the current survey; OR
- Deficiencies of Substandard Quality of Care (SQC) that are not IJ are identified on the current survey; <u>OR</u>
- Any G level deficiency is identified on the current survey in 42 CFR 483.13, Resident Behavior and Facility Practices, 42 CFR 483.15, Quality of Life, or 42 CFR 483.25 Quality of Care; **OR**
- Deficiencies of actual harm or above (level G or above) on the current survey as well as having deficiencies of actual harm or above on the previous standard health or Life Safety Code (LSC) survey **OR** deficiencies of actual harm or above on any type of survey between the current survey and the last standard survey. These surveys must be separated by a period of compliance (i.e., from different noncompliance cycles).; **OR**
- A facility is classified as a Special Focus Facility (SFF) <u>AND</u> has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

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

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

• State Monitoring effective April 25, 2017. (42 CFR 488.422)

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

• Civil money penalty for the deficiency cited at F314. (42 CFR 488.430 through 488.444)

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

Good Samaritan Society - Specialty Care Community April 20, 2017 Page 4

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by July 1, 2017 (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 October 1, 2017 (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.

Good Samaritan Society - Specialty Care Community April 20, 2017 Page 5

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm</u>

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

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

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

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

Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525 Good Samaritan Society - Specialty Care Community April 20, 2017 Page 6 Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

Kamala Fiske-Downing Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: <u>Kamala.Fiske-Downing@state.mn.us</u>

DEPART	MENT OF HEALTH	AND HUMAN SERVICES		·		APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES		0	<u>MB NO.</u>	. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	/	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	ſS	F 000			
F 221 SS=D	as your allegation o Department's accept enrolled in ePOC, y at the bottom of the form. Your electronic be used as verificat Upon receipt of an a on-site revisit of you validate that substa regulations has beet your verification. 483.10(e)(1), 483.1 FROM PHYSICAL I §483.10(e) Respect The resident has a and dignity, includin §483.10(e)(1) The r physical or chemical purposes of discipli required to treat the consistent with §483.12(a)(2). 42 CFR §483.12, 44 The resident has th neglect, misappropria and exploitation as includes but is not I corporal punishmer any physical or chemical	acceptable electronic POC, an ur facility may be conducted to ntial compliance with the en attained in accordance with 2(a)(2) RIGHT TO BE FREE RESTRAINTS t and Dignity. right to be treated with respect ag: right to be free from any al restraints imposed for ne or convenience, and not e resident's medical symptoms, 83.12(a)(2) e right to be free from abuse, riation of resident property, defined in this subpart. This imited to freedom from nt, involuntary seclusion and mical restraint not required to	F 221			5/15/17
	treat the resident's					
	(a) The facility must	[-				
LABORATORY	DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	ATURE	TITLE		(X6) DATE
Electron	ically Signed					05/01/2017

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

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION		E SURVEY PLETED
		245279	B. WING			03/31/2017	
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY ROBBINSDALE, MN 55422		
	SUMMARY STA	TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTIO	N	(¥5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 221	Continued From pa	ge 1	F 2	221			
	or chemical restrain discipline or conver- required to treat the symptoms. When the indicated, the facility alternative for the le document ongoing restraints. This REQUIREMEN by: Based on observat review, the facility fa bilateral (bilat) thigh potential restraint for reviewed for restrain Findings include: On 3/29/17, at 7:20 seated in a Broda of chair) in the hallway restrained by thigh behind the chair. Re- chair with elbows pl a.m. trained medicat were observed to ta Broda chair and to legs were released restraint closure wa wheelchair (W/C) we the restraint himself of the room in the E re-applied the restra a.m., that same day again by TMA-A and resident with toiletin	the use of restraints is y must use the least restrictive east amount of time and re-evaluation of the need for NT is not met as evidenced ion, interview and document ailed to assess the use of a positioning device as a or 1 of 3 residents (R40) nts. a.m. R40 was observed hair (tilt and recline positioning /. Both of R40's legs were straps that were secured 40 was leaning forward in the aced on his knees. At 8:41 ation aides (TMAs)-A and C ake R40 to his room in the readjust his clothing. R40's from the restraint as the is located in the back of the /here R40 could not release f. Before taking R40 back out Broda chair, the TMA aint to R40's legs. At 10:48 /, R40 was taken to his room d TMA-C who assisted the ag and clothing adjustment.			Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in a statement of deficiencies. The plar correction is prepared and/or exec solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of particit this response and plan of correction constitutes the center □s allegation compliance in accordance with sec 7305 of the State Operations Manu F221 A Mobilization Data Collection Tool resident R40 was completed on 4/2 and Physical Device and Restraint Assessment on 5/1/2017 and the op plan updated as appropriate. Resi R40 was picked up on OT case loa 5/1/2017.	ent by the of uted For the nce pation, of ction ual. for 28/2017 care dent ad on	
	The restraint was a	gain released from behind the			All residents with bilateral thigh stra	aps will	

Facility ID: 00890

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TATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·			E SURVEY PLETED	
		245279	B. WING		0.2/	03/31/2017	
	PROVIDER OR SUPPLIER	240213		STREET ADDRESS, CITY, STATE, ZIP CO		31/2017	
		- SPECIALTY CARE COMMUNIT	v :	3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 221	was taken back ou R40 was admitted according to the Fa schizophrenia, dem disturbances, supra cognitive, and gait A Physician's Verba 8/29/13, indicated thad back latching f safety/positioning. OT (occupational T An OT evaluation of "in Broda chair with support device whi sitting position to p wheelchair mobility extremities] to prop flexion with upper to pelvic posture durint thigh pads recomm pelvis sitting posture promotes upright v within environment The Mobilization St dated 2/25/17, indic himself upright from enough torso strem seated position. R4 transfer between st himself up and rise stand/sit/stand with	e, but re-applied before R40 t of the room. to the facility on 10/5/11, ace Sheet, with diagnoses of nentia with behavioral anuclear palsy (behavioral, disturbances). al Telephone Order dated the pelvic device was ok and for wheelchair The facility was to discontinue The facility was to discontinue Therapy) services. dated 3/15/16, indicated R40 n bilateral thigh pad postural ch provides a neutral pelvis romote independence with the Uses BLE [bilateral lower bel wheelchair and forward body that results in anterior ng wheelchair mobility. Bilateral hended to provide neutral re when in wheelchair and isual alignment for interaction	F 221	be reassessed by the Nurse restraint determination and o updated as appropriate. The GSS Policy & Procedure Restraints will be reviewed w licensed nursing staff by the Nursing Services and/or des The Director of Nursing Serv designee will be responsible compliance through routine a conducted weekly x4, month results will be taken to the Q committee for further recomm	e for Physical vith all Director of ignee. vices and/or to ensure audits ly x3. Audit API		

Facility ID: 00890

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		AND HUMAN SERVICES			FORM): 05/18/2017 APPROVED). 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	'Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 221	report that his abilit inconsistent, and of up or will attempt to them or want them stand aid (mechani transfers." A Physical Devices assessment dated straps for Broda ch self-propelling chai bolded note in the a device, material or easily by the reside movement or norm then it is a restraint this criteria, then it assessment then a for this resident?" a A Good Samaritan Community Progres indicated R40 had activities of daily liv He had been deper and personal hygie dated 3/2/17, indica physical therapy (P appropriate for ther program in the pas it was discontinued thigh straps to assidue to his forceful r hand rail to propel I A PT evaluation for dated 2/28/17, indice	when assessed, however staff y to pull self-upright was ften R40 will not pull himself o grab onto staff and hang on to lift him. "May need to utilize ical transfer device) for and Restraint Review 2/25/17, indicated: Thigh air - assists resident in r w/out sliding out of it. A assessment indicated: "If the equipment cannot be removed ent and it restricts freedom of al access to one's own body, If the device does not meet may be used." The facility sked "is this device a restraint and the facility checked no. Society Specialty Care ss Note dated 2/27/17, declined in three areas of ing function since last review. ndent with dressing, toileting ne. A quarterly assessment ated R40 was assessed by T), but was not felt to be rapy. R40 did have a walking t but refused to participate and . Soft back latching bilateral st with positioning in the chair rocking back and forth using	F 22'			

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		I AND HUMAN SERVICES E & MEDICAID SERVICES			PRINTED: 05/18/201 FORM APPROVE OMB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245279	B. WING		03/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZI 3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE COMPLÉTION THE APPROPRIATE DATE
F 221	chair in unit. Demo activity tolerance, s affecting transfers a patient and nursing Recommending us due to decreased E and BLE." The significant cha dated 3/2/17, indica R40 was noted to h needed assist for tr and bed. R40 displ grabbing, hitting, ar was at risk for falls. The care plan revis indicated R40 was history of striking o risk for falls was im risks. Had impaired and standing balan remote history of fr strip (mat) next to b An intervention of E straps when up. R4 activities, cognitive interaction. R40 ha or impaired though needs known and w incontinence, irregu unable to verbalize self-care deficit and grooming, bathing, transfers.	baseline. Self-propels Broda nstrates decreased strength, safety awareness, and balance and bed mobility. Educated g staff on safety with transfers. e of EZ-Way transfer for safety BUE [bilateral upper extremity] nge Minimum Data Set (MDS) ated R40 had no restraint use. have severe cognitive loss, ransfers to and from the toilet ayed behavioral symptoms of nd pacing in wheelchair. R40	F 22		
		taff to use the Broda chair with			

		AND HUMAN SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245279	B. WING _			03/3	31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422	2		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN C (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIEI	CTION SHOULD D THE APPROPF	BE	(X5) COMPLETION DATE
F 221	front, side, and real positioning device. minutes and releas load/reposition and On 3/29/17, at 2:10 indicated R40 used the heels and pullin around in his chair chair. The thigh stra aide, so he can self the chair." RN-F rev wording and stated as a positioning too On 3/29/17, at 2:45 thigh straps for self RN-E stated in the restraint because h consistently. By hav afforded him a high they were using the was pulling at staff, was safety of the st he could release th stated no, but it was in the facility. On 3/30/17, at 3:00 (DON) was intervie straps were conside The facility's Physical method or physical material or equipmer	r tip bars, and bilateral thigh Staff were to check every 30 e every two hours and off offer toileting. p.m. registered nurse (RN)-F, to propel himself by planting g forward, he was sliding a lot, and kept falling out of aps were considered a mobility f-propel without sliding out of <i>v</i> iewed the restraint form "I was told therapy classified it	F 22	11			

Facility ID: 00890

If continuation sheet Page 6 of 81

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 05/18/201 FORM APPROVE MB NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245279	B. WING		03/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y S	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETIO
F 221 F 242 SS=D	restraints may inclu hand mitts soft ties, and side rails that the Also included as rea- that meet the defini Using devices in co- trays, tables and be from rising." R40 has facility did not assess restraint. 483.10(f)(1)-(3) SEI RIGHT TO MAKE C (f)(1) The resident H schedules (includin health care and pro- consistent with his of and plan of care and of this part. (f)(2) The resident H about aspects of his are significant to the (f)(3) The resident H members of the con- community activities facility. This REQUIREMEN by: Based on interview facility failed to ensit	he's own body. Physical de, but are not limited to, vests, lap cushions, lap trays he resident cannot remove. straints are location practices tion of a restraint, such as: njunction with a chair such as elts that prevent a resident ad both legs restrained and the ss the leg straps as a potential LF-DETERMINATION - CHOICES has a right to choose activities, g sleeping and waking times), viders of health care services or her interests, assessments, d other applicable provisions has a right to make choices s or her life in the facility that	F 242		nsure ately all

Event ID:2GLR11

Facility ID: 00890

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		<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION		0938-039 E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G		PLETED
		245279	B. WING		- 03/	31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	TE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 554	422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY)	(X5) COMPLETIC DATE
F 242	Continued From pa	age 7	F 24	2		
	care unit on 3/22/1	I to the facilities post-acute 7, with diagnoses of spinal , insomnia, and recent fall per		process by the Direc Services and/or desi		
	the Admission Face	e Sheet.		Resident Dignity will	Procedure regarding be reviewed with the	
		admit Data Collection dated R246 would like to have two uring the day shift.		appropriate staff by t Nursing Services an		
	A nursing assistant	care sheet dated 3/22/17, needed assist of one staff with		x4, monthly x3. Aud	consible to ensure ts conducted weekly lit results will be taken	
An ha ree (bl sp ba An no sh Or an da	had a self-care per recent hospitalizati (blood between the spinal fracture at th balance and neede An intervention of b	dated 3/22/17, indicated R246 formance deficit related to on, falls, subdural hematoma e brain and lining (dura), and horacic-8. R246 had poor ed for brace when out of bed. bathing assist of one staff, did ten R246 was to receive a		to the QAPI committ recommendations.	ee for further	
	and stated he had	a.m. R246 was interviewed not yet received a shower (six on), and he had asked for two				
	stated R246 was o	a.m. registered nurse-G n the bath schedule for was not scheduled for a				
	verified staff should admission (nursing) p.m. the director of nursing d be transferring data from the admission data collection) ave been scheduled for two				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	: 05/18/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING _		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP COE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 242 F 246 SS=D	The policy Residen Ideas for maintainir include, but not be residents as they w 483.10(e)(3) REAS OF NEEDS/PREFE	t Dignity dated 2/17, indicated: ng a resident's dignity may limited to: "a. Grooming ish to be groomed." ONABLE ACCOMMODATION	F 24			5/15/17
	a right to be treated including: (e)(3) The right to re the facility with reas resident needs and do so would endang resident or other re This REQUIREMEN by: Based on observat review, the facility five within reach for 1 or not have the call lig staff to move in the In addition, the facil properly for 1 of 2 re reviewed for use of Findings include: R243 was observed sitting upright in a re four feet from the e light was lying across to reach the call ligh use it when he need	I with respect and dignity, eside and receive services in conable accommodation of preferences except when to ger the health or safety of the sidents. NT is not met as evidenced tion, interview, and document ailed to ensure a call light was f 35 residents (R243) who did ht in reach, was dependent on room and was at risk for falls. ity failed to ensure a helmet fit esidents (R135) who was helmet.		Call light for resident R243 was within reach on 3/27/17, upon by the surveyor. The helmet of R135 was discontinued by the primary physician on 4/25/201 All residents were reviewed for placement on 3/31/2017 and a needed. All residents were re 5/1/2017 and there are no oth with helmets in the facility. All staff will be reeducated on procedure by Director of Nurs and/or designee. The Occupa therapy staff that are responsi assessment of helmets will be by the Rehab Coordinator reg responsibility to assess for pro- fit and condition.	notification rder for e resident⊡s 7. or call light adjusted if viewed on er residents call light ing Services tional ble for e reeducated arding their	

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TATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DAT	. 0938-039
ND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	CON	IPLETED
		245279	B. WING			31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 246	mobility, transfers, room. The Care Are 3/23/17, indicated F to weakness, decor mobility. R243's car 3/27/17, indicated F staff was to encour to ask for assistance During interview on registered nurse (R "capable and does not get up on his ow him. During interview on administrator stated call light would be w that needed it, unle around the room or The facility Call Lig 2012, indicated the resident always has assistance and dire room, place call light if in bed. If out of be across bed so resid R135 was observed sitting in a Broda ch before dinner weart was observed to fit over the resident's push the helmet up	assistance of two staff for bed toilet use and walking in the ea Assessment (CAA) dated R243 was at risk for falls due nditioning, and impaired re plan with revision date of R243 was at risk for falls and age R243 to use a grabber or ce. 3/31/17, at 10:44 a.m. N)-A stated R243 was use the call light", but could wn to reach it if it was not near 3/31/17, at 10:50 a.m. the d it was an expectation that the within reach for any resident ss they are capable of moving	F 24		to ensure udits y x3. Audit API	

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		AND HUMAN SERVICES				FORM	: 05/18/2017 APPROVED . 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		TE SURVEY IPLETED
		245279	B. WING			03	/31/2017
NAME OF PROVIDER OR SUPPL	ER	-		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCI	ΤY	- SPECIALTY CARE COMMUNIT	Y		815 WEST BROADWAY ROBBINSDALE, MN 55422		
PREFIX (EACH DEFICIE	NC	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
 was complete, helmet back on again, the helmet op so it versident's eyes. R135 was obsein a Broda chain helmet was attachair. R135 was obsein a Broda chain helmet was attachair. R135 was uncontrolled more and moved her her hands were try to get out of R135 was obsein a Size and the pink helmet Broda chair bother room. R135 made no attemp R135 was obsein a Broda chair bother room seater helmet was hoo attemp R135 was obsein a Broda chair bother room seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp R135 was obsein a transmitter of the seater helmet was hoo attemp. R135 was obsein a transmitter of the seater helmet was hoo attemp. R135 was obsein a transmitter of the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo attemp. R135 was obsein at the seater helmet was hoo a	real of the transformed of transformed of the transformed of	A-D was observed to put the 35 at 6:44 p.m. and once ame down over the resident's d to unsuccessfully push the ild not come down over the d, 3/29/17, at 7:40 a.m., sitting the dining room. The pink ed to the back of the Broda served to have multiple ments with her legs and arms per torso back and forth and constant motion. R135 did not	F2	246			

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CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. (
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE	
	4/0047
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	1/2017
3815 WEST BROADWAY	
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY ROBBINSDALE, MN 55422	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)PREFIX TAG(EACH CORRECTIVE ACTION SHOULD BE 	COMPLETION DATE
DEFICIENCY)	
F 246Continued From page 11F 246	
to wear.	
The Progress Note, 3/6/17, for the MDS, "Does	
wear a soft helmet to help protect head." R135	
has been several times sitting self on floor,	
seems comfortable and will often do this especially over by the couch. Had been	
introducing wheel chair but changed to Broda	
chair which R135 has accepted and appears	
comfortable.	
The MDS and CAA dated 1/26/17, indicated no	
falls that past quarter, R135 was at risk for falls	
related to unsteady gait, poor balance, needs	
assist for mobility needs. R135 was impulsive,	
had Huntington's chorea was primary reason for loss of mobility, had dementia and schizophrenia.	
R135 needed assist of one to two with bed	
mobility, staff were to ensure safe positioning,	
assist of one to two with transfers, and R135	
used the Broda chair when up walking. R135 had	
behaviors symptoms of care rejection with physical cares and displayed behaviors of	
throwing or smearing of objects.	
The Progress Note dated 3/6/17, for the MDS,	
"Does wear a soft helmet to help protect head." R135 had been several times sitting self on	
floor, seems comfortable and will often do these	
especially over by the couch. The facility had	
been introducing wheel chair but changed to	
Broda chair which R135 had accepted.	
The RN-D, was interviewed on 3/30/17, at 10:24	
a.m., and confirmed R135 wore a helmet. RN-D	
agreed the helmet did go down over R135's eyes.	
RN-D stated the helmet for R135 was the best	
product R135 had to wear. In addition, the front part of the helmet was originally customized	

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		AND HUMAN SERVICES				FORM	: 05/18/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING _			03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	3815	EET ADDRESS, CITY, STATE, ZIP CODE 5 WEST BROADWAY BBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246	The occupational th 3/30/17, at 10:42 a.	to be reassessed again. herapist-A was interviewed on m. and confirmed R135 was	F 24	16			
	that was completed on admission. The 12/18/20 (had year wore a helmet and	pist-A shared the assessment I by occupational therapy (OT) OT assessment done on wiped out), indicated R135					
F 272 SS=D	and confirmed R13 was covering her e helmet touched the will get red.	ewed on 3/31/17, at 9:52 a.m. 5 can only push it up when it yes. In addition, when the bridge of the nose, the nose PREHENSIVE	F 27	2			5/15/17
	must make a comp resident's needs, st preferences, using instrument (RAI) sp	Assessments sement Instrument. A facility rehensive assessment of a trengths, goals, life history and the resident assessment becified by CMS. The nclude at least the following:					
	 (ii) Customary rour (iii) Cognitive patte (iv) Communication (v) Vision. (vi) Mood and beha (vii) Psychological v 	rns. n. avior patterns.					

		AND HUMAN SERVICES			RINTED: 05/18/2017 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245279	B. WING		03/31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y I	3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETION
F 272	problems. (ix) Continence. (x) Disease diagno (xi) Dental and nutr (xii) Skin Conditions (xiii) Activity pur (xiv) Medication (xv) Special treatme (xvi) Discharge (xvii) Documenta regarding the addition (xvii) Documenta regarding the addition on the care area of the Minimum Data (xviii) Documenta assessment. The a include direct observation the resident, as well licensed and non-licen on all shifts. The assessment probservation non-licensed direct shifts. This REQUIREMEN by: Based on observation review, the facility face assess the use of a positioning device a 3 residents (R40) refacility failed to com	osis and health conditions. ritional status. s. suit. s. ents and procedures. planning. ation of summary information fonal assessment performed as triggered by the completion	F 272	A Mobilization Data Collection Toc resident R40 was completed on 4/ and Physical Device and Restraint Assessment on 5/1/2017. Residen was picked up on OT case load or 5/1/2017. Resident R243 had a Pl Device and Restraint Assessment on 3/29/2017.	28/2017 It R40 N hysical

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		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING		03/3	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	v	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 272	Findings include: Bilateral thigh device R40 was admitted to admission diagnose with behavioral dist (behavioral, cognitin On 3/29/17, at 7:20 hallway, both legs with chair (tilt and recline (W/C), and he was On 3/29/17, at 8:41 (TMAs)-A and C toor readjusted the cloth from the restraint a located in the back not reach the closu himself. Before R40 re-applied the restra R40 was taken to he toileting and clothin was again released R40 left the room the restraint. A Physician's Verbate 8/29/13, indicated at with a back latching safety/positioning. OT (occupational T An OT evaluation do "in Broda chair with support device white sitting position to pro- wheelchair mobility extremities] to prop	ce: to the facility on 10/5/11, with es of schizophrenia, dementia urbances, supranuclear palsy ve, and gait disturbances). a.m. R40 was sitting in the vere restrained in a Broda e positioning wheelchairs leaning forward in the chair. a.m. trained medication aides ok R40 to his room and hing. R40's legs were released s the restraint closure was of the W/C where R40 could re to release the restraint 0 left the room the TMA aint. On 3/29/17, at 10:48 a.m. is room By TMA-A and C for g adjustment. The restraint from behind the W/C. Before the TMA re-applied the al Telephone Order dated a pelvic device was approved g for wheelchair The facility was to discontinue	F 272	All residents with bilateral the reassessed for restraint and care plans updated as the Nurse Management stat with side rails will be review Nurse Managers to ensure determination and care plan accurate. All staff with responsibility for retrained by the Director of Services on 4/25/2017. The Director of Nursing Ser designee will be responsible compliance through routine conducted weekly x4, mont results will be taken to the C committee for further recom	determination appropriate by ff. All residents red by the restraint ns are or MDS were Nursing vices and/or e to ensure audits hly x3. Audit QAPI	

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		AND HUMAN SERVICES				FORM	: 05/18/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245279	B. WING			03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY COBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 272	Continued From pa	•	F 2	272			
	pelvic posture durin thigh pads recomm pelvis sitting posture promotes upright vi- within environment. The Mobilization Su dated 2/25/17, indic himself upright from enough torso streng seated position. R4 transfer between su himself up and rise stand/sit/stand with assistive device to t to pull self-up. Was comment indicated standing position wi reported his ability t inconsistent, and of up or would attempt on them or want the utilize stand aid for A Physical Devices assessment dated 2 for Broda chair - ass chair w/out sliding of assessment indicate equipment cannot b resident and it restr normal access to or restraint. If the devic then it may be used then asked "is this of resident?" and the f	and wheelchair mobility. Bilateral ended to provide neutral e when in wheelchair and sual alignment for interaction " upport Data Collection Tool cated R40 was able to pull n lying to sitting. R40 did have gth to maintain an upright, 0 had the leg strength to urfaces, was able to push 1-2 inches. R40 could limited support. "Used transfer, stationary hand hold unable to ambulate." A R40 was able to pull self to hen assessed, however staff to pull self-upright was ften R40 would not pull himself t to grab onto staff and hang em to lift him. "May need to transfers." and Restraint Review 2/25/17, indicated thigh straps sists resident in self-propelling but of it. A bolded note in the ed: "If the device, material or be removed easily by the icts freedom of movement or ne's own body, then it is a ce does not meet this criteria, d." The facility assessment device a restraint for this facility checked no. However ot able to remove the thigh					

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		AND HUMAN SERVICES			FORM): 05/18/201 1 APPROVE). 0938-039
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y 38	TREET ADDRESS, CITY, STATE, ZIP C 815 WEST BROADWAY OBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 272	Community Progreindicated R40 had activities of daily living activities of daily living eview. He had been toileting and person assessment dated assessed by physic felt to be appropriate walking program in participate and it will atching bilateral the positioning in the clib back and forth using hallway. Those remains a PT evaluation for dated 2/28/17, indice increased difficulty non-ambulatory at chair in unit. Demo activity tolerance, sea ffecting transfers a patient and nursing Recommending us due to decreased E and BLE." The significant chard dated 3/2/17, indice and bed. R40 displayed assist for the and bed. R40 displayed assist for the and bed. R40 displayed assist for the care plan revise indicated R40 was ast risk for falls.	Society Specialty Care ss Note dated 2/27/17, declined in three areas of ing (ADL) function since last en dependent with dressing, hal hygiene. A quarterly 3/2/17, indicated R40 was cal therapy (PT), but was not te for therapy. R40 did have a the past but refused to as discontinued. Soft back igh straps to assist with hair due to his forceful rocking ig hand rail to propel himself in hained appropriate. T patient and nursing safety cated R40 was assessed for with transfers. "Nonverbal and baseline. Self-propels Broda instrates decreased strength, afety awareness, and balance and bed mobility. Educated is staff on safety with transfers. e of EZ-Way transfer for safety BUE [bilateral upper extremity] ange Minimum Data Set (MDS) ated R40 had no restraint use. have severe cognitive loss, ransfers to and from the toilet ayed behavioral symptoms of nd pacing in wheelchair. R40	F 272			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	: 05/18/2017 APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245279	B. WING			03/	31/2017
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		815 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 272	risk for falls was im risks. Had impaired and standing balan- remote history of fre- strip (mat) next to b An intervention lister thigh straps when u The nursing assista 3/30/17, directed st front, side, and rear positioning device. minutes and "releas load/reposition and On 3/29/17, at 2:10 indicated R40 used the heels and pullin around in his chair chair. The thigh stra- aide, so he can self the chair." RN-F rev wording and stated as a positioning too On 3/29/17, at 2:45 thigh straps for self because he used to forceful movements was not considered stand up by himself use the thigh straps mobility. RN-E was thigh straps himself assessed as a restr On 3/30/17, at 3:00	pulsive and unaware of safety judgement, impaired sitting ce, gait disturbance. Had a equent falls, laying on landing ed and crawling on the floor. ed of Broda chair with bilateral p. ant (NA) care sheet printed aff to use the Broda chair with tip bars, and bilateral thigh Staff were to check every 30 se every two hours" and off offer toileting. p.m. registered nurse (RN)-F, to propel himself by planting g forward, he was sliding a lot, and kept falling out of aps were considered a mobility -propel without sliding out of <i>i</i> ewed the restraint form "I was told therapy classified it l." p.m. RN-E stated R40 used -propelling in Broda chair, o slide out of the W/C with his s. RN-E stated "in the facility it a restraint because he cannot consistently."By having R40 it afforded him a high level of asked if he could release the and stated no, "but it was not aint in the facility." p.m. the director of nursing	F2	272			
	On 3/30/17, at 3:00 (DON) was intervie	-					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES						FORM	05/18/2017 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING			03/3	31/2017	
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY OBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 272	272 Continued From page 18		F 2	72				
	indicated, "To ensur restraints: Physical method or physical material or equipmer resident's body that easily that restricts normal access to or restraints may inclu hand mitts soft ties, and side rails that the Also included as rest that meet the definit Using devices in co	aints Procedure dated 11/16, re appropriate use of Restraints - any manual or mechanical device, ent attached or adjacent to the the individual cannot remove freedom of movement or ne's own body. Physical de, but are not limited to, vests, lap cushions, lap trays ne resident cannot remove. straints are location practices tion of a restraint, such as: njunction with a chair such as lts that prevent a resident						
	diagnoses which ind (inflammation betwee back), osteomyelitis the R243's admission MDS indicated R24 required assistance transfers, toilet use Care Area Assessm R243 was at risk for deconditioning, and medical lacked evid siderails. On 3/27/17, at 5:03 were observed to be R243's bed. The side	on 3/16/17, and had cluded lumbar discitis een discs in vertebra of the and arthritis as indicated on on MDS dated 3/23/17. The 3 was cognitively intact and of two staff for bed mobility, and walking in the room. The nent dated 3/23/17, indicated r falls due to weakness, impaired mobility. R243's lence of an assessment for p.m. the quarter siderails e loose on both upper ends of derails moved approximately and were not secure to the						

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	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		245279	B. WING			03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		115 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 278	assessment for the medical doctor order bilateral siderails were mobility. During interview on stated occupational assess for any assise the siderails were and they are wobbly. During interview on stated R243 required grab bar and will us bed was in that roop probably came with RN-A verified the siat least two inches not good, we will ge immediately." During interview on environmental assist that shouldn't be lik moving both sideral "large frame" and the been on the bed wite EA-A stated he was nursing that the side During interview on DON stated "we do an assist bar" and ve loose and that there 483.20(g)-(j) ASSE	ed completion of any device use of side rails and a er indicating the quarter ere to be used for bed 3/29/17, at 9:38 a.m. OT therapy would typically stive devices but she did not ere loose, "I see your concern, y." 3/29/17, at 9:41 a.m. RN-A ed and was assessed for a e it to sit up. RN-A stated the m when he arrived and the siderails. At 10:17 a.m. derails were loose and moved inward, stating "oh my, that's et them switched out 3/29/2017, at 10:19 a.m. stant (EA)-A stated the bed had a he siderails shouldn't have thout an oversized mattress. a not aware nor notified by erails were loose. 3/29/17, at 12:06 p.m. the n't consider it a restraint, it's verified both siderails were e was no siderail assessment.	F 2				5/15/17

Facility ID: 00890

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		AND HUMAN SERVICES			FORM	: 05/18/2017 APPROVED . 0938-0391
			IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZI 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 278	 (g) Accuracy of Ass must accurately ref (h) Coordination A registered nurse each assessment v participation of hea (i) Certification (1) A registered nur the assessment is of (2) Each individual assessment must se that portion of the a (j) Penalty for Falsifi (1) Under Medicare who willfully and kn (i) Certifies a mater resident assessme penalty of not more assessment; or (ii) Causes another and false statemen subject to a civil mo \$5,000 for each ass (2) Clinical disagree material and false s This REQUIREMEN by: Based on interview facility failed to ens Data Set (MDS) wa 	sessments. The assessment lect the resident's status. must conduct or coordinate with the appropriate lth professionals. rese must sign and certify that completed. who completes a portion of the sign and certify the accuracy of assessment. fication and Medicaid, an individual owingly- rial and false statement in a nt is subject to a civil money than \$1,000 for each individual to certify a material t in a resident assessment is oney penalty or not more than sessment.	F 27	Resident R200 was disc facility on 1/14/2017. The resident R200 was modif to include pressure ulcer.	e MDS for ied on 4/28/2017	

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		AND HUMAN SERVICES	1		FORM	: 05/18/2017 APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l`´´	TIPLE CONSTRUCTION	()	E SURVEY IPLETED
		245279	B. WING		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, 2 3815 WEST BROADWAY ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 278	Continued From pa	ge 21	F 27	78		
	R200 did not have a greater. A Care Are 12/17/16, indicated ulcers related to de weakness and freq did not identify a cu discharge - return a 12/20/17, indicated entry tracking recor indicated no pressu MDS dated 1/14/17 a pressure ulcer, st A Nursing Admit/ R 12/4/16, identified a collection tool furthe the following: press surgical wound, art surgical wound or s but did not identify w A review of R200's Specialty Care trea 2016 identified the on 12/10/16: Clean with Mepiles [sic] M foam dressing) dail skin breakdown pre on spine with norma Mepilex dressing dail A review of R200's Specialty Care Com 12/12/16 through 1/	e-admit Data Collection dated a "red coccyx." The data er indicated R200 had one of ure ulcer, venous ulcer, erial ulcer, diabetic ulcer, suspected deep tissue injury, which wound R200 had. Good Samaritan Society tment record dated December following treatments initiated se coccyx, pat dry and cover lepilex dressing (an absorbent y in the morning for stage I evention, Cleanse open area al saline, pat dry and apply aily. Good Samaritan Society munity Progress Notes dated /5/16, identified the following: t continued to receive skilled		Documentation for all re- reviewed to ensure that pressure ulcers are app assessed, documented information is coded acc MDS by the Nurse Mana All staff with responsibili management will be retu- protocols for wound ass documentation by the D Services and/or designer responsibility for comple- were retrained by the Di Services on 4/25/2017. The Director of Nursing designee will be respon- compliance through rou- conducted weekly x4, m results will be taken to th committee for further re-	identified ropriately and that curately on the agers. ity for wound rained on the essment and irector of Nursing ee. All staff with eting the MDS rector of Nursing Services and/or sible to ensure tine audits nonthly x3. Audit he QAPI	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COWPLETED NAME OF PROVIDER OR SUPPLIER B. WING 03/31/2017 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)			I AND HUMAN SERVICES E & MEDICAID SERVICES			FORM): 05/18/2017 // APPROVED). 0938-0391
MAKE OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY; STATE, ZIP CODE GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY STREET ADDRESS, CITY; STATE, ZIP CODE Image: Comparison of the stress of the str	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	· ,		(X3) DA	TE SURVEY
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CTV, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY SIB WEST BROADWAY MAIN DE SUMMARY STATEMENT OF DEFICIENCIES In PRETEX REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDER PLAN OF CORRECTION F 278 Continued From page 22 In nursing care for management of fragile skin on coccyx and pee name on spine. 12/13/16 - wounds (two) are covered with Mepilex and dressing intact. 12/15/16 - wounds (two) are covered with Mepilex and dressing intact. 12/15/16 - wounds on mid-back and coccyx clean, dry and intact N2/25/16 - wounds clean, dry and intact. 12/15/16 - wounds on mid-back and coccyx clean, dry and intact. 12/15/16 - wounds on mid-back and coccyx clean, dry and intact. A physician visit Progress Note dated 12/13/16, indicated R200 had a "pressure ulcer along the mid spine." F 278 A Nursing Admit/Re-admit Data Collection dated 12/23/16, indicated R200 had a the following wounds: Sacrum; closed wound 0.5 centimeters (cm) x.75 cm, open to air. During an interview on 3/30/17, at 10:33 a.m., registered nurse (RN)-B stated she had never seen R200's wounds. She stated when a nurse finds a wound, the nurse should initiate the wound observation tool which would trigger an RN assessment. She stated the nurses should also be completing a skin check each week on bath day. At 11:36 a.m., RN-B. Stated she was unable to locate any wound assessments for R200 and stated, "We have a process, but it was not followed." She further stated the nurses should also be completing a skin check each week on bath day. At 11:36 a.m. RN-B. Stated she was unable to locate any wound assessments for R200 and stated, "We ha			245279	B. WING		03	/31/2017
CODD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY ROBBINSDALE, MN 55422 (X1)D PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSCIDENTIFYING INFORMATION) ID PREFIX TAG PROVIDERS PLAN OF CORRECTION (EACH CORRECT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMELET CACH CORRECT ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 278 Continued From page 22 nursing care for management of fragile skin on coccys and open area on spine. 12/13/16 - wounds (two) are covered with Mepilex and dressing intact. 12/15/16 - wounds clean, dry and intact with no signs of infection. 12/27/16 - wounds of mid-back and coccyx clean, dry and intact, 12/16 - wound on coccyx was covered with Mepilex and intact. F 278 A Nursing Admit/Re-admit Data Collection dated 12/23/16, indicated R200 had a the following wounds: Sacrum; closed wound 0.5 centimeters (cm) x.75 cm, open to air. A Nursing Admit/Re-admit Data Collection dated 12/23/16, indicated R200 had a the following wounds: Sacrum; closed wound 0.5 centimeters (cm) x.75 cm, open to air. During an interview on 3/30/17, at 10:33 a.m., registered nurse (RN)-B stated she had never seen R200's wounds. She stated when a nurse finds a wound, the nurse should also be completing a skin check each week on bath day. At 11:36 a.m., RN-B stated she had never seen R200's wound assessments for R200 and stated, "We have a process, but it was not followed." She further stated the nurses	NAME OF F	PROVIDER OR SUPPLIER					
PPEFX TAG (EACH DEFICIENCY MIST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFX TAG CEACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) COMPLETM DEFICIENCY F 278 Continued From page 22 nursing care for management of fragile skin on coccyx and open area on spine. 12/13/16 - wounds (two) are covered with Mepilex and dressing intact. 12/15/16 - dressing change to coccyx and mid back. 12/25/16 - wounds clean, dry and intact with no signs of infection. 12/27/16 - wounds on mid-back and coccyx clean, dry and intact, 12/216 - wound on coccyx was covered with Mepilex and intact. F 278 A Nursing Admit/Re-admit Data Collection dated 12/23/16, indicated R200 had a "pressure ulcer along the mid spine." A Nursing Admit/Re-admit Data Collection dated 12/23/16, indicated R200 had a the following woundo: Sacrum; closed wound 0.5 centimeters (cm) x. 75 cm, open to air and Other; mid back closed wound 0.25 cm x 0.5 cm, open to air. During an interview on 3/30/17, at 10:33 a.m., registered nurse (RN)-B stated when a nurse finds a wound, the nurse should also be completing a skin check each week on bath day. Att 136 a.m., RN-B stated she had never seen R200's wound assessments for R200 and stated, "We have a process, but it was not followed." She further stated the nurses	GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y I			
 nursing care for management of fragile skin on coccyx and open area on spine. 12/13/16 - wounds (two) are covered with Mepilex and dressing intact. 12/15/16 - dressing change to coccyx and mid back. 12/25/16 - wounds clean, dry and intact with no signs of infection. 12/27/16 wounds on mid-back and coccyx clean, dry and intact, 11/216 - wound on coccyx was covered with Mepilex and intact. A physician visit Progress Note dated 12/13/16, indicated R200 had a "pressure ulcer along the mid spine." A Nursing Admit/Re-admit Data Collection dated 12/23/16, indicated R200 had a the following wounds: Sacrum; closed wound 0.5 centimeters (cm) x .75 cm, open to air and Other; mid back closed wound 0.25 cm x 0.5 cm, open to air. During an interview on 3/30/17, at 10:33 a.m., registered nurse (RN)-B stated she had never seen R200's wounds. She stated when a nurse finds a wound, the nurse should initiate the wound observation tool which would trigger an RN assessment. She stated the nurses should also be completing a skin check each week on bath day. At 11:36 a.m., RN-B stated she was unable to locate any wound assessments for R200 and stated, "We have a process, but it was not followed." She further stated the nurses 	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP	OULD BE	COMPLETION
because she was responsible for coding the MDS. The director of nursing stated resident's skin condition should be documented at least weekly. She stated if a pressure ulcer was present on admit she would expect the staff to follow up on it	F 278	nursing care for ma coccyx and open a wounds (two) are of dressing intact. 12/ coccyx and mid ba dry and intact with - wounds on mid-bo intact, 1/2/16 - wou with Mepilex and in A physician visit Pr indicated R200 had mid spine." A Nursing Admit/Re 12/23/16, indicated wounds: Sacrum; of (cm) x .75 cm, ope closed wound 0.25 During an interview registered nurse (F seen R200's wound finds a wound, the wound observation RN assessment. S also be completing bath day. At 11:36 unable to locate an R200 and stated, " not followed." She should have inform because she was r MDS. The director of nurse of the a press	anagement of fragile skin on rea on spine. 12/13/16 - covered with Mepilex and (15/16 - dressing change to ck. 12/25/16 - wounds clean, no signs of infection. 12/27/16 ack and coccyx clean, dry and and on coccyx was covered stact. ogress Note dated 12/13/16, d a "pressure ulcer along the e-admit Data Collection dated R200 had a the following closed wound 0.5 centimeters n to air and Other; mid back cm x 0.5 cm, open to air. (on 3/30/17, at 10:33 a.m., RN)-B stated she had never ds. She stated when a nurse nurse should initiate the tool which would trigger an he stated the nurses should a skin check each week on a.m., RN-B stated she was by wound assessments for We have a process, but it was further stated the nurses ued her of his skin condition esponsible for coding the	F 278			

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		AND HUMAN SERVICES			FORM): 05/18/201 /I APPROVE). 0938-039
TATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	-y 3	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 278	R200 had two sepa identified on admiss 12/10/16, both docu discharge, the facilit four separate times	blan to be developed. While irate pressure ulcers, one sion and one identified on umented through the time of ity coded the MDS inaccurately				
F 279 SS=D	assessments comp months in the resid results of the asses		F 279			5/15/17
	comprehensive per each resident, cons set forth at §483.10 includes measurab to meet a resident's and psychosocial n comprehensive ass care plan must des (i) The services tha or maintain the resi	t develop and implement a son-centered care plan for sistent with the resident rights O(c)(2) and §483.10(c)(3), that le objectives and timeframes s medical, nursing, and mental eeds that are identified in the sessment. The comprehensive cribe the following - t are to be furnished to attain dent's highest practicable				
	physical, mental, ar required under §48 (ii) Any services tha	nd psychosocial well-being as 3.24, §483.25 or §483.40; and at would otherwise be required 33.25 or §483.40 but are not				

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		AND HUMAN SERVICES			FORM	05/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03/3	31/2017
NAME OF	PROVIDER OR SUPPLIER	L		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y I	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 279	provided due to the under §483.10, incl treatment under §4 (iii) Any specialized rehabilitative servic provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation w resident's represent (A) The resident's g desired outcomes. (B) The resident's g future discharge. Fa whether the resider community was ass local contact agence entities, for this pur (C) Discharge plans plan, as appropriate requirements set for section. This REQUIREMEN by: Based on interview facility failed to imp prevent the develop (localized injury to t tissue usually over result of pressure, o with shear and/or fi	resident's exercise of rights uding the right to refuse 83.10(c)(6). services or specialized es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative (s)- goals for admission and preference and potential for acilities must document nt's desire to return to the sessed and any referrals to sies and/or other appropriate	F 279	Resident R181 is no longer in the as of 1/23/2017; during their stay of care was amended on 1/17/20 include a mepilex dressing, char 3 days. And on 1/20/2017 to inclifollowing interventions: a low-air mattress, heel protectors to weat times when in bed, reposition events a static s	y, the plan 017 to nge every ude the loss r at all	

Facility ID: 00890

		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVEI
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION		SURVEY PLETED
		245279	B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y I	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 25	F 279	9		
	Findings include:			small amount of barrier crear mepilex dressing.	n and apply	
	address pressure u did instruct home h with lotion on body and arms, observe care and foot care. 3/30/17, was review R181's admission of on 1/23/17. The ca identification of pre development of fou (partial thickness s dermis, or both. Th presents clinically a shallow crater). The interventions to pre R181's admission I dated 12/13/17, inc intact and had not r seven days. R181 of one staff for bed toileting and identiff bowel and bladder. did not have any pr for developing press indicated R181 had ischemic cardiomy heart to pump bloo obstructive pulmon lungs that reduces required continuous	Ir stage II pressure ulcers kin loss involving epidermis, e ulcer is superficial and as an abrasion, blister, or e care plan lacked any event or treat pressure ulcers. Minimum Data Set (MDS) dicated R181 was cognitively rejected cares during previous required extensive assistance mobility, transfers and ied R181 was continent of R181's MDS indicated R181 ressure ulcers but was at risk asure ulcers. R181's MDS d diagnosis of depression, opathy (decreased ability of the d to the body) and chronic ary disease (a disease of the air flow to the lungs) and s oxygen.		Care plans for all residents w for skin integrity issues were modified as needed by the Ne Management staff on 4/28/20 GSS Care Plan Policy and G Procedure for Skin Assessme Ulcer Prevention and Docum Requirements will be reviewe all appropriate staff by the Din Nursing Services and/or design the Director of Nursing Servi designee will be responsible to compliance through routine a conducted weekly x4, monthl results will be taken to the QA committee for further recomm	reviewed and urse 117. SS ent, Pressure entation ed by the with rector of gnee. ces and/or to ensure udits y x3. Audit API	
	The Care Area Ass 12/19/16, indicated ulcers related to ca	essment (CAA) dated R181 was at risk for pressure irdiomyopathy shortness of mpaired mobility and need for			ntinuation short F	

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		AND HUMAN SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING _			03/:	31/2017
NAME OF	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		315 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	staff assistance with R181 did not have a indicated pressure developed and R18 participate in therage goal of discharging A Progress Note da "found a stage II p of resident's coccyy Mepilex dressing w and protected. Writ Care for seniors to need for tx [treatmen nursing is awaiting A Progress Note da indicated, "writer also open area on coccy of 4 open areas tha [millimeter] in size. [signs/symptoms] of areas and applied N cover and keep clear repositioning and w when in bed and free out of bed. Writer h dietician] of open and air mattress for resist this time." A Progress Note dat indicated new order an air mattress, hee one hour and the act open areas with dree During interview on	h bed mobility. CAA indicated a pressure ulcer. The CAA ulcer care plan would be 1 would continue to by to become stronger with a nome. Atted 1/15/17, indicated staff, pressure ulcer on the left side c. Area was cleansed and as applied to keep area clean er hss [sic] placed call to Total report new open area and ent], voicemail was left and return call at this time." Atted 1/20/17, at 12:42 p.m. so needs to update on new <i>xx</i> . At this time there are a total it are 0.25 x 0.25 mm Areas are free of s/sx of infection. Writer has cleaned Mepilex dressing to area to an. Resident is resistant to ill turn herself onto her back equently does not wish to get as notified RD [registered reas. Writer will request and ident. Awaiting return call at the 1/20/17, at 13:50 p.m. rs received from hospice for el protectors, reposition every ddition of barrier cream to	F 27	79			

Facility ID: 00890

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		& MEDICAID SERVICES				<u>). 0938-039</u>
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION G		TE SURVEY MPLETED
		245279	B. WING		03	8/31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (ODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y I	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 279	Continued From pa	ge 27	F 279	9		
	and that on 1/2017, ulcers were identifie pressure ulcer care admission or when pressure ulcers on stated an initial care opened by the adm of admision. RN-B update the care plat or risks on the Tran Hospice would typic then the facility wou asked what is part of "The electronic care During interview on of nurses (DON) sa risk for pressure ull to be developed for there to be a care p care plan is the electronic sa section. If they are assessment and care wounds if they are of care plan to say pre- not necessarily to in pressure ulcers. Th During interview on	first documented on 1/15/17, three new stage II pressure ed. RN-B verified there was no plan developed upon the staff identified the 1/15/17, or 1/20/17. RN-B e plan would have been issions nurse with in 24 hours said the floor nurses were to in when they found open areas isitional Care unit. RN-B stated cally do a paper care plan and uld scan it into the chart. When of the care plan? RN-B said, e plan is the only care plan." 3/30/17, at 3:35 p.m. director and, "If a patient is identified at cers would expect a care plan prevention. I would expect olan for a pressure ulcer. The ctronic one in PCC." When an includes any other sections aid, "No just the care plan on hospice I would expect an are plan. It gets harder to heal on hospice. I would expect the essure ulcers are present but ndicate goal is to heal the are goal is individualized."				
	was a stage II. She "It had started out a she would not get o	ressure ulcer on January 15. It was not eating." RN-C said, as a reddened bottom because but of bed. Then she y small open areas. There				

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		AND HUMAN SERVICES			FORM): 05/18/2017 APPROVED). 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING _		03	/31/2017
NAME OF F	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, 2		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 279 F 282 SS=D	she would not." RN the care plan, I was of her." RN-C verific care plan. RN-C sa pressure ulcers, the prominences." During interview on DON said, "All of our reducing and it will someone is at risk f skin care plan." During interview on medical director sta part of the care plan The facility care plan reviewed for period admission on 12/6/ 1/23/17. The care plan identification of presi development of four care plan lacked an treat pressure ulcer 483.21(b)(3)(ii) SEF PERSONS/PER CA (b)(3) Comprehens The services provid as outlined by the of must- (ii) Be provided by of	to heal. I know we get out of bed and to eat but -C said, "I did not think to write a more focused on taking care ed there should have been a id, "The wounds were ey were over bony 3/31/17, at 11:23 a.m. the ar mattress are pressure not be on the care plan. If for pressure ulcers we do a 3/31/17, at 11:54 a.m. the ated that physician orders are n." an printed 3/30/17, was of time from R181's 16, until R181's death on blan did not include ssure ulcer risk or r stage II pressure ulcers. The hy interventions to prevent or rs. RVICES BY QUALIFIED ARE PLAN	F 27			5/15/17

Facility ID: 00890

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		AND HUMAN SERVICES	1			FORM	05/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONS			E SURVEY IPLETED
		245279	B. WING			03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET /	ADDRESS, CITY, STATE, ZIP (
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		EST BROADWAY NSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 282	This REQUIREMEN	ge 29 NT is not met as evidenced tion, interview and document	F 2		sident R59 care plan wa	as modified on	
	review the facility fa dementia interventia addition, the facility residents (R40) was and had his hands self-touch and the f and skin protocol w residents (R55) who ulcers. Findings include: Dementia: R59's Admission Re sheet indicated a di behavioral symptom Data Set (MDS) da severely cognitively behaviors directed behavioral symptom 1/20/17, identified a disturbance, and be aggression, hitting, singing. The care p behavior problems	ailed to follow the care plan for ons for1 of 1 resident (R59). In failed to ensure 1 of 3 is kept free of nasal discharge cleaned after personal facility failed to ensure pericare ras followed for 1 of 3 to had identified pressure ecord Resident Information fagnosis of dementia with ns. His quarterly Minimum ted 12/29/16, indicated he was r impaired and displayed toward others and verbal ns. R59 care plan dated a sleep/wake cycle ehaviors that included physical pushing and loud disruptive lan directed staff to minimize		4/28 reed Serv follor inter infor thos Resi rhini char on 4 reed and 3/29 resic The dem Man follor infor infor infor	Additional and the second side of the second	ff will be of Nursing egarding e plan ponsibility to if and when ffective. allergic allergies was e medication A-C were opriate hand ent R40 on no longer 4/12/2017. ents with y the Nurse patients with by the Nurse pligation to ns and to those e. NA-B and ecifically on	
	if needed. The care offer music and the diversion and admin During observations R59 was seated in intermittent non-ser returned to the dinin	as available, go to another unit e plan further directed staff to use of head phones as a nister medications as ordered. s on 3/29/17, at 7:26 a.m., the dining room making nsical noises. At 7:57, R59 ng room table after getting coffee cup in front of him, he		All s All s Care resp and Perii	skin to wash the penis orming male pericare. taff will be reeducated e Plan Policy, staff oblig bond appropriately to na the GSS Policy and Pro neal Care by the Direct vices and/or designee.	on the GSS gation to asal discharge ocedure for	

Facility ID: 00890

If continuation sheet Page 30 of 81

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				<u>. 0938-039</u> E SURVEY IPLETED
		245279	B. WING		0.2	04/0047
NAME OF	PROVIDER OR SUPPLIER	243213		 STREET ADDRESS, CITY, STATE, ZIP CODI		31/2017
		- SPECIALTY CARE COMMUNIT	. :	3815 WEST BROADWAY ROBBINSDALE, MN 55422	-	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 282	repeatedly. At 7:59 ambulated past R5 staff member did n swore. At 3/29/17, 1 the table singing, y 8:33 a.m., staff beg residents, however food. At 8:39 a.m., clap his hands. Sta 8:43 a.m., one hou was seated at the t quietly, calling out of 8:56 a.m., staff esc where he was yellin continued to yell un observation on 3/29 his room with the d loudly. R59 was sit music playing in his head phones as din During observation R59 sat at a table i and clapping his ha meal, however R59 residents on the ad breakfast. At 9:09 a meal and started ye staff escorted R59 continued to yell ou observed lying in b blinds were open. N	age 30 ands and calling out, swearing a.m., a staff member 9. R59 called out "hey," the ot acknowledge R59 who then at 8:18 a.m., R59 remained at elling out and swearing. At gan serving breakfast to other 7, R59 had not yet received any R59 continued to yell out and dff served R59 his breakfast at r and 27 minutes after R59 able. R59 ate his breakfast conce for scrambled eggs. At corted R59 back to his room ng with the door shut. He ntil 9:33 a.m. During a second 9/17, at 1:19 p.m., R59 was in loor open. He was calling out ting on his bed, there was no s room and he was not wearing rected in his plan of care. s on 3/30/17, at 8:53 a.m., n the dining room yelling out ands. Staff was setting up the 0 did not have any food. The djoining unit had already eaten a.m., R59 finished eating his elling out, "hey." At 9:12 a.m., to his room where he ut. At 9:19 a.m., R59 was ed. The lights were on and the No music was on and no head ent. He continued to yell out.	F 282	The Director of Nursing Servic designee will be responsible to compliance through routine au conducted weekly x4, monthly results will be taken to the QAF committee for further recommendation of the second second second second second second second second second second second second second second second second	ensure dits x3. Audit Pl	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMENT OF DEFICIENCI AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,				E SURVEY PLETED
		245279	B. WING			03/3	31/2017
NAME OF PROVIDER OR SI	JPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
GOOD SAMARITAN S	OCIETY	- SPECIALTY CARE COMMUNITY	YI	3815 WEST BROADWAY ROBBINSDALE, MN 5542	2		
PREFIX (EACH DE	FICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE / CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPR	BE	(X5) COMPLETION DATE
out. She sta staff are sup stated it call offered him During an in registered n noise. She s difficult to re up too early She stated I she got ther and if they h night before she was not him breakfa stated R59 would put it think R59 he During an o R59 was in headphones his lunch. R During an in RN-E stated morning and when he wa R59 was ag headphones even if the h helped to ca	terview best as so ited he l posed ms him any mu terview urse (R stated h i-direct. and wa e and s ave gra she wo avare st as so iked mu on for h ead pho bservati the dinin s and hu 59 displ terview l R59 w d stated s up ea itated s s or mus incel ou terview ursing (room, but he came right back has a radio in his room and to put music on for him and down. She stated she had not	F 282				

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		AND HUMAN SERVICES			FORM): 05/18/201 / APPROVE). 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245279	B. WING		03	/31/2017	
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY			03/31/2011	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From pa	ge 32	F 282	2			
	Hygiene: R40 was observed in the hallway, he w chair, clear thick m nose, and R40 pus mouth. At 7:35 a.m across the unit. Mu his nose. At 7:38 a. he continued to hav nose. At 8:41 a.m. his room, and releat the chair, assisted R40 was able to put assist of the EZ sta his right hand from pushed mucous int receiving peri-care his penis, and then he put his hand into was taken to his roo and NA-C. Cares w scratched his penis pull mucous from h into his mouth. NA- hands when they gu had his hands was R40 had touched h mouth, and that mu put into his mouth, he had done that in a.m. as well. NA-C The care plan revis indicated R40 had a assist for dressing, bed mobility and tra	requested but not received. on 3/29/17, at 7:20 a.m. sitting vas leaning forward in the ucus was running out of his hed the mucous into his . R40 was self-propelling cous continued to drain from m. staff assisted R40 to eat, ve mucous drain from his NA-B and NA-C took R40 to used the restraint from behind with brief using the EZ stand. Il himself upright without the nd. R40 repeatedly removed the EZ lift assist handle and o his mouth. When he was R40 touched and scratched pulling mucous from his nose o his mouth. At 10:48 a.m. R40 om to change brief by NA-B vere provided, R40 again a, and then lifted his hand to is nose and put his right hand B said they would wash his et him back in the chair. R40 ned, NA-B and NA-C verified is penis, put his hand in his icous draining was also being NA-B and NA-C also verified the cares provided at 8:41 then washed his face. ed 3/28/17 (during survey), a self-care deficit and needed grooming, bathing, eating, ansfers. R40 was not provided nd and face hygiene with the		aciity ID: 00890			

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		AND HUMAN SERVICES				FO	ED: 05/18/2017 RM APPROVED NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>'</i>	PLE CONST G		(X3) DATE SURVEY COMPLETED		
		245279	B. WING _				03/31/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, Z			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		ST BROADWAY SDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT ROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 282	Continued From pa	ige 33	F 28	2				
	8:41 a.m. cares.							
		p.m. RN-F stated she would f to wash his face and hands, icous.						
	have expected the	p.m. RN-E stated she would staff to clean the mucous and wash his hands after he						
		p.m. the DON stated she ed staff to provide cares, wash						
	two nursing assista a.m. NA-B and NA- and reposition the r were going to lower lowered and both N hands in R55's batt face. NA-B next rer R55's legs. R55 ha socks. The two NA- resident using draw The back dressing dated 3/28/17. The was checked and fe urine. The incontine was also wet and b ungloved and left th that the suprapubic and the dressing ne got a wash cloth to area. NA-B only slig and perineal area, s	during morning cares done by nts (NAs) on 3/29/17, at 9:40 •C entered R55's room to turn resident. NA-B explained they r the bed. The bed was IAs gloved after washing their nroom. NA-C washed R55's moved pillows from between d heel protectors on over skid s worked together in turning v sheet from left to right side. was checked, dry and intact, suprapubic catheter dressing ound to be saturated with ent product under the resident ut absent of stool. NA-C ne room to inform the nurse catheter dressing was wet eeded to be changed. NAR-B clean the perineal and buttock ghtly washed over the penis she did not pull back the 155's penis was observed for						

Facility ID: 00890

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING _			03/:	31/2017
NAME OF I	PROVIDER OR SUPPLIER				EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		5 WEST BROADWAY BBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282	reddened areas and none. The left hip a bony prominence w laying on (from 7:30 removed her gloves applying a barrier ci NAs worked togethe put on. R55's plan of care of was a total assist of R55's Minimum Dat R55 recently had a last thirty days and with hygiene. R55 w impairment and had begin prostatic hype Registered nurse (Fi immediately after th 10:58 a.m. and con withdrew the foresk genitals. The director of nurs 3/30/17, at 10:00 a. are supposed to wa area according to th are just washing ov not the correct way The facility's policy indicated the purpor keep the perineal a and odors in the pe perineal hygiene, an The procedure for r	d open areas and there was rea was reddened over the which the resident had been 0 a.m. till 9:40 a.m.). NA-B s and put a new set on before ream to scrotal area. The two er to put the resident's brief dated 2/16/17, indicated R55 f one with hygiene. ta Set dated 2/22/17, indicated urinary tract infection in the required extensive assistant vas also had severe memory d diagnoses of dementia and	F 28	32			

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		AND HUMAN SERVICES				INTED: 05/18 FORM APPR 1B NO: 0938	OVE
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		(X3) DATE SURV COMPLETE	
		245279	B. WING _			03/31/20	17
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CIT 3815 WEST BROADV ROBBINSDALE, M	VAY		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORR	R'S PLAN OF CORRECTION RECTIVE ACTION SHOULD B RENCED TO THE APPROPR DEFICIENCY)	BE COMP	X5) ILETIC ATE
F 282	Begin at meatus ar toward the base of circumcised, draw f penis is washed. F replace the foreskin scrotum. Lift scrotu new wash cloth, ren washed; Pat dry with necessary; Turn res on side to wash, rin removing soiled glo wash with soap and on clean gloves to p clothing." R55 was pericare as directed Pressure injury care R55 was observed two nursing assista 3/29/17, at 9:40 a.m room to turn and re explained they were bed was lowered at washing their hand next removed pillow The right ankle had closed area which y protectors on over s worked together in sheet from left to rig was checked, dry a left hip area was re prominence which f on (from 7:30 a.m. positioned between were not floating bu	d wash in a circular motion the penis; If resident is not foreskin back. Be sure entire tinse thoroughly. Be careful to a to normal position; Wash m and wash perineum; With a make mitt and rinse area just th towel. Reposition foreskin if sident (both male and female) ise and dry anal area. After oves, use hand sanitizer to d water to cleanse hands. Put put on clean pad and/or not assisted with total d by the plan of care. e: during morning cares done by nts (NAs)-B and NA-C on n. The NAs entered R55's position the resident. NA-B e going to lower the bed. The nd both NA gloved after s in R55's bathroom. NA-B vs from between R55's legs. I a loose dressing over a was pea size. R55 had heel skid socks. The two NAs turning resident using draw ght side. The back dressing nd intact, dated 3/28/17. The ddened over the bony the resident had been laying till 9:40 a.m. A pillow was o the resident's legs, heels at resting on the pillow. The e resident's heels off a pillow	F 28	32			

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		& MEDICAID SERVICES				<u>). 0938-039</u>
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	()	TE SURVEY MPLETED
		245279	B. WING		03	8/31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	тү	3815 WEST BROADWAY ROBBINSDALE, MN 55422	2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG		CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLETIO DATE
F 282	Continued From pa	age 36	F 2	282		
		s Note, 3/29/17, Late Entry				
		the following: Dressing or suspicious areas of skin				
		of concern were 1. 2.2 cm				
		back; appears to be larger,				
		ansed, Mepilex applied. 2. 2.0 area on coccyx. Cleansed,				
		B. Area to lateral right ankle				
		cm unopened, non				
		rcular area on right heel. Foan I sheepskin heel protectors on				
		would continue to monitor.				
	following: R55 was extra caution during prevent striking arm any sharp or hard s dry, use lotion on d injury, and resident i.e. sheepskin boot	e sheet undated, indicated the at high risk for skin injury, use g transfers and bed mobility to ns, legs, and hands against surface, keep skin clean and ry skin, do not apply on site of needs protection for the feet s, float heels. The kardex did ident refused to have the				
	on 3/30/17, at 2:02 more alert this wee about floating the re- the resident did not the resident liked to did not have the he plan of care. 483.24, 483.25(k)(l	nurse (LPN)-A was interviewed p.m. and indicated R55 was k than last week. When asked esident's heels, LPN-A stated want his feet to float and that o sit in the recliner a lot. R55 rels floated as directed per the) PROVIDE CARE/SERVICES		609		5/15/17
	FOR HIGHEST WE	ELL BEING				
	Quality of life is a ful applies to all care a	undamental principle that				

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		AND HUMAN SERVICES			FORM	: 05/18/2017 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l` í	IPLE CONSTRUCTION		e survey Ipleted
		245279	B. WING _		03/	31/2017
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 309	facility must provide services to attain of practicable physical well-being, consiste comprehensive ass 483.25 Quality of ca Quality of care is a applies to all treatm facility residents. Be assessment of a re- that residents recei- accordance with pr practice, the compre- care plan, and the re- but not limited to th (k) Pain Management the facility must er provided to residen consistent with pro- the comprehensive and the residents' of (l) Dialysis. The fac- residents who requiservices, consistent of practice, the com- care plan, and the re- provided to residents' of the comprehensive and the residents' of the comprehensive and the residents' of preferences. This REQUIREMENT by: Based on observative review, the facility frelated skin condition R245, R116) with o bruising reviewed for	sident must receive and the e the necessary care and r maintain the highest I, mental, and psychosocial ent with the resident's sessment and plan of care. are fundamental principle that nent and care provided to ased on the comprehensive sident, the facility must ensure ve treatment and care in ofessional standards of rehensive person-centered residents' choices, including e following:	F 30	An incident report was creater resident R244 on 3/29/2017 assessed the laceration on again on 3/30/2017. The cresident R244 was modified The laceration was assessed	7 an RN 3/29/2017 and are plan for d on 3/31/2017.	

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		AND HUMAN SERVICES			_	APPROVE
TATEMENT	TOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			U938-U38 E SURVEY PLETED
		245279	B. WING		03/;	31/2017
NAME OF F	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY,		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORREC CROSS-REFEREN	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE EFICIENCY)	(X5) COMPLETIO DATE
F 309	Continued From pa	-	F 3(
	resident (R59) revie	olanned interventions for 1 of 1 ewed with dementia, who s during the survey.		left the facility on weekly skin obser UDA began for re	1 4/3/2017. The resident 4/5/2017. On 3/29/2017 rvation and monitoring sident R245. Per our lure, an incident report	
		on of unknown cause was not tored.		for resident R245 situation; the resid and the bruise wa	was not needed in this dent is alert and oriented as not suspicious in	
	that included toxic e	l on 3/24/17, with diagnoses encephalopathy, pneumonia ned from the Admission 17.		tear was assesse RN on 3/29/2017 and 4/8/2017. Re was modified on 4	R116 right forearm skin d and observed by an and again on 3/30/2017 esident R59 care plan 4/28/2017. Appropriate icated by the Director of	
	was observed to ha one inch in length a how he had sustain that he fell and hit h	a.m. during interview, R244 ave a laceration approximately above his left eye. When asked hed the laceration, R244 stated his head going into the ated it happened a "couple		Nursing Services regarding followin interventions and	and/or designee og resident R59 care plan their responsibility to Manager if and when	
	days ago, maybe ye R244's Nursing Adr dated 3/24/17, indic person, place and t and did not have ar	esterday." mit Re-Admit Data Collection cated R244 was oriented to time, had normal skin integrity ny pressure, venous, arterial or ns, deep tissue injury, and/or		reviewed by Nurs that any bruises/o abrasions are app documented. RN her obligation to o monitor skin issue	or all residents will be e Managers to ensure contusions/skin tears and propriately assessed and I-A was reeducation on observe, report and es for all residents. will be reeducated by the	
	3/25/17, indicated F function or thought impaired decision n due to psychotropic	plan with revision date R244 had impaired cognitive processes due to dementia, naking, had had an actual fall c medication use, weakness		resident R59 care their responsibility Manager if and w are ineffective.	regarding following e plan interventions and y to inform the Nurse hen those interventions	
	one for ambulation did not indicate any			GSS Procedure for Pressure Ulcer Pr Documentation R	equirements by the	
	Review of nursing p	progress notes dated 3/24/17		Director of Nursin	g Services and/or	

Facility ID: 00890

		AND HUMAN SERVICES			FORM	: 05/18/20 ² APPROVE . 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03/	31/2017
IAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	-v I	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE
F 309	Continued From pa	ige 39	F 309			
	through 3/28/17, re documentation on t	vealed there was no the head laceration.		designee. All nursing staff w reeducated on daily skin obs reporting procedures by the	ervation and Director of	
	registered nurse (R transfer and has so	3/29/17, at 1:56 p.m. N)-A stated R244 does self ome erratic behaviors. When		Nursing Services and/or des	or designee. g Services and/or onsible to ensure outine audits monthly x3. Audit the QAPI	
	RN-A stated "I've of caregiver," further s	ware of the head laceration, bserved it, but am not his stating they did not have a fallen. RN-A verified that there of the laceration.		designee will be responsible compliance through routine a conducted weekly x4, month results will be taken to the Q committee for further recommi		
	director of nursing (tell anyone that he laceration. DON sta	3/30/17, at 2:36 p.m. the (DON) stated that R244 did not fell and staff didn't notice the ated an incident report should "the nurses missed it."				
	R245 bruise of unk nor monitored.	nown cause was not assessed				
	that included celluli atrial fibrillation and	l on 3/15/17, with diagnoses tis of left lower limb, chronic I venous insufficiency obtained Record dated 3/30/17.				
	was observed to ha approximate 2" X 4	" bruise on his upper left arm. not know where it came from,				
	dated 3/15/17, indic oriented to person, left lower leg ulcers	mit Re-Admit Data Collection cated R245 was alert and place and time, had right and and rashes on the upper not indicate any bruising.				

	IMENT OF HEALTH		FORM APPROVED OMB NO. 0938-0391				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		245279	B. WING			03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADW. ROBBINSDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRE CROSS-REFERE	S PLAN OF CORRECTION ECTIVE ACTION SHOULD ENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Review of the Orde 3/30/17, indicated a ratio (INR-laborator takes blood to form Friday until 3/31/17 measured high at 4 1.0 - 1.2). Review of the care 3/30/17, indicated F skin integrity due to anticoagulant use, i to observe for majo plan directed staff t treatment of skin in the health care pro- skin observation by did not indicate any monitoring. Review of nursing p through 3/28/17, re documentation on t On 3/29/17, at 2:48 bruising was noted investigate, and if a necessary, nurses progress notes and not." RN-B stated s but did not docume monitoring was not On 3/30/17, at 2:36 have expected if so would tell a nurse w report and if a nurse	r Summary Report dated in international normalized y measurement of how long it a clot) was to be drawn every An INR result dated 3/29/17, .1 (normal reference range plan with revision date R245 had actual impairment to cellulitis of left lower limb, ncreased risk for bruising and r or fatal bleeding. The care o monitor location, size and jury, to report abnormalities to vider, and to conduct weekly licensed nurse. The care plan upper arm bruising or progress notes dated 3/24/17 vealed there was no he upper arm bruise. p.m. RN-B stated if unknown for a resident, nursing would n incident report wasn't would document in the monitor if "it got bigger or he was aware of the bruise, nt it and verified that	F 30	9			

If continuation sheet Page 41 of 81

		AND HUMAN SERVICES			FOR	D: 05/18/2017 M APPROVED D. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING _		- 03	8/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STA 3815 WEST BROADWAY ROBBINSDALE, MN 554	TE, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION E ACTION SHOULD BE) TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE
F 309	R116's skin tear of assessed nor moni R116 was admitted that included sepsis lower limb and peri cellulitis obtained fr dated 3/30/17. The (MDS) dated 1/31/1 cognitively intact an rashes, cuts or skin On 3/28/17, at 10:5 was observed to had discoloration/bruisin above the area. During observation R116 showed surve bandage on it and s stated he bruises e During observation R116's bandage on removed and replac Review of the Orde 3/30/17, indicated F sodium tablet (bloo one time a day. Review of the care 1/29/17, indicated F impairment to skin cellulitis with open a anticoagulant thera	unknown cause was not tored. on 1/24/17, with diagnoses s, atrial fibrillation, cellulitis of pheral vascular disease om the Admission Record Admission Minimum Data Set 17 indicated R116 was ad had no open lesions, a tears. 1 a.m. during interview, R116 ove mid forearm ng with a 2" X 4" bandage on 3/29/17, at 10:13 a.m. eyor his right arm with the stated "my skin opened." R116 asily. on 3/30/17, at 9:28 a.m. his right forearm was ced with steri strips. r Summary Report dated R116 was to receive warfarin d thinner) 3 mg (milligrams) plan with revision date R116 had fragile skin, actual integrity due to lower extremity	F 30	99		

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		AND HUMAN SERVICES			FORM	D: 05/18/2017 MAPPROVED D: 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	IPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING _		03	8/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STAT 3815 WEST BROADWAY ROBBINSDALE, MN 5542	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 309	directing staff to pro facility standing ord high risk for skin inj during transfers and R116's Nursing Adr dated 1/24/17, indic oriented to person a redness, ulcer and Review of Wound F 1/24/17, 1/31/17 an forearm injury and Review of Wound D 2/15/17 addressed and did not address bandage. Review of nursing p through 3/28/17, re documentation on t bandage. During interview on stated she was awa discolored, but was issue on his forearr During interview on stated staff should monitored the skin Review of the facilit Ulcer Prevention ar Requirements polic indicated all resider skin inspection don	 by ide skin tear wound care per lers and indicated R116 was at jury and to use extra caution d bed mobility. mit Re-Admit Data Collection cated R116 was alert and and time, had lower extremity scab. RN Assessments dated ad 2/14/17, did not address any bandage. Data Collection forms dated lower extremity skin injuries any forearm injury and brogress notes dated 1/24/17 vealed there was no the right forearm injury and 3/29/17, at 2:46 p.m. RN-B are R116's skin is fragile and a not aware there was a skin m. 3/30/17, at 2:36 p.m. DON have documented and injury. ty Skin Assessment, Pressure 	F 30	9		

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	со	MPLETED
		245279	B. WING		03	3/31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETIO DATE
F 309	Continued From pa	age 43	F 30	9		
	· ·	out not limited to, pressure				
	ulcers, and the res	ults will be documented in PCC				
		a). Under the "Assessment and Bruises/Contusions/Skin				
		ection of the policy, if a bruise,				
	contusion, abrasior	n or skin tear is observed on a				
		d be reported to the nurse d be monitored weekly and any				
		gress toward healing should				
		the Skin Observation sheet				
	and on the resident	t's care plan.				
	R59's Admission R	ecord Resident Information				
	sheet indicated a d	iagnosis of dementia with				
		ns. His quarterly MDS dated				
		he was severely cognitively ayed behaviors directed toward				
		behavioral symptoms. R59 care				
		identified a sleep/wake cycle				
		ehaviors that included physical pushing and loud disruptive				
		lan directed staff to minimize				
	behavior problems	with the following				
		ake early, give R59 breakfast available, go to another unit if				
		blan further directed staff to				
	offer music and the	use of head phones as a				
	diversion and admi	nister medications as ordered.				
	During observation	s on 3/29/17, at 7:26 a.m.,				
	R59 was seated in	the dining room making				
		nsical noises. At 7:57, R59				
		ng room table after getting coffee cup in front of him, he				
	was clapping his ha	ands and calling out, swearing				
	repeatedly. At 7:59	a.m., a staff member				
		9. R59 called out "hey," the ot acknowledge R59 who then				
		at 8:18 a.m., R59 remained at				

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DEPAR CENTE	FORM	APPROVED . 0938-0391					
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTI	ON	(X3) DAT	E SURVEY IPLETED
		245279	B. WING _			03/	31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRES	S, CITY, STATE, ZIP CODE	•	
GOOD S	SAMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BRO ROBBINSDAL			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH 0	VIDER'S PLAN OF CORRECT CORRECTIVE ACTION SHOU EFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 309	the table singing, ye 8:33 a.m., staff beg residents, however, food. At 8:39 a.m., clap his hands. Stat 8:43 a.m., one hour was seated at the ta quietly, calling out of 8:56 a.m., staff esc where he was yellin continued to yell un observation on 3/29 his room with the de loudly. R59 was sitt music playing in his head phones as dir During observations R59 sat at a table in and clapping his ha meal, however R59 residents on the ad breakfast. At 9:09 a meal and started ye staff escorted R59 continued to yell ou observed lying in be blinds were open. N phones were prese During an interview nursing assistant (N agitated sometimes and is hard to re-dii R59 to his room, bu She stated he had a are supposed to pu	elling out and swearing. At yan serving breakfast to other , R59 had not yet received any R59 continued to yell out and ff served R59 his breakfast at r and 27 minutes after R59 able. R59 ate his breakfast once for scrambled eggs. At orted R59 back to his room ng with the door shut. He til 9:33 a.m. During a second 9/17, at 1:19 p.m., R59 was in oor open. He was calling out ting on his bed, there was no s room and he was not wearing rected in his plan of care. s on 3/30/17, at 8:53 a.m., n the dining room yelling out ands. Staff was setting up the 0 did not have any food. The joining unit had already eaten a.m., R59 finished eating his elling out, "hey." At 9:12 a.m., to his room where he it. At 9:19 a.m., R59 was ed. The lights were on and the No music was on and no head ant. He continued to yell out.	F 30	9			

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	-	AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	Continued From pa	ge 45	F 30	9		
	RN-F stated R59 m he wandered a lot a RN-F stated R59 w wanted breakfast rij usually up at 6:30 a stated she brought granola bars left ov would offer him one aware staff were su as soon as it was a music and sometim him. RN-F stated sl phones were workin During an observati R59 was in the dinin headphones and hu his lunch. R59 displ During an interview RN-E stated R59 w morning and stated when he was up ea R59 was agitated si headphones or mus even if the headpho helped to cancel ou During an interview DON stated staff sh	ion on 3/30/17, at 12:40 p.m., ng room. He was wearing his umming to himself while he ate layed no signs of agitation. on 3/30/17, at 2:46 a.m., as up at 6:00 a.m., that staff should offer him food rly. She further stated when taff should offer his sic in his room. She stated ones were not working, they it excess noise. on 3/30/17, at 2:46 a.m., the				
F 312 SS=D	A facility policy was 483.24(a)(2) ADL C	requested but not received. ARE PROVIDED FOR	F 31	2		5/15/17

Facility ID: 00890

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
			A. BUILDIN	G		
		245279	B. WING			31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP COE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	DE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETIC DATE
F 312	activities of daily livi services to maintain personal and oral h This REQUIREMEN by: Based on observat review, the facility fa perineal hygiene wa (R55) observed to r personal hygiene ca Findings include: R55 was observed two nursing assistant a.m. NA-B and NA- and reposition the r were going to lower lowered and both N hands in R55's bath face. NA-B next ren R55's legs. R55 had socks. The two NAs resident using draw The back dressing of dated 3/28/17. The was checked and for urine. The incontine was also wet and bo ungloved and left th that the suprapubic and the dressing ne got a wash cloth to	no is unable to carry out ing receives the necessary in good nutrition, grooming, and ygiene. NT is not met as evidenced ion, interview and document ailed to ensure appropriate as provided for 1 of 3 residents receive assistance with	F 31	2 Resident R55 no longer resid facility as of 4/12/2017. NA-B and NA-C were reeduca specifically on 5/1/2017 regard back the foreskin to wash the performing male pericare. All staff will be reeducated on and Procedure for Perineal Ca 5/15/2017. The Director of Nursing Servia designee will be responsible to compliance through routine at conducted weekly x4, monthly results will be taken to the QA committee for further recomm	ated ding pulling penis when the Policy are by ces and/or o ensure udits v x3. Audit PI	

If continuation sheet Page 47 of 81

		AND HUMAN SERVICES			FORM	: 05/18/201 APPROVEI . 0938-039
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLETIOI DATE
F 312	laying on (from 7:30 removed her gloves applying a barrier of NAs worked togeth put on. R55's plan of care of was a total assist w R55's Minimum Da R55 recently had a last thirty days and with hygiene. R55 w impairment and had begin prostatic hype Registered nurse (fi immediately after th 10:58 a.m. and con withdrew the foresk genitals. The director of nurse 3/30/17, at 10:00 a. are supposed to wa area according to th are just washing ow not the correct way The facility's policy indicated the purpo keep the perineal a and odors in the pe perineal hygiene, a The procedure for n 'Grasp penis gently	which the resident had been 0 a.m. till 9:40 a.m.). NA-B s and put a new set on before ream to scrotal area. The two er to put the resident's brief dated 2/16/17, indicated R55 with hygiene. ta Set dated 2/22/17, indicated urinary tract infection in the required extensive assistant vas also had severe memory d diagnoses of dementia and	F 31			

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		AND HUMAN SERVICES		F	TED: 05/18/201 ORM APPROVE NO. 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3	8) DATE SURVEY COMPLETED
		245279	B. WING		03/31/2017
NAME OF I	PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	V I	815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 312 F 314 SS=G	circumcised, draw f penis is washed. F replace the foreskin scrotum. Lift scrotu new wash cloth, ren washed; Pat dry win necessary; Turn res on side to wash, rin removing soiled glo wash with soap and on clean gloves to p clothing." 483.25(b)(1) TREA PREVENT/HEAL P (b) Skin Integrity - (1) Pressure ulcers comprehensive ass facility must ensure (i) A resident receiv professional standa pressure ulcers and ulcers unless the in demonstrates that f (ii) A resident with p necessary treatmen professional standa healing, prevent inf from developing. This REQUIREMEN by: Based on observat review, the facility f interventions to pre	 Foreskin back. Be sure entire Rinse thoroughly. Be careful to in to normal position; Wash im and wash perineum; With a make mitt and rinse area just th towel. Reposition foreskin if sident (both male and female) ase and dry anal area. After oves, use hand sanitizer to d water to cleanse hands. Put put on clean pad and/or TMENT/SVCS TO RESSURE SORES Based on the sessment of a resident, the e that- res care, consistent with ards of practice, to prevent d does not develop pressure idividual's clinical condition they were unavoidable; and preceives and services, consistent with ards of practice, to promote ection and prevent new ulcers NT is not met as evidenced tion, interview and document 	F 312	The facility has pressure redistribution mattresses as a standard intervention all residents and was already in place resident R55; then a low air loss mattr	for for

Facility ID: 00890

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					OMB NO.	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·	TIPLE CONSTRUCTION		E SURVEY PLETED
		245279	B. WING_		03/3	31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z	ZIP CODE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 314	Continued From pa	ge 49	F 3 ⁻	14		
	underlying tissue us as a result of press combination with sh residents (R55, R18 at risk for pressure responsive care res who had identified p addition, the facility include: stage, size bed, surrounding tis healing for 1 of 3 re Findings include: R55 was observed two nursing assista 3/29/17, at 9:40 a.m room to turn and re explained they were bed was lowered at washing their hands next removed pillow The right ankle had closed area which y protectors on over s worked together in sheet from left to rig was checked, dry a left hip area was re- prominence which to on (from 7:30 a.m. positioned between were not floating bu NAs did not float the which was in the re- into resident's room 3/29/17, at 9:53 a.m	sually over a bony prominence, ure, or pressure in hear and/or friction.), for 2 of 3 31) who had been identified as ulcers. Lack of timely sulted in actual harm for R55 pressure ulcer on the heel. In failed to assess wounds to , characteristics of the wound ssue, or progress toward		 was put in place on 4/7/2 for resident R55 was an Wound RN Assessment resident R55 on 3/30/20 R181 no longer resided 1/23/2017. Resident R22 resided in the facility as Documentation for all re reviewed by the Nurse M ensure that identified pro were appropriately asse documented and monito plans for all residents wi skin integrity issues wer modified as needed. GSS Care Plan Policy a Procedure for Skin Asse Ulcer Prevention and Do Requirements will be rev appropriate staff. The Director of Nursing designee will be respons compliance through rout conducted weekly x4, m results will be taken to th committee for further red 	nended 3/29/2017. s began for 17. Resident in the facility as of 00 no longer of 1/14/2017. sidents will be Managers to essure ulcers ssed, ored by. Care th potential for e reviewed and and the GSS assment, Pressure boumentation viewed with all Services and/or sible to ensure tine audits onthly x3. Audit ne QAPI	

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COM	PLETED
		245279	B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 50	F 31	4		
	2/22/17, indicated F Care Area Assessm at risk for developin prostate cancer, pa deconditioning. R55 balance and neede and ambulation. Th receiving hospice s during the end of lif extensive assist wit care. R55 was on a antidepressants. In of diabetes, chronic disease, and deme	5 had impaired mobility and d assistance with transfers e CAA also indicated R55 was ervices for additional care e process. R55 required h bed mobility and incontinent ntipsychotics and addition, R55 had diagnoses e end stage liver, heart ntia. R55 had a suprapubic ecently admitted to the facility				
	indicated there was spine. The hospite had come in and pu and would leave a r (CM), there were no In addition, the note	ary of the hospice visit a small red open area mid visit notes indicated the nurse at a Mediplex dressing on it, message for case manager o documented measurements. as indicated that on 3/17/17, en area on right ankle (no				
	following: R55 had round, open but sca Mediplex, had a rec area but scabbed o X .5 cm width, had cm circle open, cow over, and had a new non-blanching, dark	ted 3/20/17, indicated the a mid-back open area 1 cm abbed over. Covered with Idened coccyx with one open ver 2 centimeters (cm) length a right lateral ankle bone .5 ered with Band-Aid, scabbed w left heel "mushy", c colored area approximately opened. Mepilex and heel				

Facility ID: 00890

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	ΓIPL	E CONSTRUCTION	(X3) DAT	E SURVEY
AND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COM	IPLETED
		245279	B. WING			03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314	protectors applied.	-	F 3	14			
		ice note indicated dressing ur areas on R55's back and					
	as a Late Entry white Dressing changes to of skin on 3/28/17. If cm open area on m dark open are. Clea cm x .5 cm open ar Mediplex applied. 3 bone healed. 4.) 2 c dark circular area of dressing and sheep	s Note dated 3/29/17, entered ch documented the following: o all open or suspicious areas Areas of concern were 1.) 2.2 id back; appears to be larger, ansed, Mepilex applied. 2.) 2 ea on coccyx. Cleansed, .) Area to lateral right ankle cm unopened, non blanchable, n right heel. Foam island oskin heel protectors on. The ild continue to monitor.					
	resident had limited terminal illness (car deconditioning, pair balance. Required s by placing equipme weight bearing supp include intervention the mid-back open been updated to inco of care did not indic cares. The NA Kardex she following: R55 was extra caution during prevent striking arm	ised on 2/26/17, indicated the l physical mobility related to neer) evidenced by weakness, n, impaired mobility and staff assistance with mobility nt nearby and providing bort. The plan of care did not ns for treatment of the coccyx, area on the spine, not had it clude the heel area. The plan cate the resident refused eet undated, indicated the at high risk for skin injury, use g transfers and bed mobility to ns, legs, and hands against urface, keep skin clean and					
	dry, use lotion on di	ry skin, do not apply on site of needs protection for the feet					

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	-	AND HUMAN SERVICES			FORM	APPROVED 0938-0391	
STATEMENT OF DEFIC AND PLAN OF CORREC	IENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	·	IPLE CONSTRUCTION	(X3) DATI	(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		03/	31/2017	
NAME OF PROVIDER	OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARIT	AN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422			
	CH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
i.e. she not indi heels fl During a.m., R neoplas facility f medica hospice had a c over a and on R55's o there w three d LPN-A and indi last we residen not war liked to The NF p.m. ar increas NP-A w or non- residen due to increas R55 wa areas.	cate the res oated. an interview 55 was on h sm of prosta sm of prosta sm of bone. for palliative tions were a e. R55 did no ressing to a kyphotic are the right he tressings we ras an order ays and prn was intervie licated R55 ek. When as t's heels, LF ot his feet to sit in the re P-A was inter d indicated ed pain so s vas asked if avoidable al t started to poor nutritio ed skin brea as admitted cliity's policy re Ulcers, P	s, float heels. The Kardex did ident refused to have the with RN-C on 3/29/17, at 7:14 hospice care for malignant the and secondary malignant R55 was admitted to the care on 2/15/17. R55's pain adjusted one week ago by ot verbalize any longer. R55 in open wound on his mid back a, one dressing on the coccyx, el which was dark in color. ere changed on 3/28/17, and for dressing changes every weed on 3/30/17, at 2:02 p.m. was more alert that week than sked about floating the PN-A stated the resident did float and that the resident	F 31				

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		AND HUMAN SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245279	B. WING			03/:	31/2017
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	r		815 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	of this policy were the assess residents will breakdown, to accur and assessments of appropriately use pro- pressure redistribution residents at risk for pressure ulcer is pro- accompanying docur or change is identified following: - An evaluation of the present - An evaluation of the present (whether it if if present, is or is no - The status of the (that can be observed dressing) - The presence of pro- as signs of increasing tissue infection (for each or swelling around the drainage from the work The pressure ulcer assessed/evaluated documented on the sheet. If the residend daily on the Wound every treatment char ulcer's characteristic licensed nurse and following: Measurer Characteristics of ul-	he following: to systematically ith regard to risk of skin arately document observations of residents, and to revention techniques and tion surfaces on those pressure ulcers. "When a resent, daily monitoring (with umentation when complication ied) should include the the ulcer, if no dressing is the status of the dressing; if is intact and whether draining, ot leaking) area surrounding the ulcer red without removing the possible complications, such ing area of ulceration of soft example, increased redness the wound or increased yound)."	F 3	14			

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		AND HUMAN SERVICES				FORM	05/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING			03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	381	REET ADDRESS, CITY, STATE, ZIP CODE 15 WEST BROADWAY DBBINSDALE, MN 55422	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 314	the plan of care/trea and evaluated by the failed to implement potential development worsening of the rig R181's significant of indicated R181 was rejected cares during required extensive mobility, transfers a R181 was continent MDS indicated R18 ulcers but was at ris ulcers. R181's MDS diagnosis of depress cardiomyopathy and pulmonary disease oxygen. R181's MDS diagnosis of depress cardiomyopathy and pulmonary disease oxygen. R181's MDS hospice. Progress Note date "found a stage II thickness skin loss or both. The ulcer is clinically as an abra on the left side of re- cleansed and Mepi keep area clean and placed call to Total open area and nee- was left and nursing time." The Care Area Ass indicated R181 was related to cardiomy weakness, impaired	ealing and any modifications to atments should be assessed ne registered nurse. The facility interventions to prevent the ent of pressure ulcers or ght ankle ulcer for R55. change MDS dated 1/2/17, s cognitively intact and had not ng previous seven days. R181 assistance of one staff for bed and toileting and identified t of bowel and bladder. R181's 81 did not have any pressure sk for developing pressure 5 indicated R181 had	F 3	14			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG .		COM	PLETED
		245279	B. WING			03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER		·		TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY COBBINSDALE, MN 55422		
(X4) ID			ID PREFIX	,			(X5) COMPLETION
PRÉFIX TAG		YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	TAG	•	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)		DATE
F 314	Continued From pa	ao 55	ГЭ	4.4			
1 014	• • • • • • • • • • • • • • • • • • • •	A indicated R181 did not	F 3	14			
	have a pressure uld	er. CAA indicated staff would					
		nning with goal to avoid ninimize risks of pressure					
	ulcers.						
	A Progress Note da	ted 1/20/17, at 12:42 p.m.					
	indicated, "Writer al	so needs to update on new					
		x. At this time there are a total that are 0.25 x 0.25mm					
	[millimeter] in size.	Areas are free of s/sx					
		f infection. Writer has cleaned Mepilex dressing to area to					
	cover and keep clea	an. Resident is resistant to					
		ill turn herself onto her back equently does not wish to get					
	out of bed. Writer h	as notified RD [registered					
		eas. Writer will request and dent. Awaiting return call at					
	this time."						
		ted 1/20/17, at 1:50 p.m.					
		rs received from hospice for el protectors, reposition every					
	one hour and the ad	ddition of barrier cream to					
	open areas with dre	essing changes.					
		n printed 3/30/17, was					
		of time from R181's 16, until R181's death on					
	1/23/17. The care p	lan did not include					
	identification of pres	ssure ulcer risk or r stage II pressure ulcers. The					
	care plan lacked an	y interventions to prevent or					
	treat pressure ulcer	S.					
		3/30/17, at 3:10 p.m.					
		N)-B verified a stage II first documented on 1/15/17,					

Facility ID: 00890

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		AND HUMAN SERVICES			FORM): 05/18/2017 / APPROVED). 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONSTRUCTION	(X3) DA	TE SURVEY MPLETED
		245279	B. WING		03	/31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, 3815 WEST BROADWAY ROBBINSDALE, MN 55422	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 314	and that on 1/20/17 ulcers were identifie pressure ulcer care admission or when pressure ulcers on stated an initial care opened by the adm of admission. RN-E update the care plat or risks on the Trar Hospice would typit then the facility would asked what is part "The electronic care RN-B said, "I would be completed to at done." During interview on of nurses (DON) sat assessment to be of pressure ulcer. I would for a pressure ulcer. I would for a pressure ulcer electronic one in Por record-PointClick C plan includes any of said, "No just the chospice I would exp pressure ulcers are indicate goal is to h goal is individualized	7, three new stage II pressure ed. RN-B verified there was no e plan developed upon the staff identified the 1/15/17, or 1/20/17. RN-B e plan would have been dissions nurse within 24 hours 8 said the floor nurses were to an when they found open areas histional Care unit. RN-B stated cally do a paper care plan and uld scan it into the chart. When of the care plan? RN-B said, e plan is the only care plan." d expect a Wound Data tool to least get the assessment a 3/30/17, at 3:35 p.m. director aid, "I would expect wound completed for a patient with a build expect the daily skill notes til healed." DON said, "If a at risk for pressure ulcers e plan to be developed for expect there to be a care plan r. The care plan is the CC (an electronic health care Care)." When asked if the care other sections of the chart DON are plan section. If they are on opect an assessment and care to heal wounds if they are on the care plan to say e present but not necessarily to neal the pressure ulcers. The	F 3 ⁻	14		

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	OF DEFICIENCIES	& MEDICAID SERVICES		PLE CONSTRUCTION		TE SURVEY
	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		G		MPLETED
		245279	B. WING		03	8/31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 57	F 31	4		
	was a stage II. She "It had started out a she would not get of developed four very were two on either very small. As she expect the wounds encouraged her to g she would not." RN the care plan, I was of her." RN-C verific care plan. RN-C sa pressure ulcers, the prominences." RN notes but said, "I di During interview on DON said, "All of ou reducing and it will someone is at risk f skin care plan." Re documentation of ir	get out of bed and to eat but -C said, "I did not think to write a more focused on taking care ed there should have been a id, "The wounds were				
	medical director sta of the care plan. Th wound rounds on a weekly. It is unusua pressure ulcers, be preventing pressure R181 was admitted ulcers but was iden	to the facility without pressure tified as at risk for ssure ulcers. An individualized				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING			03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	identified on 1/15/17 prevention of press prevention of additional understanding R200's admission M he required extensive bed mobility, transfer R200 was frequently bladder. A CAA date was at risk for press dependence on stat frequent incontinent current pressure under limited physical mobilitying (ADL) self-car stooling and a need care plan did not action A Nursing Admit/ Ref 12/4/16, identified at include a measurent area was blanchabl further indicated R2 pressure ulcer, vent arterial ulcer, diabet suspected deep tiss which wound R200's Specialty Care treat 2016 identified the for on 12/10/16: Cleans with Mepiles [sic] M dressing) daily in th breakdown prevent	7, but interventions for the ure ulcers worsening or onal pressure ulcers were not /20/17, after the development ulcers. MDS dated 12/11/16, indicated ve assistance of two staff for ers and toileting and identified y incontinent of bowel and ed 12/17/16, indicated R200 sure ulcers related to ff for mobility, weakness and ce. The CAA did not identify a cer. R200's care plan identified bility and an activity of daily re deficit and frequent loose I for staff assistance. R200's ddress skin condition. e-admit Data Collection dated a "red coccyx," but did not nent or an indication if the e. The data collection tool 200 had one of the following: ous ulcer, surgical wound, tic ulcer, surgical wound or sue injury, but did not identify had. Good Samaritan Society tment record dated December following treatments initiated se coccyx, pat dry and cover lepilex dressing (an absorbent e morning for stage I skin ion, Cleanse open area on aline, pat dry and apply	F 3	14			

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		AND HUMAN SERVICES				FORM	APPROVED
	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II -	тірі	E CONSTRUCTION	MB NO. 0938-0391 (X3) DATE SURVEY	
	F CORRECTION	IDENTIFICATION NUMBER:			LE CONSTRUCTION		IPLETED
		245279	B. WING				24/2047
NAME OF F	PROVIDER OR SUPPLIER	245215	STREET ADDRESS, CITY, STATE, ZIP CODE			03/	31/2017
					815 WEST BROADWAY		
GOODS	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Ŷ	R	OBBINSDALE, MN 55422		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	X	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
E 244		50					
F 314	Continued From pa	-	F 3	14			
		Good Samaritan Society munity Progress Notes dated					
		5/16, identified the following:					
	12/12/16 Resident	t continued to receive skilled					
		nagement of fragile skin on					
	coccyx and open ar						
	12/13/16 - wounds	(two) are covered with Mepilex					
	and dressing intact.						
	12/15/16 - dressing back.	change to coccyx and mid					
	12/25/16 - wounds signs of infection.	clean, dry and intact with no					
	12/27/16 - wounds clean, dry and intac	on mid-back and coccyx t					
	1/2/16 - wound on c and intact.	coccyx is covered with Mepilex					
		ogress Note dated 12/13/16, a "pressure ulcer along the					
	12/23/16, indicated wounds: Sacrum; c	-admit Data Collection dated R200 had a the following losed wound 0.5 cm x .75 cm, er; mid back closed wound open to air.					
	RN-E stated resider check each week o	on 3/29/17, at 1:37 p.m., nts receive a weekly skin n their bath day. She stated if ncern, it would show up in an electronic record.					

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		AND HUMAN SERVICES			FORM	: 05/18/2017 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		245279	B. WING		03/31/201		
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 314 F 323 SS=D	RN-B stated she ha She stated when a nurse should initiate which would trigger stated the nurses s skin check each we RN-B stated she wa assessments for R2 process, but it was stated the nurses s skin condition beca coding the MDS. The DON stated re- be documented at I pressure ulcer was expect the staff to f care plan to be dev While R200 had tw there was no evider wounds to include: the wound bed, sur toward healing, nor implemented interv of existing ulcers or 483.25(d)(1)(2)(n)(HAZARDS/SUPER (d) Accidents. The facility must en (1) The resident en from accident haza (2) Each resident re-	on 3/30/17, at 10:33 a.m., ad never seen R200's wounds. nurse finds a wound, the e the wound observation tool an RN assessment. She hould also be completing a eek on bath day. At 11:36 a.m., as unable to locate any wound 200 and stated, "We have a not followed." She further hould have informed her of his use she was responsible for sident's skin condition should east weekly. She stated if a present on admit she would ollow up on it and expect a eloped. o separate pressure ulcers, nce the facility assessed the stage, size, characteristics of rounding tissue, or progress was there evidence the facility entions to prevent worsening prevention of new ones. 1)-(3) FREE OF ACCIDENT VISION/DEVICES	F 314			5/15/17	

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/18/2017 APPROVED 0938-0391	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION (2	(X3) DATE SURVEY COMPLETED		
		245279	B. WING			03/3	31/2017	
NAME OF F	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		815 WEST BROADWAY OBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOUL TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 323	Continued From pa	ge 61	F 3	23				
	appropriate alternative de rail. If a bed or must ensure correct maintenance of bed to the following eler (1) Assess the resider from bed rails prior (2) Review the risks the resident or resider informed consent p (3) Ensure that the appropriate for the formal manner for the facility factor assessed for use and functional manner for the formal manner formal ma	dent for risk of entrapment to installation. s and benefits of bed rails with dent representative and obtain			On 3/29/2017 the siderails and bed resident R243 were removed and replaced with a bed with secure pivo assist bar. All side rails and pivot assist bars attached to resident beds were inspe- on 3/29/2017. Procedures for reporting equipment issues and completion of work order be reviewed with all staff. The Director of Nursing Services and designee will be responsible to ensu compliance through routine audits conducted weekly x4, monthly x3. A results will be taken to the QAPI	ot ected rs will d/or re		
	indicated R243 was	at low risk for falls. R243's eletion of any device			committee for further recommendation	ons.		

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CENTERS FOR MEDICARE & MEDICAID S	-	APPROVED 0938-0391			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SU IDENTIFICATIO	PPLIER/CLIA	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
2452	279	B. WING		03/	31/2017
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY		
GOOD SAMARITAN SOCIETY - SPECIALTY CA	RE COMMUNITY		ROBBINSDALE, MN 55422		
(X4) ID SUMMARY STATEMENT OF DEFICIE PREFIX (EACH DEFICIENCY MUST BE PRECEDE TAG REGULATORY OR LSC IDENTIFYING INF	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRC DEFICIENCY)	LD BE	(X5) COMPLETION DATE
 F 323 Continued From page 62 assessment for the use of side rails medical doctor order indicating the bilateral siderails were to be used for mobility. R243 was admitted on 3/16/17, and diagnoses which included lumbar d (inflammation between discs in vert back), osteomyelitis and arthritis as the R243's Admission Minimum Dat dated 3/23/17. The MDS indicated I cognitively intact and required assis staff for bed mobility, transfers, toild walking in the room. The Care Area dated 3/23/17, indicated R243 was due to weakness, deconditioning, a mobility. R243's care plan with revision date indicated R243 was at risk for falls a limited physical mobility due to deco The care plan directed staff to educ instruct resident and family on safe assistive devices, remind resident r over to pick up dropped items and t R243 to use a grabber or to ask for During interview on 3/29/17, at 9:29 stated he used the siderails to help "but they're wobbly." During interview on 3/29/17, at 9:38 occupational therapist (OT) stated of therapy would typically assess for a devices but she did not see the side loose, "I see your concern, and they During interview on 3/29/17, at 9:41 registered nurse (RN)-A stated R24 	quarter or bed had iscitis tebra of the indicated on ta Set (MDS) R243 was stance of two et use and Assessment at risk for falls nd impaired of 3/27/17, and had onditioning. tate and use of not to bend to encourage assistance. a.m. R243 sit up in bed, a.m. boccupational iny assistive erails were y are wobbly."	F 32	3		

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		AND HUMAN SERVICES				FORM AF)5/18/2017 PPROVED 938-0391		
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE S COMPL	SURVEY		
		245279	B. WING _			03/31	/2017		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	, ZIP CODE				
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	TY 3815 WEST BROADWAY ROBBINSDALE, MN 55422						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD	BE	(X5) COMPLETION DATE		
F 323 F 356 SS=C	up. RN-A stated the he arrived and prob At 10:17 a.m. RN-A loose and moved a stating "Oh my, that switched out immed During interview on environmental assis that shouldn't be lik moving both sideral "large frame" and th been on the bed wit EA-A stated he was nursing that the side During interview on director of nursing (consider it a restrai verified both sideral Review of the facilit rails/Side Rails/Assis date of 11/16, indica assessed for the ap rails/specialty mattro only when medical that annual inspectio bedframes, mattress assist bars and trar eliminate any poten ensure that bed rail frame and mattress	 grab bar and will use it to sit grab bar and will use it to sit bed was in that room when bably came with the siderails. verified the siderails were t least two inches inward, t's not good, we will get them diately." 03/29/2017, at 10:19 a.m. stant (EA)-A stated "Oh wow, e that" when inspecting and iis. EA-A stated the bed had a he siderails shouldn't have thout an oversized mattress. a not aware nor notified by erails were loose. 3/29/17, at 12:06 p.m. the (DON) stated "We don't nt, its an assist bar" and iis were loose. ty Bed Safety - Including Bed ist Bars policy with revision ated residents were to be porpriateness of side ess/overlays, usage will occur necessity is documented and ions will be conducted of all ases and bed rails (side rails, isfer devices) to identify and itial entrapment issues and to s are compatible with the bed 	F 35			5.	/15/17		
	67(02.00) Brovious Versions	Obsolate Event ID: 201 B1	1	Facility ID: 00800	If a sufficient		a 64 of 91		

Facility ID: 00890

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DEPART CENTEF	FORM	APPROVED 0938-0391							
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245279	B. WING _		03/	31/2017			
NAME OF F	PROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, ZIP CODE						
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422					
(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 CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	VE ACTION SHOULD BE COMPLE ED TO THE APPROPRIATE DAT				
F 356	 (g) Nurse Staffing In (1) Data requirement the following inform (ii) Facility name. (iii) The current data (iii) The total number by the following cata unlicensed nursing resident care per sh (A) Registered nurse (B) Licensed praction vocational nurses (at (C) Certified nurses (at (iv) Resident censure (2) Posting requirement (i) The facility must specified in paragratic daily basis at the best (ii) Data must be post (A) Clear and reada (B) In a prominent presidents and visito (3) Public access to The facility must, up 	Anformation ents. The facility must post ation on a daily basis: e. e. er and the actual hours worked egories of licensed and staff directly responsible for hift: ees. cal nurses or licensed as defined under State law) aides. s. nents. post the nurse staffing data uph (g)(1) of this section on a eginning of each shift. ested as follows: able format. place readily accessible to rs. posted nurse staffing data. pon oral or written request,	F 35						
	(3) Public access to The facility must, up	posted nurse staffing data.							

		AND HUMAN SERVICES			PRINTED: FORM OMB NO.	APPROVE
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y F			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 356	Continued From pa	ge 65	F 356			
	for review at a cost standard.	not to exceed the community				
	facility must mainta staffing data for a n	ention requirements. The in the posted daily nurse ninimum of 18 months, or as w, whichever is greater.				
	by: Based on observat failed to post nurse accessible to reside	NT is not met as evidenced tion and interview, the facility staffing hours that were ents, family, and visitors. This affect 88 of 88 residents,		The sign was lowered on 5/1/20 Staff with responsibility for posti sign will be reeducated on placir	ng the	
	Findings include: The posted nurse s	staffing hours were not posted veryone could view the		The Administrator and/or design responsible to ensure compliant routine audits conducted weekly monthly x3. Audit results will be the QAPI committee for further recommendations.	mpliance through weekly x4, s will be taken to	
	12:00 p.m., the pos to the right of the el enclosed case for 3 was very high up in to stand on their tip read the posting. D	ur of the facility on 3/27/17, at ted nurse staffing was posted evators on first floor in a glass 8/27/17. However, the posting the case and one would have toes and stretch their neck to uring all days of the survey, aff remained posted high up in case.				
	3/30/17, at 10:45 a. wheelchair resident the posted nurse st short stature. The I	sing (DON) was interviewed on m. and confirmed that is would not be able to view affing nor would someone of a DON confirmed the posted be lowered to a height where osting.				

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		AND HUMAN SERVICES	1			FORM	05/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED
		245279	B. WING _			03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER		·		EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y		5 WEST BROADWAY BBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOULD BE) BE	(X5) COMPLETION DATE
F 371	Continued From pa	ge 66	F 37	71			
F 371 SS=E	483.60(i)(1)-(3) FO	-	F 37	71			5/15/17
		f from sources approved or tory by federal, state or local					
		e food items obtained directly s, subject to applicable State gulations.					
	facilities from using gardens, subject to	pes not prohibit or prevent produce grown in facility compliance with applicable pod-handling practices.					
		loes not preclude residents ods not procured by the facility.					
		re, distribute and serve food in ofessional standards for food					
	foods brought to re visitors to ensure s handling, and cons	regarding use and storage of sidents by family and other afe and sanitary storage, umption. NT is not met as evidenced					
	Based on observative review, the facility for sanitary manner for (Arrowhead and Wo safety procedures to borne illness which of 88 residents who	tion, interview, and document ailed to serve food in a 2 of 6 dining rooms oodlands), failed to follow food o minimize the risk of food had the potential to affect 84 o were served food out of the a system for checking expired ducts.		r t f f t	Dietary DA-A was reeducated on h responsibility for proper food handl hand washing on 3/30/2017. On 3/27/2017 the uncovered dishes of peaches were disposed of. The dr fan was thrown out on 3/27/2017. The facility had no residents that were us the Two Cal HN, it was in our overf storage awaiting disposal. It was disposed of on 3/30/2017.	ing and ying The using	

Facility ID: 00890

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		AND HUMAN SERVICES			FORM	: 05/18/2017 APPROVED . 0938-0391
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245279	B. WING		03/	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP (3815 WEST BROADWAY ROBBINSDALE, MN 55422		<u></u>
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO) CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 371	Findings include: During observation Arrowhead unit on aide (DA)-A reached buns with his right, opened a cabinet w reached into the bas set it on a plate. At sweat off his forehed hand, placed the ra washing his hands a resident's plate. During an interview DA-A stated, he ha years and had not gloves while servin and vegetable. He what I'm touching." On 3/29/17, at 8:22 observed on Arrow observed to be weat his hands prior to th but during service I stomach and pushe (both with left hand out foam bowls usi up food again, place food surface. A die hands after touchir opening cupboards prior to serving ado During an observat unit on 3/29/17, at serve the breakfas	a of a meal service on the 3/27/17, at 5:19 p.m., dietary ed into a bag of hamburger un-gloved hand. He then with the same hand and again ag of buns, pulled one out and 5:28 p.m., DA-A wiped the ead with a rag, using his right ag on a counter and without touched a hamburger bun on v on 3/27/17, at 5:40 p.m., ad been at the facility for two been told he needed to wear g unless he was serving fruits then stated, "I'll keep in mind". A a.m. breakfast service was wood unit. The server was aring a stocking cap, washed he start of the meal service, he touched his apron over his ed his glasses up on his face I), opened the cabinet to get ng both hands and then dished bing his thumb on the plate tary aide did not wash his ng his apron, his glasses, or and getting out foam bowls	F 37	1 All Dietary staff will be reed Director of Dietary Services Food Handling Policy and I GSS Policy and Procedure Services Handwashing Teo Dining Service Standards F the GSS Food Transport P procedure for Enteral Stora reviewed by the Director of Services with applicable sta The Director of Dietary Ser designee will be responsibl compliance through routine conducted weekly x4, mon results will be taken to the committee for further recor	s on the GSS Procedure, for Dietary chniques, GSS Procedure and rocedure. The age will be Dietary aff. vices and/or le to ensure audits thly x3. Audit QAPI	

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DEPAR ⁻ CENTEI	FORM	APPROVED 0938-0391				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		03/:	31/2017
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		
F 371	towel, then used the the sweat off his for area through a door returned, and witho up a plate and bega cabinet and pulled of into another cabine He then wiped the se the back of his hand cabinet to get a whit DA-A sneezed into with his left hand, d continued plating for bowels and holding During an interview director of food and conducted a training contamination and hands prior to servi re-wash hands if the back, if they touch of drawers. The direct stated staff should it themselves and plat and if they sneeze it wash their hands and A facility policy titled Handwashing Tech indicated staff will w safeguard the healt on their service. Wa work, after touching (face, hair, body or sneezing or blowing Dessert/snack food	e same paper towel to wipe rehead. DA-A left the serving r leading to an adjoining unit, ut washing his hands, picked an serving. He reached into a but a tray, he then reached t and took out a yellow pate. sweat off of his forehead with d and reached into another te basket out. At 8:43 a.m., his apron, holding the apron id not wash his hands, and od, touching the inside of onto plates with his left hand. on 3/30/17, at 11:00 a.m., the nutrition stated he recently g on handwashing and cross stated staff should wash their ng. He stated staff should ey leave the unit and come objects such as doors or or of food and nutrition further not be wiping the sweat off ucing the rag on the counter nto their apron, staff should nd change their apron. d Good Samaritan Society nique, dated February 2013, vash their hands as needed to h of those who are dependent ash hands: when reporting to g any contaminated object clothing), after coughing,	F 37			

Facility ID: 00890

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		AND HUMAN SERVICES					FORM	05/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION		(X3) DATE	E SURVEY PLETED
		245279	B. WING				03/:	31/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, 2	ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY COBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD	BE	(X5) COMPLETION DATE
F 371	a.m. the following w by the foodservice of A four tier food rack next to the cook's p four racks contained second tier from the dishes of peaches. heavily soiled with of matter was position away on the floor, fa the exposed tray of not seen the dryer k came from." FD ver dryer should not ha the food rack, statir with parchment pap before going up to t During followup kito a.m. with the FD, the In the dry storage c the kitchen area ele observed to have a 2016. At the time of	n tour on 3/27/17, at 11:45 vas observed and confirmed director (FD): a was positioned in the kitchen preparation table. Three of the d dishes of desserts, the e bottom contained uncovered A commercial speed dryer, dirt, dust and dark particulate red approximately four feet acing and blowing directly on peaches. FD stated he had before, "I don't know where it rified the heavily soiled floor ve been blowing directly on ng "all food should be covered ber, a pan or plastic wrap the floor, its policy."	F 3	71	DEFICIEN	ΣΥ)		
	responsible for the "I think nursing is." During interview on registered nurse (R orders the product, responsible for it, fu takes in delivery sho both tube fed reside	facility. FD stated he was not enteral feedings in the facility, 3/30/17, at 1:20 p.m. N)-D stated administration she was not sure who was urther stating "I think whoever ould rotate it." RN-D verified ents on the unit did not use the						
	product.							

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TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	(X3) DA). 0938-039 TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		CO	MPLETED
		245279	B. WING		03	/31/2017
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	FY I	8815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE	(X5) COMPLETIOI DATE
F 371	Continued From pa	qe 70	F 371			
	During interview on stated she stocks h orders the product a put it away. RN-E s was responsible, but check the expiration off the shelf and ge both tube fed reside did not use the prod During interview on registered dietitian resident on a tube f storeroom to look a products and look a would go up to the checks and balance	3/30/17, at 1:39 p.m. RN-E ler own floors, administration and thought maintenance may tated she was not sure who ut "if I am getting the formula, I in date, if it's expired I take it t it destroyed." RN-E verified ents on Boundary Waters unit duct. 3/30/17, at 1:56 p.m. (RD) stated if she had a feeding she would go to the t the available tube feeding at the expiration dates before it floor. RD stated "we have es between myself and nursing stating "I understand" when				
	dated February 201 to ensure food is ke staff would practice	ty Food Preparation policy 3 indicated the purpose was ept free of contamination and techniques in food otect against food-borne				
	revision date of 2/1 ensure safe practic	ty Food Transport policy with 6 indicated the purpose was to es when transporting food and dicated "all food items will be nd dated."				
F 431 SS=E	not provided. 483.45(b)(2)(3)(g)(f	nula policy was requested but n) DRUG RECORDS, UGS & BIOLOGICALS	F 431			5/15/17

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL ⁻ A. BUILDI		E CONSTRUCTION		E SURVEY PLETED
		245279	B. WING			03/3	31/2017
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 431	The facility must prodrugs and biological them under an agres §483.70(g) of this punlicensed personnel aw permits, but onlisupervision of a lice (a) Procedures. An explanation of a lice (a) Procedures. An explanation of a lice (a) Procedures and a supervision of a lice (a) Procedures. An explanation of a lice (b) Service Consult employ or obtain the pharmacist who (2) Establishes a sy disposition of all condition of all condition of all conditions and performing and biological of that an account of a maintained and performing and biological principal propriate access instructions, and the applicable. (h) Storage of Drug (1) In accordance withe facility must stored and the	 by ide routine and emergency als to its residents, or obtain ement described in art. The facility may permit all to administer drugs if State by under the general ensed nurse. Facility must provide vices (including procedures urate acquiring, receiving, ministering of all drugs and at the needs of each resident. ation. The facility must eservices of a licensed Astem of records of receipt and ntrolled drugs in sufficient accurate reconciliation; and ating records are in order and all controlled drugs is iodically reconciled. ags and Biologicals. als used in the facility must be facility must be over with currently accepted alles, and include the ory and cautionary expiration date when 	F 4	.31			

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		AND HUMAN SERVICES	T			FORM	05/18/201 APPROVEI 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ·		DNSTRUCTION		E SURVEY PLETED
		245279	B. WING			03/3	31/2017
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	3815	ET ADDRESS, CITY, STATE, ZIP C WEST BROADWAY BINSDALE, MN 55422	ODE	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 431	have access to the (2) The facility must permanently affixed controlled drugs list Comprehensive Dru Control Act of 1976 abuse, except when package drug distri quantity stored is m be readily detected. This REQUIREMEN by: Based on observat review, the facility fa personal were supe rooms. This had the residents residing of Findings include: During an observat registered nurse (R Waters medication environmental assis RN-A left the EA un room, with the door An observation of th medication room or revealed medication counter and unlock residents residing of accessible to the Affi medication room wa unsupervised includes	t only authorized personnel to keys. t provide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to n the facility uses single unit bution systems in which the ninimal and a missing dose can NT is not met as evidenced tion, interview and document ailed to ensure unauthorized ervised in 1 of 6 medication e potential to affect all 16 on the unit.	F4	F ol st un ol A G D E re av th T du c c c c re	RN-F was reeducated rega bligation to ensure the med corage room is secure and nauthorized people do not n 3/29/2017. Il applicable staff will be ree SS Procedure for Acquisiti ispensing and Storage of N nvironmental Services staf eeducated that they are on ccess to the medication sto he Director of Nursing Serves he Director of Nursing Serves signee will be responsible ompliance through routine onducted weekly x4, monthes usults will be taken to the Committee for further recom	dication ensure that have access educated the ion, Receiving, Medications. ff will be ly to have orage areas in staff. vices and/or e to ensure audits hly x3. Audit QAPI	

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		AND HUMAN SERVICES & MEDICAID SERVICES					FORM	05/18/2017 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	TIPLE CONST		_	(X3) DAT	E SURVEY IPLETED
		245279	B. WING				03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER				DDRESS, CITY, STAT	E, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		ST BROADWAY SDALE, MN 5542	22		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	- ,	PROVIDER'S PLAN EACH CORRECTIVE OSS-REFERENCED DEFICI	ACTION SHOULD	BE	(X5) COMPLETION DATE
	and mood disorders seizure disorders at conditions), Effexor medication) and lor medication used tree During an interview RN-F stated only nu aides (TMAs) have rooms. She stated of be going in and out unattended. RN-F s check the regulation was allowed to be in During an interview RN-E stated, only n in the medication ro stated if a housekee she be supervising supervised by a nur alone in the medicat A facility policy titled Acquisition, Receive of Medications, date reviewed and indicate medications are del the appropriate stor stored in a locked n cupboard. Only the medications and the will be permitted to storage areas. 483.80(a)(1)(2)(4)(e PREVENT SPREAR	s), Depakote (used to treat ind certain psychiatric (an anti-depressant azepam (a benzodiazepine eat anxiety disorders). on 3/29/17, at 1:11 p.m., urses and trained medication access to the medication non-medical staff should not of med rooms or left stated she would have to in on whether or not the EA in the medication rooms. on 3/29/17, at 1:24 p.m., urses and TMA's are allowed boms unsupervised. She eper goes in the room, nursing them. RN-E stated unless rse, the EA should not be left tition rooms. d Good Samaritan Society ing, Dispensing and Storage ed September 2016 was ated the following: Once livered, they will be secured in rage area. Medications will be nedication cart, drawer or person passing the e director of nursing services have access to the medication e)(f) INFECTION CONTROL,	F 4					5/15/17

Facility ID: 00890

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	DEPARTMENT OF HEALTH AND HUMAN SERVICES <u>CENTERS FOR MEDICARE & MEDICAID SERVICES</u> O						
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		245279	B. WING		03/	31/2017	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y I	3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 441	Continued From pa	ge 74	F 441	1			
	The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:						
	investigating, and c communicable dise volunteers, visitors, providing services u arrangement based conducted accordin	l upon the facility assessment ig to §483.70(e) and following tandards (facility assessment					
		ds, policies, and procedures ich must include, but are not					
	possible communic	eillance designed to identify able diseases or infections ead to other persons in the					
		om possible incidents of ase or infections should be					
		ansmission-based precautions event spread of infections;					
	(iv) When and how resident; including b	isolation should be used for a out not limited to:					
	depending upon the involved, and	uration of the isolation, e infectious agent or organism hat the isolation should be the					

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		AND HUMAN SERVICES			FORM	05/18/2017 APPROVED 0938-0391
	OF DEFICIENCIES IF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING		03/	31/2017
NAME OF F	PROVIDER OR SUPPLIER		· [STREET ADDRESS, CITY, STATE, ZI		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 441	 circumstances. (v) The circumstances must prohibit emploid disease or infected contact with resider contact with resider contact will transmit (vi) The hand hygie by staff involved in a (4) A system for requirer the facility's I actions taken by the (e) Linens. Person process, and transport spread of infection. (f) Annual review. (f) Annual review of its program, as necess This REQUIREMEN by: Based on observation of the second seco	sible for the resident under the ces under which the facility byees with a communicable skin lesions from direct hts or their food, if direct t the disease; and ne procedures to be followed direct resident contact. cording incidents identified PCP and the corrective e facility. nel must handle, store, port linens so as to prevent the The facility will conduct an IPCP and update their sary. NT is not met as evidenced tion, interview and document	F 4	41 RN-C was reeducated or	n proper hand	
	hand washing and g dressing change fro clean barrier during This practice had the resident (R55) who	ailed to provide appropriate glove changes during a om dirty to clean area, and a dressing change for supplies. ne potential to affect 1 of 1 was observed during a n addition, the facility failed to		washing during treatment Dressing Change policy of The siderails with black e resident R116 were remo 3/30/2017.	on 3/29/2017. lectrical tape for ved on	
	ensure that residen to allow the surface potential infection for	t equipment was maintained to be cleaned and prevent or 1 of 1 resident (R116) that tape on the siderails.		for the presence of electr were found. All staff will be reeducate for Hand Washing and W Changes by the Director	ical tape, none d on the policies ′ound Dressing	

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		& MEDICAID SERVICES	1			0938-03	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVE COMPLETED		
		245279	B. WING		03/3	31/2017	
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP	CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	YI	815 WEST BROADWAY OBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION			
F 441	Wound care: Registered nurse (I room with a rolling a.m. RN-C explained to check the resided back dressing locat dry and intact, dated left, no gloves used into bathroom got of to the dressing start dressings (gauge) counter. RN-C ther on the resident's bl (NA)-C cleaned out discarded gloves a used hand sanitize to the resident that dressing change to RN-C touched the and tape after remo- dressing which was remove gloves afted dressing. RN-C use to wipe around ope gauge. No redness dressing she remo- checked tubing, uri removed and place container. RN-C the solution and placed RN-C then left R55 dressing cart with t for R55.	RN)-C came into resident's computer on 3/29/17, at 9:53 ed to R55 that she was going nt's back dressing first. The ted over a kyphotic area was ed 3/28. RN-C checked heel d. No open areas. RN-C went one set of gloves. RN-C went on wheels and got out and tape placed on the n placed the wound cleanser anket. Nursing assistant t garbage bag that had nd an incontinent brief. RN-C d and gloved. RN-C explained she was going to do a o the suprapubic catheter. outside of dressing package bying suprapubic catheter s urine soaked. RN-C did not er removing the soiled ed sterile saline wound cleaner ening for catheter using a a noted. RN-C applied the cut ved from the package, ne started to flow. Gloves ed in plastic lined garbage en took the wound cleansing d it on the rolling dressing cart. 's room with the rolling he wound cleanser she used	F 441	Services and/or designee. reeducated that black elect allowed by the Director of Services and/or designee. The Director of Nursing Set designee will be responsib compliance through routin conducted weekly x4, mor results will be taken to the committee for further reco	trical tape is not Nursing ervices and/or le to ensure e audits thly x3. Audit QAPI		

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		& MEDICAID SERVICES	-				. 0938-039	
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· /	E SURVEY IPLETED	
		245279	B. WING			03/	31/2017	
NAME OF	PROVIDER OR SUPPLIER			STRE	ET ADDRESS, CITY, STATE, ZIP CODE			
good s	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	ry		WEST BROADWAY BINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	ĸ	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 441	Continued From pa	age 77	F 4	41				
	-	ved immediately after the		••				
	dressing change 3/29/17, at 10:58 a.m. and							
		hould have been changed						
		biled dressing and apply a						
		-C did not remove gloves or fter removing the urine soaked						
		plying a new dressing around						
	the suprapubic cat							
	revised 5/16, indicative was to promote wo	on Wound Dressing Change, ated the purpose of the policy und healing and that the						
	wound would rema procedure was as f	in free of infection. The follows:						
		order; review previous						
		otes; Position resident for						
		ommodate dressing change; sen tape from resident's						
		lown on surrounding skin						
		/ lift one edge of the dressing						
		inue to carefully lift the edge of	:					
		he skin by moving slowly						
		argins until edges are free; ding dressing over itself and						
		ction of the hair growth. If the						
		to remove, loosen edges with						
		Remove soiled dressing and						
		ag, avoiding contact and thus						
		ther surfaces. Remove gloves						
		e plastic bag. Perform hand						
		Id with equipment/dressing ile technique if required; Open						
		ur solutions if ordered; Put on						
		und and surrounding area to						
		n of the appropriate-sized						
		the skin and wound thoroughly						
		using gauze wipes, wound						
		d antiseptic solution. Clip						
	excess nair at sites	s needed; Allow the skin to dry					1	

Facility ID: 00890

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	05/18/2017 APPROVED 0938-0391
STATEMEN	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING			03/:	31/2017
NAME OF	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		815 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	completely before a resident's skin is fra to go beyond the wa a skin protection pro- Remove dressing fur- finger contact with the dressing over the wo on the skin. Firmer depending upon skin rolling motion is hel stretching of the dra items in plastic bag discard according the date, and initials on change and wound Data Collection. Eye drops: On 3/29/17, at 10:00 that she was going RN-C applied drops and then put in drops was reddened and substance. On 3/29 tears were administ RN-C was interviewed dressing change or confirmed RN-C did utilize hand sanitize before the eye dropp Wound cleanser: RN-C came into res computer on 3/29/1 explained to R55 the resident's back dress located over a kyptic	ge 78 applying the dressing. If the agile, or drainage is expected bund edge, consider applying eparation around the wound; rom the inner wrapper; avoid the dressing. Position the round and press down gently pressure be used on edges in condition. Sometimes a pful. Avoid unnecessary essing; Place all disposable with dressings, seal and o procedure. Identify time, dressing; Chart dressing observation on the Wound 1 a.m. RN-C stated to resident to put drops in R55's eyes. to left eye first which was dry os times two to right eye that had a buildup of a yellow 0/17, at 10:02 a.m. artificial tered to R55 for eye moisture. wed immediately after the n 3/29/17, at 10:58 a.m. and d not wash their hands or er after the wound care and us were administered.	F 4	41			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES							APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY IPLETED
		245279	B. WING _			03/:	31/2017
NAME OF I	PROVIDER OR SUPPLIER		<u> </u>		REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y		15 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG			ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 441	used. No open area got one set of glove stand on wheels an and tape placed on placed the wound of blanket. RN-C was interview and confirmed that room a rolling dress top shelf was set up shelf was used to p the shelf before ent carts are not room a but only two of the of RN had a cart and the during a shift. RN-C cleanser she used of another resident be on the shelf for dress wound cleanser wa put the wound clean back on the cart with of the container. Siderails: R116's room was o p.m. R116's bed hat wrapped fully aroun which are a highly to rendered the surface uncleanable. The director of envit the facility administ and both were not a tape. It was verified surface was no long	age 79 as. RN-C went into bathroom as. RN-C went to the dressing of got out dressings (gauge) the counter. RN-C then cleanser on the resident's wed on 3/29/17, at 1:13 p.m. she had brought into R55's sing cart. RN-C said that the o for a computer and the lower out dressing and supplies on tering the resident's room. The specific. There are three carts carts are used because each there are only two RNs on C confirmed the same wound on R55 could be used on ecause the skin cleanser was ssing change on the cart. The s not disinfected as RN-C had nser on R55's bed and then thout disinfecting the outside bserved on 3/30/17, at 2:00 d black electrical tape nd the bilateral grab bars, ouched surface. The tape to be hygienically ironmental services (EVS) and rator was along on the tour aware of the black electrical l by the administrator the ger a cleanable surface. The had not been notified of the	F 44	41			

If continuation sheet Page 80 of 81

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVE COMPLETED 245279 B. WING 03/31/201	DEPARTMENT OF HEALTH AND HUMAN SERVICES FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391									
65/51/201	SURVEY									
	1/2017									
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY ROBBINSDALE, MN 55422										
(X4) ID PREFIX TAGSUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGID PREFIX TAGPROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)(X5 COMPLE DAT	(X5) COMPLETION DATE									
F 441 Continued From page 80 use of the electrical tape on the bilateral grab bars.										

Facility ID: 00890

		AND HUMAN SERVICES		F	6279027	FORM	: 05/02/2017 APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BLDG		(X3) DATE SURVEY COMPLETED		
245279		B. WING			03/29/2017		
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			Y		15 WEST BROADWAY DBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS	кc	000			
	FIRE SAFETY						
	ALLEGATION OF C DEPARTMENT'S A SIGNATURE AT TH PAGE OF THE CM	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR IE BOTTOM OF THE FIRST S -2567 FORM WILL BE ATION OF COMPLIANCE.					
	ON-SITE REVISIT CONDUCTED AT V SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE /ALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.					
	Minnesota Departm Fire Marshal Divisio time of this survey, Society-Specialty C in compliance with participation in Med Subpart 483.70(a), 2012 edition of Nati Association (NFPA)	Survey was conducted by the nent of Public Safety, State on on March 29, 2017. At the Good Samaritan care Community was found not the requirements for licare/Medicaid at 42 CFR, Life Safety from Fire, and the ional Fire Protection) Standard 101, Life Safety er 18 New Health Care.					
	PLEASE RETURN CORRECTION FO DEFICIENCIES TO	R THE FIRE SAFETY			EPO	C	
	Healthcare Fire Ins State Fire Marshal 445 Minnesota St., St. Paul, MN 55101	Division Suite 145			L		
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 05/01/2017

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

		AND HUMAN SERVICES & MEDICAID SERVICES			RINTED: 05/02/2 FORM APPRO MB NO. 0938-0	VED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER;				PLE CONSTRUCTION G 02 - MAIN BLDG	(X3) DATE SURVEY COMPLETED	
245279		B, WING		03/29/2017		
NAME OF PROVI	IDER OR SUPPLIER	9.		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			r	3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLE	
By o Mai Ang THI DEI FOI 1. A to c 2. T 3. T res pre This con (11' kitc bas on t floc spe The the det cor dep cap time	FICIENCY MUS LLOWING INFC A description of v correct the deficient The actual, or pro- the name and/or ponsible for correvent a reoccurrent s 3-story building astructed in 2012 1) construction. Then and mechan sement, long-term the first floor, lor for and long-term the first floor, lor for and long-term ecial locking arra building is fire a building has a fection in the corre- ridors that is mo partment notifica pacity of 96 beds e of the survey. T MET as evide PA 101 HVAC	tate.mn.us n@state.mn.us RRECTION FOR EACH T INCLUDE ALL OF THE PRMATION: what has been, or will be, done ency. oposed, completion date. title of the person ection and monitoring to ence of the deficiency. g with a basement was and determined to be Type II The building has a garage, nical equipment in the m care and transitional care ng-term care on the second care on the third floor utilizing ngements for memory care. sprinkler protected throughout. fire alarm system with smoke ridors and spaces open to the nitored for automatic fire tion. The facility has a and had a census of 90 at the 42 CFR, Subpart 483.70(a) is	K 00		5/15/1	17
FORM CMS-2567(02-99) Previous Versions Obsolete Event ID: 2GLR21 Facility ID: 00890 If continuation sheet Page 2						2 of 3

		AND HUMAN SERVICES			FORM	05/02/2017 APPROVED 0938-0391	
CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A, BUILDING 02 - MAIN BLDG			(X3) DATE SURVEY COMPLETED	
245279			B. WING			03/29/2017	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y 3815 WEST BROADWAY ROBBINSDALE, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
K 521	Heating, ventilation comply with 9.2 and accordance with the specifications. 18.5.2.1, 19.5.2.1, 9 This STANDARD i Based on observat could not be verifie ventilating and air of was maintained in a (2000) Chapter 19, 9, Section 9.1 and emergency, a nonc adversely affect all FINDINGS INCLUE On 03/29/2017 at 1 with facility staff, it was system does contaid dampers, however, inspected and tested in accordance with Section 3-4.7.	, and air conditioning shall d shall be installed in e manufacturer's 9.2 s not met as evidenced by: tion and a staff interview, it d whether the facility's general conditioning system (HVAC) accordance with NFPA 101 Section 19.5.2.1 and Chapter NFPA 90A. In a fire compliant HVAC system could residents.	K 52	The smoke dampers were inspec 4/4/2017. The Environmental Ser Director was retrained on the GSS and Procedure for Extinguishment Fire Suppression System Require on 3/30/2017. The smoke dampe was added to The Equipment Life System (TELS)to provide reminde testing every 4 years. The Administrator and/or designed responsible to ensure compliance random audits. Audit results will b to the QAPI committee for further recommendations.	vices Policy and ments r testing cycle rs for e will be through the taken		

Facility ID: 00890

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