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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GLR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245279**

2. STATE VENDOR OR MEDICAID NO. (L2) **138218700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMU**
(L4) **3815 WEST BROADWAY**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/26/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lou Anne Page, HFE NE II 01/17/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/17/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO.
00140 (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

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 Peterson

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

MDH
Minnesota Department of Health

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)

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 Peterson

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

MDH
Minnesota
Department
of Health

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.

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.

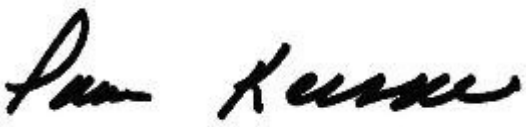
This in not a valid example of a deficient practice under this regulation and will be removed from the CMS 2567 Statement of Deficiencies.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Revised 2567 as a result of an Informal Dispute Resolution. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 242	Resident R246 no longer resides in the	5/15/17

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

Electronically Signed | 05/01/2017

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F 242	Continued From page 1 facility failed to ensure residents choices for bathing preferences were honored for 1 of 3 residents (R246). Findings include: R246 was admitted to the facilities post-acute care unit on 3/22/17, with diagnoses of spinal fracture with repair, insomnia, and recent fall per the Admission Face Sheet. A nursing admit-readmit Data Collection dated 3/22/17, indicated R246 would like to have two showers a week, during the day shift. A nursing assistant care sheet dated 3/22/17, indicated resident needed assist of one staff with bathing. An initial care plan dated 3/22/17, indicated R246 had a self-care performance deficit related to recent hospitalization, falls, subdural hematoma (blood between the brain and lining (dura), and spinal fracture at thoracic-8. R246 had poor balance and needed for brace when out of bed. An intervention of bathing assist of one staff, did not indicate how often R246 was to receive a shower. On 3/28/17, at 9:26 a.m. R246 was interviewed and stated he had not yet received a shower (six days after admission), and he had asked for two showers a week. On 3/30/17, at 8:38 a.m. registered nurse-G stated R246 was on the bath schedule for Wednesday's and was not scheduled for a second day.	F 242	facility as of 4/11/2017. Systemic changes were made to ensure that bathing preferences are accurately transferred to bath schedules. And all applicable staff will be retrained on this process by the Director of Nursing Services and/or designee. The GSS Policy and Procedure regarding Resident Dignity will be reviewed with the appropriate staff by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 242	Continued From page 2 On 3/30/17, at 3:00 p.m. the director of nursing verified staff should be transferring data from the admission (nursing admission data collection) and R246 should have been scheduled for two showers a week. The policy Resident Dignity dated 2/17, indicated: Ideas for maintaining a resident's dignity may include, but not be limited to: "a. Grooming residents as they wish to be groomed."	F 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was within reach for 1 of 35 residents (R243) who did not have the call light in reach, was dependent on staff to move in the room and was at risk for falls. In addition, the facility failed to ensure a helmet fit properly for 1 of 2 residents (R135) who was reviewed for use of helmet. Findings include: R243 was observed on 3/27/17, at 4:39 p.m. sitting upright in a recliner situated approximately four feet from the edge of R243's bed. The call	F 246	Call light for resident R243 was placed within reach on 3/27/17, upon notification by the surveyor. The helmet order for R135 was discontinued by the resident□s primary physician on 4/25/2017. All residents were reviewed for call light placement on 3/31/2017 and adjusted if needed. All residents were reviewed on 5/1/2017 and there are no other residents with helmets in the facility. All staff will be reeducated on call light procedure by Director of Nursing Services	5/15/17

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F 246	Continued From page 3 light was lying across the bed. R243 was unable to reach the call light but stated he can and does use it when he needs help. R243's admission Minimum Data Set (MDS) dated 3/23/17, indicated R243 was cognitively intact and required assistance of two staff for bed mobility, transfers, toilet use and walking in the room. The Care Area Assessment (CAA) dated 3/23/17, indicated R243 was at risk for falls due to weakness, deconditioning, and impaired mobility. R243's care plan with revision date of 3/27/17, indicated R243 was at risk for falls and staff was to encourage R243 to use a grabber or to ask for assistance. During interview on 3/31/17, at 10:44 a.m. registered nurse (RN)-A stated R243 was "capable and does use the call light", but could not get up on his own to reach it if it was not near him. During interview on 3/31/17, at 10:50 a.m. the administrator stated it was an expectation that the call light would be within reach for any resident that needed it, unless they are capable of moving around the room on their own. The facility Call Light policy dated September 2012, indicated the purpose was to ensure resident always has a method of calling for assistance and directed staff "When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it." R135 was observed on 3/27/17, at 5:27 p.m., sitting in a Broda chair at the dining room table before dinner wearing a pink helmet. The helmet	F 246	and/or designee. The Occupational therapy staff that are responsible for assessment of helmets will be reeducated by the Rehab Coordinator regarding their responsibility to assess for proper helmet fit and condition. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 246	Continued From page 4	F 246		

was observed to fit so it was positioned down over the resident's eyes and R135 kept trying to push the helmet up. Due to continuous erratic movements with her hands and arms, the resident was unsuccessful. Prior to assistance with eating, trained medication aide (TMA)-D removed R135's helmet. After the evening meal was complete, TMA-D was observed to put the helmet back on R135 at 6:44 p.m. and once again, the helmet came down over the resident's eyes and R135 tried to unsuccessfully push the helmet up so it would not come down over the resident's eyes.

R135 was observed, 3/29/17, at 7:40 a.m., sitting in a Broda chair in the dining room. The pink helmet was attached to the back of the Broda chair. R135 was observed to have multiple uncontrolled movements with her legs and arms and moved her upper torso back and forth and her hands were in constant motion. R135 did not try to get out of the Broda chair.

R135 was observed throughout the day shifts on 3/29/17 and 3/30/17, sitting in a Broda chair with the pink helmet hooked to on the back of the Broda chair both at the dining room table and in her room. R135 did not wear the helmet and made no attempts to get out of the Broda chair.

R135 was observed on 3/31/17, at 9:48 a.m. in her room seated in the Broda chair, the pink helmet was hooked on the back of the chair. R135 was observed to have multiple arm and leg movements but did not attempt to get out of the chair.

A Physician's Order for R135's care dated 1/14/15, included "ok for soft helmet."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 246	Continued From page 5	F 246		

The care plan initiated on 1/14/15 and revised on 3/17/15, read R135 had limited physical mobility and risk for falls related to Huntington's, unsteady gait, and history of falls. The safety intervention was to apply a soft helmet, assist and encourage to wear.

The Progress Note, 3/6/17, for the MDS, "Does wear a soft helmet to help protect head." R135 has been seen 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 seen 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 246	Continued From page 6 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 initially but needed to be reassessed again. The occupational therapist-A was interviewed on 3/30/17, at 10:42 a.m. and confirmed R135 was admitted to the facility with a helmet. Occupational therapist-A shared the assessment that was completed by occupational therapy (OT) on admission. The OT assessment done on 12/18/20 (had year wiped out), indicated R135 wore a helmet and was a fall risk. The assessment failed to indicate the condition and fit of the helmet. TMA-C was interviewed on 3/31/17, at 9:52 a.m. and confirmed R135 can only push it up when it was covering her eyes. In addition, when the helmet touched the bridge of the nose, the nose will get red.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine.	F 272		5/15/17

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F 272	Continued From page 7 (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the use of a bilateral (bilat) thigh	F 272	A Mobilization Data Collection Tool for resident R40 was completed on 4/28/2017 and Physical Device and Restraint	

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F 272	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. Findings include: Bilateral thigh device: R40 was admitted to the facility on 10/5/11, with admission diagnoses of schizophrenia, dementia with behavioral disturbances, supranuclear palsy (behavioral, cognitive, and gait disturbances). On 3/29/17, at 7:20 a.m. R40 was sitting in the hallway, both legs were restrained in a Broda chair (tilt and recline positioning wheelchairs (W/C), and he was leaning forward in the chair. On 3/29/17, at 8:41 a.m. trained medication aides (TMAs)-A and C took R40 to his room and readjusted the clothing. R40's legs were released from the restraint as the restraint closure was located in the back of the W/C where R40 could not reach the closure to release the restraint himself. Before R40 left the room the TMA re-applied the restraint. On 3/29/17, at 10:48 a.m. R40 was taken to his room By TMA-A and C for toileting and clothing adjustment. The restraint was again released from behind the W/C. Before R40 left the room the TMA re-applied the restraint. A Physician's Verbal Telephone Order dated 8/29/13, indicated a pelvic device was approved with a back latching for wheelchair safety/positioning. The facility was to discontinue OT (occupational Therapy) services. An OT evaluation dated 3/15/16, indicated R40	F 272	Assessment on 5/1/2017. Resident R40 was picked up on OT case load on 5/1/2017. Resident R243 had a Physical Device and Restraint Assessment done on 3/29/2017. All residents with bilateral thigh straps will be reassessed for restraint determination and care plans updated as appropriate by the Nurse Management staff. All residents with side rails will be reviewed by the Nurse Managers to ensure restraint determination and care plans are accurate. All staff with responsibility for MDS were retrained by the Director of Nursing Services on 4/25/2017. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations	

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F 272	Continued From page 9 "in Broda chair with bilateral thigh pad postural support device which provides a neutral pelvis sitting position to promote independence with wheelchair mobility. Uses BLE [bilateral lower extremities] to propel wheelchair and forward flexion with upper body that results in anterior pelvic posture during wheelchair mobility. Bilateral thigh pads recommended to provide neutral pelvis sitting posture when in wheelchair and promotes upright visual alignment for interaction within environment." The Mobilization Support Data Collection Tool dated 2/25/17, indicated R40 was able to pull himself upright from lying to sitting. R40 did have enough torso strength to maintain an upright, seated position. R40 had the leg strength to transfer between surfaces, was able to push himself up and rise 1-2 inches. R40 could stand/sit/stand with limited support. "Used assistive device to transfer, stationary hand hold to pull self-up. Was unable to ambulate." A comment indicated R40 was able to pull self to standing position when assessed, however staff reported his ability to pull self-upright was inconsistent, and often R40 would not pull himself up or would attempt to grab onto staff and hang on them or want them to lift him. "May need to utilize stand aid for transfers." A Physical Devices and Restraint Review assessment dated 2/25/17, indicated thigh straps for Broda chair - assists resident in self-propelling chair w/out sliding out of it. A bolded note in the assessment indicated: "If the device, material or equipment cannot be removed easily by the resident and it restricts freedom of movement or normal access to one's own body, then it is a restraint. If the device does not meet this criteria,	F 272		

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then it may be used." The facility assessment then asked "is this device a restraint for this resident?" and the facility checked no. However the resident was not able to remove the thigh straps [restaint] himself.

A Good Samaritan Society Specialty Care Community Progress Note dated 2/27/17, indicated R40 had declined in three areas of activities of daily living (ADL) function since last review. He had been dependent with dressing, toileting and personal hygiene. A quarterly assessment dated 3/2/17, indicated R40 was assessed by physical therapy (PT), but was not felt to be appropriate for therapy. R40 did have a walking program in the past but refused to participate and it was discontinued. Soft back latching bilateral thigh straps to assist with positioning in the chair due to his forceful rocking back and forth using hand rail to propel himself in hallway. Those remained appropriate.

A PT evaluation for patient and nursing safety dated 2/28/17, indicated R40 was assessed for increased difficulty with transfers. "Nonverbal and non-ambulatory at baseline. Self-propels Broda chair in unit. Demonstrates decreased strength, activity tolerance, safety awareness, and balance affecting transfers and bed mobility. Educated patient and nursing staff on safety with transfers. Recommending use of EZ-Way transfer for safety due to decreased BUE [bilateral upper extremity] and BLE."

The significant change Minimum Data Set (MDS) dated 3/2/17, indicated R40 had no restraint use. R40 was noted to have severe cognitive loss, needed assist for transfers to and from the toilet and bed. R40 displayed behavioral symptoms of

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grabbing, hitting, and pacing in wheelchair. R40 was at risk for falls.

The care plan revised 3/28/17, (during survey), indicated R40 was resistive to care and had a history of striking out during cares. R40 was at risk for falls was impulsive and unaware of safety risks. Had impaired judgement, impaired sitting and standing balance, gait disturbance. Had a remote history of frequent falls, laying on landing strip (mat) next to bed and crawling on the floor. An intervention listed of Broda chair with bilateral thigh straps when up.

The nursing assistant (NA) care sheet printed 3/30/17, directed staff to use the Broda chair with front, side, and rear tip bars, and bilateral thigh positioning device. Staff were to check every 30 minutes and "release every two hours" and off load/reposition and offer toileting.

On 3/29/17, at 2:10 p.m. registered nurse (RN)-F, indicated R40 used to propel himself by planting the heels and pulling forward, he was sliding around in his chair a lot, and kept falling out of chair. The thigh straps were considered a mobility aide, so he can self-propel without sliding out of the chair." RN-F reviewed the restraint form wording and stated "I was told therapy classified it as a positioning tool."

On 3/29/17, at 2:45 p.m. RN-E stated R40 used thigh straps for self-propelling in Broda chair, because he used to slide out of the W/C with his forceful movements. RN-E stated "in the facility it was not considered a restraint because he cannot stand up by himself consistently."By having R40 use the thigh straps it afforded him a high level of mobility. RN-E was asked if he could release the

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F 272	Continued From page 12 thigh straps himself and stated no, "but it was not assessed as a restraint in the facility." On 3/30/17, at 3:00 p.m. the director of nursing (DON) was interviewed and stated bilateral thigh straps were considered a positioning device. The Physical Restraints Procedure dated 11/16, indicated, "To ensure appropriate use of restraints: Physical Restraints - any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's own body. Physical restraints may include, but are not limited to, hand mitts soft ties, vests, lap cushions, lap trays and side rails that the resident cannot remove. Also included as restraints are location practices that meet the definition of a restraint, such as: Using devices in conjunction with a chair such as trays, tables and belts that prevent a resident from rising." Siderails: R243 was admitted on 3/16/17, and had diagnoses which included lumbar discitis (inflammation between discs in vertebra of the back), osteomyelitis and arthritis as indicated on the R243's admission MDS dated 3/23/17. The MDS indicated R243 was cognitively intact and required assistance of two staff for bed mobility, transfers, toilet use and walking in the room. The Care Area Assessment dated 3/23/17, indicated R243 was at risk for falls due to weakness, deconditioning, and impaired mobility. R243's medical lacked evidence of an assessment for siderails.	F 272		

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F 272	Continued From page 13 On 3/27/17, at 5:03 p.m. the quarter siderails were observed to be loose on both upper ends of R243's bed. The siderails moved approximately two inches inward and were not secure to the bed. R243's record lacked completion of any device assessment for the use of side rails and a medical doctor order indicating the quarter bilateral siderails were to be used for bed mobility. During interview on 3/29/17, at 9:38 a.m. OT stated occupational therapy would typically assess for any assistive devices but she did not see the siderails were loose, "I see your concern, and they are wobbly." During interview on 3/29/17, at 9:41 a.m. RN-A stated R243 required and was assessed for a grab bar and will use it to sit up. RN-A stated the bed was in that room when he arrived and probably came with the siderails. At 10:17 a.m. RN-A verified the siderails were loose and moved at least two inches inward, stating "oh my, that's not good, we will get them switched out immediately." During interview on 3/29/2017, at 10:19 a.m. environmental assistant (EA)-A stated "oh wow, that shouldn't be like that" when inspecting and moving both siderails. EA-A stated the bed had a "large frame" and the siderails shouldn't have been on the bed without an oversized mattress. EA-A stated he was not aware nor notified by nursing that the siderails were loose. During interview on 3/29/17, at 12:06 p.m. the DON stated "we don't consider it a restraint, it's	F 272		

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F 272	Continued From page 14 an assist bar" and verified both siderails were loose and that there was no siderail assessment.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement.	F 278		5/15/17

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F 278	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an accurate Minimum Data Set (MDS) was completed for 1 of 3 residents R200 reviewed for pressure ulcers. Findings include: R200's admission MDS dated 12/11/16, indicated R200 did not have a pressure ulcer stage I or greater. A Care Area Assessment (CAA) dated 12/17/16, indicated R200 was at risk for pressure ulcers related to dependence on staff for mobility, weakness and frequent incontinence. The CAA did not identify a current pressure ulcer. A discharge - return anticipated MDS dated 12/20/17, indicated no pressure ulcers and an entry tracking record MDS dated 12/23/17 also indicated no pressure ulcers present. A discharge MDS dated 1/14/17, indicated R200 did not have a pressure ulcer, stage I or greater. A Nursing Admit/ Re-admit Data Collection dated 12/4/16, identified a "red coccyx." The data collection tool further indicated R200 had one of the following: pressure ulcer, venous ulcer, surgical wound, arterial ulcer, diabetic ulcer, surgical wound or suspected deep tissue injury, but did not identify which wound R200 had. A review of R200's Good Samaritan Society Specialty Care treatment record dated December 2016 identified the following treatments initiated on 12/10/16: Cleanse coccyx, pat dry and cover with Mepiles [sic] Mepilex dressing (an absorbent foam dressing) daily in the morning for stage I skin breakdown prevention, Cleanse open area on spine with normal saline, pat dry and apply	F 278	Resident R200 was discharged from the facility on 1/14/2017. The MDS for resident R200 was modified on 4/28/2017 to include pressure ulcer. Documentation for all residents will be reviewed to ensure that identified pressure ulcers are appropriately assessed, documented and that information is coded accurately on the MDS by the Nurse Managers. All staff with responsibility for wound management will be retrained on the protocols for wound assessment and documentation by the Director of Nursing Services and/or designee. All staff with responsibility for completing the MDS were retrained by the Director of Nursing Services on 4/25/2017. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 278	Continued From page 16 Mepilex dressing daily. A review of R200's Good Samaritan Society Specially Care Community Progress Notes dated 12/12/16 through 1/5/16, identified the following: 12/12/16 - Resident continued to receive skilled 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, 1/2/16 - 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 should have informed her of his skin condition because she was responsible for coding the	F 278		

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F 278	Continued From page 17 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 and expect a care plan to be developed. While R200 had two separate pressure ulcers, one identified on admission and one identified on 12/10/16, both documented through the time of discharge, the facility coded the MDS inaccurately four separate times.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain	F 279		5/15/17

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F 279	Continued From page 18 or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to prevent the development of pressure ulcers	F 279	Resident R181 is no longer in the facility as of 1/23/2017; during their stay, the plan of care was amended on 1/17/2017 to	

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F 279	Continued From page 19 (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for 1 of 1 resident (R181) identified as at risk for pressure ulcers. Findings include: R181's hospice care plan dated 12/28/16, did not address pressure ulcer risk or development but did instruct home health aide to, "Assist patient with lotion on body gentle massage to back feet and arms, observe and report skin changes, nail care and foot care." The Facility care plan printed 3/30/17, was reviewed for period of time from R181's admission on 12/6/16, until R181's death on 1/23/17. The care plan did not include identification of pressure ulcer risk or development of four stage II pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The care plan lacked any interventions to prevent or treat pressure ulcers. R181's admission Minimum Data Set (MDS) dated 12/13/17, indicated R181 was cognitively intact and had not rejected cares during previous seven days. R181 required extensive assistance of one staff for bed mobility, transfers and toileting and identified R181 was continent of bowel and bladder. R181's MDS indicated R181 did not have any pressure ulcers but was at risk for developing pressure ulcers. R181's MDS indicated R181 had diagnosis of depression, ischemic cardiomyopathy (decreased ability of the heart to pump blood to the body) and chronic obstructive pulmonary disease (a disease of the lungs that reduces air flow to the lungs) and	F 279	include a mepilex dressing, change every 3 days. And on 1/20/2017 to include the following interventions: a low-air loss mattress, heel protectors to wear at all times when in bed, reposition every hour as resident allows, cover open areas with small amount of barrier cream and apply mepilex dressing. Care plans for all residents with potential for skin integrity issues were reviewed and modified as needed by the Nurse Management staff on 4/28/2017. GSS Care Plan Policy and GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements will be reviewed by the with all appropriate staff by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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required continuous oxygen.

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 R181 did not have a pressure ulcer. The CAA indicated pressure ulcer care plan would be developed and R181 would continue to participate in therapy to become stronger with a goal of discharging home.

A Progress Note dated 1/15/17, indicated staff, "...found a stage II pressure ulcer on the left side of resident's coccyx. Area was cleansed and Mepilex dressing was applied to keep area clean and protected. Writer hss [sic] placed call to Total Care for seniors to report new open area and need for tx [treatment], voicemail was left and nursing is awaiting return call at this time."

A Progress Note dated 1/20/17, at 12:42 p.m. indicated, "writer also needs to update on new open area on coccyx. At this time there are a total of 4 open areas that are 0.25 x 0.25 mm [millimeter] in size. Areas are free of s/sx [signs/symptoms] of infection. Writer has cleaned areas and applied Mepilex dressing to area to cover and keep clean. Resident is resistant to repositioning and will turn herself onto her back when in bed and frequently does not wish to get out of bed. Writer has notified RD [registered dietician] of open areas. Writer will request and air mattress for resident. Awaiting return call at this time."

A Progress Note dated 1/20/17, at 13:50 p.m. indicated new orders received from hospice for

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an air mattress, heel protectors, reposition every one hour and the addition of barrier cream to open areas with dressing changes.

During interview on 3/30/17, at 3:10 p.m. registered nurse (RN)-B verified a stage II pressure ulcer was first documented on 1/15/17, and that on 1/2017, three new stage II pressure ulcers were identified. RN-B verified there was no pressure ulcer care plan developed upon admission or when the staff identified the pressure ulcers on 1/15/17, or 1/20/17. RN-B stated an initial care plan would have been opened by the admissions nurse with in 24 hours of admision. RN-B said the floor nurses were to update the care plan when they found open areas or risks on the Transitional Care unit. RN-B stated Hospice would typically do a paper care plan and then the facility would scan it into the chart. When asked what is part of the care plan? RN-B said, "The electronic care plan is the only care plan."

During interview on 3/30/17, at 3:35 p.m. director of nurses (DON) said, "If a patient is identified at risk for pressure ulcers would expect a care plan to be developed for prevention. I would expect there to be a care plan for a pressure ulcer. The care plan is the electronic one in PCC." When asked if the care plan includes any other sections of the chart DON said, "No just the care plan section. If they are on hospice I would expect an assessment and care plan. It gets harder to heal wounds if they are on hospice. I would expect the care plan to say pressure ulcers are present but not necessarily to indicate goal is to heal the pressure ulcers. The goal is individualized."

During interview on 3/31/17, at 8:51 a.m. RN-C said, "I found the pressure ulcer on January 15. It

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F 279	Continued From page 22 was a stage II. She was not eating." RN-C said, "It had started out as a reddened bottom because she would not get out of bed. Then she developed four very small open areas. There were two on either side of her coccyx. They were very small. As she got closer to death we did not expect the wounds to heal. I know we encouraged her to get out of bed and to eat but she would not." RN-C said, "I did not think to write the care plan, I was more focused on taking care of her." RN-C verified there should have been a care plan. RN-C said, "The wounds were pressure ulcers, they were over bony prominences." During interview on 3/31/17, at 11:23 a.m. the DON said, "All of our mattress are pressure reducing and it will not be on the care plan. If someone is at risk for pressure ulcers we do a skin care plan." During interview on 3/31/17, at 11:54 a.m. the medical director stated that physician orders are part of the care plan." The facility care plan printed 3/30/17, was reviewed for period of time from R181's admission on 12/6/16, until R181's death on 1/23/17. The care plan did not include identification of pressure ulcer risk or development of four stage II pressure ulcers. The care plan lacked any interventions to prevent or treat pressure ulcers.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility,	F 282		5/15/17

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F 282	Continued From page 23 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 for1 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 self-touch and 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 dementia with behavioral symptoms. His quarterly Minimum Data Set (MDS) dated 12/29/16, indicated he was severely cognitively impaired and displayed behaviors directed toward others and verbal behavioral symptoms. R59 care plan dated 1/20/17, identified a sleep/wake cycle disturbance, and behaviors that included physical aggression, hitting, pushing and loud disruptive singing. The care plan directed staff to minimize behavior problems with the following interventions: If awake early, give R59 breakfast as soon as food was available, go to another unit if needed. The care plan further directed staff to offer music and the use of head phones as a diversion and administer medications as ordered.	F 282	Resident R59 care plan was modified on 4/28/2017. Appropriate staff will be reeducated by the Director of Nursing Services and/or designee regarding following resident R59 care plan interventions and their responsibility to inform the Nurse Manager if and when those interventions are ineffective. Resident R40 has seasonal allergic rhinitis; his medication for allergies was changed to a more effective medication on 4/1/2017. NA-B and NA-C were reeducated regarding appropriate hand and face hygiene for resident R40 on 3/29/2017. Resident R55 no longer resides in the facility as of 4/12/2017. The care plans of all residents with dementia were reviewed by the Nurse Manager. Staff caring for patients with dementia were reeducated by the Nurse Manager regarding their obligation to follow care plan interventions and to inform the her if and when those interventions are ineffective. NA-B and NA-C were reeducated specifically on 5/1/2017 regarding pulling back the foreskin to wash the penis when performing male pericare. All staff will be reeducated on the GSS	

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F 282	Continued From page 24 During observations on 3/29/17, at 7:26 a.m., R59 was seated in the dining room making intermittent non-sensical noises. At 7:57, R59 returned to the dining room table after getting dressed. He had a coffee cup in front of him, he was clapping his hands and calling out, swearing repeatedly. At 7:59 a.m., a staff member ambulated past R59. R59 called out "hey," the staff member did not acknowledge R59 who then swore. At 3/29/17, at 8:18 a.m., R59 remained at the table singing, yelling out and swearing. At 8:33 a.m., staff began serving breakfast to other residents, however, R59 had not yet received any food. At 8:39 a.m., R59 continued to yell out and clap his hands. Staff served R59 his breakfast at 8:43 a.m., one hour and 27 minutes after R59 was seated at the table. R59 ate his breakfast quietly, calling out once for scrambled eggs. At 8:56 a.m., staff escorted R59 back to his room where he was yelling with the door shut. He continued to yell until 9:33 a.m. During a second observation on 3/29/17, at 1:19 p.m., R59 was in his room with the door open. He was calling out loudly. R59 was sitting on his bed, there was no music playing in his room and he was not wearing head phones as directed in his plan of care. During observations on 3/30/17, at 8:53 a.m., R59 sat at a table in the dining room yelling out and clapping his hands. Staff was setting up the meal, however R59 did not have any food. The residents on the adjoining unit had already eaten breakfast. At 9:09 a.m., R59 finished eating his meal and started yelling out, "hey." At 9:12 a.m., staff escorted R59 to his room where he continued to yell out. At 9:19 a.m., R59 was observed lying in bed. The lights were on and the blinds were open. No music was on and no head	F 282	Care Plan Policy, staff obligation to respond appropriately to nasal discharge and the GSS Policy and Procedure for Perineal Care by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 282	Continued From page 25 phones were present. He continued to yell out. During an interview on 3/30/17, at 9:23 a.m., nursing assistant (NA)-A stated R59 can be very agitated sometimes. She stated he gets very loud and was hard to re-direct. NA-A stated she brought R59 to his room, but he came right back out. She stated he has a radio in his room and staff are supposed to put music on for him and stated it calms him down. She stated she had not offered him any music that day. During an interview on 3/30/17, at 9:43 a.m., registered nurse (RN)-F stated R59 made a lot of noise. She stated he wandered a lot and was difficult to re-direct. RN-F stated R59 would wake up too early and wanted breakfast right away. She stated he was usually up at 6:30 a.m., when she got there and stated she brought him coffee and if they have granola bars left over from the night before she would offer him one. She stated she was not aware staff were supposed to offer him breakfast as soon as it was available, but stated R59 liked music and sometimes staff would put it on for him. RN-f stated she did not think R59 head phones were working. During an observation on 3/30/17, at 12:40 p.m., R59 was in the dining room. He was wearing his headphones and humming to himself while he ate his lunch. R59 displayed no signs of agitation. During an interview on 3/30/17, at 2:46 a.m., RN-E stated R59 was up at 6:00 a.m., that morning and stated staff should offer him food when he was up early. She further stated when R59 was agitated staff should offer his headphones or music in his room. She stated even if the headphones were not working, they	F 282		

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F 282	Continued From page 26 helped to cancel out excess noise. During an interview on 3/30/17, at 2:46 a.m., the director of nursing (DON) stated staff should be using the interventions in place on the plan of care. A facility policy was requested but not received. Hygiene: R40 was observed on 3/29/17, at 7:20 a.m. sitting in the hallway, he was leaning forward in the chair, clear thick mucus was running out of his nose, and R40 pushed the mucous into his mouth. At 7:35 a.m. R40 was self-propelling across the unit. Mucous continued to drain from his nose. At 7:38 a.m. staff assisted R40 to eat, he continued to have mucous drain from his nose. At 8:41 a.m. NA-B and NA-C took R40 to his room, and released the restraint from behind the chair, assisted with brief using the EZ stand. R40 was able to pull himself upright without the assist of the EZ stand. R40 repeatedly removed his right hand from the EZ lift assist handle and pushed mucous into his mouth. When he was receiving peri-care R40 touched and scratched his penis, and then pulling mucous from his nose he put his hand into his mouth. At 10:48 a.m. R40 was taken to his room to change brief by NA-B and NA-C. Cares were provided, R40 again scratched his penis, and then lifted his hand to pull mucous from his nose and put his right hand into his mouth. NA-B said they would wash his hands when they get him back in the chair. R40 had his hands washed, NA-B and NA-C verified R40 had touched his penis, put his hand in his mouth, and that mucous draining was also being put into his mouth, NA-B and NA-C also verified he had done that in the cares provided at 8:41 a.m. as well. NA-C then washed his face.	F 282		

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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 checked and found to be saturated with urine. The incontinent product under the resident was also wet and but absent of stool. NA-C ungloved and left the room to inform the nurse

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that the suprapubic catheter dressing was wet and the dressing needed to be changed. NAR-B got a wash cloth to clean the perineal and buttock area. NA-B only slightly washed over the penis and perineal area, she did not pull back the foreskin to wash. R55's penis was observed for reddened areas and open areas and there was none. The left hip area was reddened over the bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m.). NA-B removed her gloves and put a new set on before applying a barrier cream to scrotal area. The two NAs worked together to put the resident's brief put on.

R55's plan of care dated 2/16/17, indicated R55 was a total assist of one with hygiene.

R55's Minimum Data Set dated 2/22/17, indicated R55 recently had a urinary tract infection in the last thirty days and required extensive assistant with hygiene. R55 was also had severe memory impairment and had diagnoses of dementia and begin prostatic hyperplasia.

Registered nurse (RN)-C was interviewed immediately after the dressing change 3/29/17, at 10:58 a.m. and confirmed the NAs should have withdrew the foreskin to completely cleanse male genitals.

The director of nursing (DON) was interviewed on 3/30/17, at 10:00 a.m. and confirmed the aides are supposed to wash the penis and perineal area according to the facility's policy. If the aides are just washing over the area quickly that was not the correct way of washing a male patient.

The facility's policy on Perineal Care, revised 5/16

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F 282	Continued From page 29 indicated the purpose of the procedure was to: keep the perineal area clean, to prevent infection and odors in the perineal area, to promote good perineal hygiene, and to observe perineal area. The procedure for male care read as follows: 'Grasp penis gently with one hand and wash. Begin at meatus and wash in a circular motion toward the base of the penis; If resident is not circumcised, draw foreskin back. Be sure entire penis is washed. Rinse thoroughly. Be careful to replace the foreskin to normal position; Wash scrotum. Lift scrotum and wash perineum; With a new wash cloth, remake mitt and rinse area just washed; Pat dry with towel. Reposition foreskin if necessary; Turn resident (both male and female) on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer to wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing." R55 was not assisted with total pericare as directed by the plan of care. Pressure injury care: R55 was observed during morning cares done by two nursing assistants (NAs)-B and NA-C on 3/29/17, at 9:40 a.m. The NAs 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 NA gloved after washing their hands in R55's bathroom. NA-B next removed pillows from between R55's legs. The right ankle had a loose dressing over a closed area which was pea size. 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 left hip area was reddened over the bony prominence which the resident had been laying	F 282		

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on (from 7:30 a.m. till 9:40 a.m. A pillow was positioned between the resident's legs, heels were not floating but resting on the pillow. The NAs did not float the resident's heels off a pillow which was in the resident's care plan.

R55 had a Progress Note, 3/29/17, Late Entry which documented the following: Dressing changes to all open or suspicious areas of skin on 3/28/17. Areas of concern were 1. 2.2 cm open area on mid back; appears to be larger, dark open are. Cleansed, Mepilex applied. 2. 2.0 cm x 0.5 cm open area on coccyx. Cleansed, Mediplex applied. 3. Area to lateral right ankle bone healed. 4. 2.0 cm unopened, non blanchable, dark circular area on right heel. Foam island dressing and sheepskin heel protectors on. The note the facility would continue to monitor.

The NA Kardex care sheet undated, indicated the following: R55 was at high risk for skin injury, use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, keep skin clean and dry, use lotion on dry skin, do not apply on site of injury, and resident needs protection for the feet i.e. sheepskin boots, float heels. The kardex did not indicate the resident refused to have the heels floated.

Licensed practical nurse (LPN)-A was interviewed on 3/30/17, at 2:02 p.m. and indicated R55 was more alert this week than last week. When asked about floating the resident's heels, LPN-A stated the resident did not want his feet to float and that the resident liked to sit in the recliner a lot. R55 did not have the heels floated as directed per the plan of care.

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F 309	Continued From page 31	F 309		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by:	F 309		5/15/17

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F 309	Continued From page 32 Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 3 of 4 residents (R244, R245, R116) with observed laceration and/or bruising reviewed for non-pressure related pressure conditions. In addition, the facility failed to implement care planned interventions for 1 of 1 resident (R59) reviewed with dementia, who displayed behaviors during the survey. Findings include: R244 head laceration of unknown cause was not assessed nor monitored. R244 was admitted on 3/24/17, with diagnoses that included toxic encephalopathy, pneumonia and dementia obtained from the Admission Record dated 3/30/17. On 3/28/17, at 8:22 a.m. during interview, R244 was observed to have a laceration approximately one inch in length above his left eye. When asked how he had sustained the laceration, R244 stated that he fell and hit his head going into the bathroom. R244 stated it happened a "couple days ago, maybe yesterday." R244's Nursing Admit Re-Admit Data Collection dated 3/24/17, indicated R244 was oriented to person, place and time, had normal skin integrity and did not have any pressure, venous, arterial or diabetic ulcers, burns, deep tissue injury, and/or traumatic or surgical wounds. Review of the care plan with revision date 3/25/17, indicated R244 had impaired cognitive function or thought processes due to dementia, impaired decision making, had had an actual fall	F 309	An incident report was created for resident R244 on 3/29/2017 an RN assessed the laceration on 3/29/2017 and again on 3/30/2017. The care plan for resident R244 was modified on 3/31/2017. The laceration was assessed again the following week on 4/3/2017. The resident left the facility on 4/5/2017. On 3/29/2017 weekly skin observation and monitoring UDA began for resident R245. Per our policy and procedure, an incident report for resident R245 was not needed in this situation; the resident is alert and oriented and the bruise was not suspicious in nature. Resident R116 right forearm skin tear was assessed and observed by an RN on 3/29/2017 and again on 3/30/2017 and 4/8/2017. Resident R59 care plan was modified on 4/28/2017. Appropriate staff will be reeducated by the Director of Nursing Services and/or designee regarding following resident R59 care plan interventions and their responsibility to inform the Nurse Manager if and when those interventions are ineffective. Documentation for all residents will be reviewed by Nurse Managers to ensure that any bruises/contusions/skin tears and abrasions are appropriately assessed and documented. RN-A was reeducation on her obligation to observe, report and monitor skin issues for all residents. Appropriate staff will be reeducated by the Nurse Manager, regarding following resident R59 care plan interventions and their responsibility to inform the Nurse Manager if and when those interventions are ineffective.	

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F 309	Continued From page 33 due to psychotropic medication use, weakness and deconditioning and required staff assist of one for ambulation and toileting. The care plan did not indicate any skin alterations. Review of nursing progress notes dated 3/24/17 through 3/28/17, revealed there was no documentation on the head laceration. During interview on 3/29/17, at 1:56 p.m. registered nurse (RN)-A stated R244 does self transfer and has some erratic behaviors. When asked if she was aware of the head laceration, RN-A stated "I've observed it, but am not his caregiver," further stating they did not have a report that he had fallen. RN-A verified that there was no monitoring of the laceration. During interview on 3/30/17, at 2:36 p.m. the director of nursing (DON) stated that R244 did not tell anyone that he fell and staff didn't notice the laceration. DON stated an incident report should have been started, "the nurses missed it." R245 bruise of unknown cause was not assessed nor monitored. R245 was admitted on 3/15/17, with diagnoses that included cellulitis of left lower limb, chronic atrial fibrillation and venous insufficiency obtained from the Admission Record dated 3/30/17. On 3/28/17, at 12:00 p.m. during interview, R245 was observed to have a large, purple, approximate 2" X 4" bruise on his upper left arm. R245 stated he did not know where it came from, "they know about it."	F 309	All licensed staff will be reeducated on the GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements by the Director of Nursing Services and/or designee. All nursing staff will be reeducated on daily skin observation and reporting procedures by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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R245's Nursing Admit Re-Admit Data Collection dated 3/15/17, indicated R245 was alert and oriented to person, place and time, had right and left lower leg ulcers and rashes on the upper body, however did not indicate any bruising.

Review of the Order Summary Report dated 3/30/17, indicated an international normalized ratio (INR-laboratory measurement of how long it takes blood to form a clot) was to be drawn every Friday until 3/31/17. An INR result dated 3/29/17, measured high at 4.1 (normal reference range 1.0 - 1.2).

Review of the care plan with revision date 3/30/17, indicated R245 had actual impairment to skin integrity due to cellulitis of left lower limb, anticoagulant use, increased risk for bruising and to observe for major or fatal bleeding. The care plan directed staff to monitor location, size and treatment of skin injury, to report abnormalities to the health care provider, and to conduct weekly skin observation by licensed nurse. The care plan did not indicate any upper arm bruising or monitoring.

Review of nursing progress notes dated 3/24/17 through 3/28/17, revealed there was no documentation on the upper arm bruise.

On 3/29/17, at 2:48 p.m. RN-B stated if unknown bruising was noted for a resident, nursing would investigate, and if an incident report wasn't necessary, nurses would document in the progress notes and monitor if "it got bigger or not." RN-B stated she was aware of the bruise, but did not document it and verified that monitoring was not completed.

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On 3/30/17, at 2:36 a.m. DON stated she would have expected if someone saw the bruise they would tell a nurse who would fill out an incident report and if a nurse did know about it, "they should have documented and monitored it"

R116's skin tear of unknown cause was not assessed nor monitored.

R116 was admitted on 1/24/17, with diagnoses that included sepsis, atrial fibrillation, cellulitis of lower limb and peripheral vascular disease cellulitis obtained from the Admission Record dated 3/30/17. The Admission Minimum Data Set (MDS) dated 1/31/17 indicated R116 was cognitively intact and had no open lesions, rashes, cuts or skin tears.

On 3/28/17, at 10:51 a.m. during interview, R116 was observed to have mid forearm discoloration/bruising with a 2" X 4" bandage above the area.

During observation on 3/29/17, at 10:13 a.m. R116 showed surveyor his right arm with the bandage on it and stated "my skin opened." R116 stated he bruises easily.

During observation on 3/30/17, at 9:28 a.m. R116's bandage on his right forearm was removed and replaced with steri strips.

Review of the Order Summary Report dated 3/30/17, indicated R116 was to receive warfarin sodium tablet (blood thinner) 3 mg (milligrams) one time a day.

Review of the care plan with revision date 1/29/17, indicated R116 had fragile skin, actual

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impairment to skin integrity due to lower extremity cellulitis with open areas and was on anticoagulant therapy. The care plan directed staff to monitor location, size and treatment of skin injury, report abnormalities to the health care provider. The care plan was updated on 3/30/17, directing staff to provide skin tear wound care per facility standing orders and indicated R116 was at high risk for skin injury and to use extra caution during transfers and bed mobility.

R116's Nursing Admit Re-Admit Data Collection dated 1/24/17, indicated R116 was alert and oriented to person and time, had lower extremity redness, ulcer and scab.

Review of Wound RN Assessments dated 1/24/17, 1/31/17 and 2/14/17, did not address any forearm injury and bandage.

Review of Wound Data Collection forms dated 2/15/17 addressed lower extremity skin injuries and did not address any forearm injury and bandage.

Review of nursing progress notes dated 1/24/17 through 3/28/17, revealed there was no documentation on the right forearm injury and bandage.

During interview on 3/29/17, at 2:46 p.m. RN-B stated she was aware R116's skin is fragile and discolored, but was not aware there was a skin issue on his forearm.

During interview on 3/30/17, at 2:36 p.m. DON stated staff should have documented and monitored the skin injury.

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Review of the facility Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements policy with revision date of 4/16, indicated all residents will have a comprehensive skin inspection done by the licensed nurse on admission/readmission to identify any skin issues present including, but not limited to, pressure ulcers, and the results will be documented in PCC (computer program). Under the "Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions" section of the policy, if a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately, should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation sheet and on the resident's care plan.

R59's Admission Record Resident Information sheet indicated a diagnosis of dementia with behavioral symptoms. His quarterly MDS dated 12/29/16, indicated he was severely cognitively impaired and displayed behaviors directed toward others and verbal behavioral symptoms. R59 care plan dated 1/20/17, identified a sleep/wake cycle disturbance, and behaviors that included physical aggression, hitting, pushing and loud disruptive singing. The care plan directed staff to minimize behavior problems with the following interventions: If awake early, give R59 breakfast as soon as food is available, go to another unit if needed. The care plan further directed staff to offer music and the use of head phones as a diversion and administer medications as ordered.

During observations on 3/29/17, at 7:26 a.m., R59 was seated in the dining room making intermittent non-sensical noises. At 7:57, R59 returned to the dining room table after getting

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dressed. He had a coffee cup in front of him, he was clapping his hands and calling out, swearing repeatedly. At 7:59 a.m., a staff member ambulated past R59. R59 called out "hey," the staff member did not acknowledge R59 who then swore. At 3/29/17, at 8:18 a.m., R59 remained at the table singing, yelling out and swearing. At 8:33 a.m., staff began serving breakfast to other residents, however, R59 had not yet received any food. At 8:39 a.m., R59 continued to yell out and clap his hands. Staff served R59 his breakfast at 8:43 a.m., one hour and 27 minutes after R59 was seated at the table. R59 ate his breakfast quietly, calling out once for scrambled eggs. At 8:56 a.m., staff escorted R59 back to his room where he was yelling with the door shut. He continued to yell until 9:33 a.m. During a second observation on 3/29/17, at 1:19 p.m., R59 was in his room with the door open. He was calling out loudly. R59 was sitting on his bed, there was no music playing in his room and he was not wearing head phones as directed in his plan of care.

During observations on 3/30/17, at 8:53 a.m., R59 sat at a table in the dining room yelling out and clapping his hands. Staff was setting up the meal, however R59 did not have any food. The residents on the adjoining unit had already eaten breakfast. At 9:09 a.m., R59 finished eating his meal and started yelling out, "hey." At 9:12 a.m., staff escorted R59 to his room where he continued to yell out. At 9:19 a.m., R59 was observed lying in bed. The lights were on and the blinds were open. No music was on and no head phones were present. He continued to yell out.

During an interview on 3/30/17, at 9:23 a.m., nursing assistant (NA)-A stated R59 can be very agitated sometimes. She stated he gets very loud

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and is hard to re-direct. NA-A stated she brings R59 to his room, but he comes right back out. She stated he had a radio in his room and staff are supposed to put music on for him and stated it calmed him down. She stated she had not offered him any music that day.

During an interview on 3/30/17, at 9:43 a.m., RN-F stated R59 makes a lot of noise. She stated he wandered a lot and was difficult to re-direct. RN-F stated R59 would wake up too early and wanted breakfast right away. She stated he was usually up at 6:30 a.m., when she got there and stated she brought him coffee and if they have granola bars left over from the night before she would offer him one. She stated she was not aware staff were supposed to offer him breakfast as soon as it was available, but stated R59 liked music and sometimes staff would put it on for him. RN-F stated she did not think R59 head phones were working.

During an observation on 3/30/17, at 12:40 p.m., R59 was in the dining room. He was wearing his headphones and humming to himself while he ate his lunch. R59 displayed no signs of agitation.

During an interview on 3/30/17, at 2:46 a.m., RN-E stated R59 was up at 6:00 a.m., that morning and stated staff should offer him food when he was up early. She further stated when R59 was agitated staff should offer his headphones or music in his room. She stated even if the headphones were not working, they helped to cancel out excess noise.

During an interview on 3/30/17, at 2:46 a.m., the DON stated staff should be using the interventions in place on the plan of care.

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F 309	Continued From page 40 A facility policy was requested but not received.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate perineal hygiene was provided for 1 of 3 residents (R55) observed to receive assistance with personal hygiene care. Findings include: 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 checked and found to be saturated with urine. The incontinent product under the resident was also wet and but absent of stool. NA-C ungloved and left the room to inform the nurse that the suprapubic catheter dressing was wet and the dressing needed to be changed. NAR-B	F 312	Resident R55 no longer resides in the facility as of 4/12/2017. NA-B and NA-C were reeducated specifically on 5/1/2017 regarding pulling back the foreskin to wash the penis when performing male pericare. All staff will be reeducated on the Policy and Procedure for Perineal Care by 5/15/2017. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	5/15/17

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got a wash cloth to clean the perineal and buttock area. NA-B only slightly washed over the penis and perineal area, she did not pull back the foreskin to wash. R55's penis was observed for reddened areas and open areas and there was none. The left hip area was reddened over the bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m.). NA-B removed her gloves and put a new set on before applying a barrier cream to scrotal area. The two NAs worked together to put the resident's brief put on.

R55's plan of care dated 2/16/17, indicated R55 was a total assist with hygiene.

R55's Minimum Data Set dated 2/22/17, indicated R55 recently had a urinary tract infection in the last thirty days and required extensive assistant with hygiene. R55 was also had severe memory impairment and had diagnoses of dementia and begin prostatic hyperplasia.

Registered nurse (RN)-C was interviewed immediately after the dressing change 3/29/17, at 10:58 a.m. and confirmed the NAs should have withdrew the foreskin to completely cleanse male genitals.

The director of nursing (DON) was interviewed on 3/30/17, at 10:00 a.m. and confirmed the aides are supposed to wash the penis and perineal area according to the facility's policy. If the aides are just washing over the area quickly that was not the correct way of washing a male patient.

The facility's policy on Perineal Care, revised 5/16 indicated the purpose of the procedure was to: keep the perineal area clean, to prevent infection

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F 312	Continued From page 42 and odors in the perineal area, to promote good perineal hygiene, and to observe perineal area. The procedure for male care read as follows: 'Grasp penis gently with one hand and wash. Begin at meatus and wash in a circular motion toward the base of the penis; If resident is not circumcised, draw foreskin back. Be sure entire penis is washed. Rinse thoroughly. Be careful to replace the foreskin to normal position; Wash scrotum. Lift scrotum and wash perineum; With a new wash cloth, remake mitt and rinse area just washed; Pat dry with towel. Reposition foreskin if necessary; Turn resident (both male and female) on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer to wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing."	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing.	F 314		5/15/17

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F 314	Continued From page 43 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent the development of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.), for 2 of 3 residents (R55, R181) who had been identified as at risk for pressure ulcers. Lack of timely responsive care resulted in actual harm for R55 who had identified pressure ulcer on the heel. In addition, the facility failed to assess wounds to include: stage, size, characteristics of the wound bed, surrounding tissue, or progress toward healing for 1 of 3 residents (R200). Findings include: R55 was observed during morning cares done by two nursing assistants (NAs)-B and NA-C on 3/29/17, at 9:40 a.m. The NAs 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 NA gloved after washing their hands in R55's bathroom. NA-B next removed pillows from between R55's legs. The right ankle had a loose dressing over a closed area which was pea size. 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 left hip area was reddened over the bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m. A pillow was positioned between the resident's legs, heels were not floating but resting on the pillow. The	F 314	The facility has pressure redistribution mattresses as a standard intervention for all residents and was already in place for resident R55; then a low air loss mattress was put in place on 4/7/2017. Care plan for resident R55 was amended 3/29/2017. Wound RN Assessments began for resident R55 on 3/30/2017. Resident R181 no longer resided in the facility as of 1/23/2017. Resident R200 no longer resided in the facility as of 1/14/2017. Documentation for all residents will be reviewed by the Nurse Managers to ensure that identified pressure ulcers were appropriately assessed, documented and monitored by. Care plans for all residents with potential for skin integrity issues were reviewed and modified as needed. GSS Care Plan Policy and the GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements will be reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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NAs did not float the resident's heels off a pillow which was in the resident's care plan. RN-C came into resident's room with a rolling computer on 3/29/17, at 9:53 a.m. RN-C explained to R55 that she was going to check the resident's back dressing first.

The admission Minimum Data Set (MDS) dated 2/22/17, indicated R55 had no open areas. The Care Area Assessment (CAA) indicated R55 was at risk for developing pressure ulcers related to prostate cancer, pain, weakness, and deconditioning. R55 had impaired mobility and balance and needed assistance with transfers and ambulation. The CAA also indicated R55 was receiving hospice services for additional care during the end of life process. R55 required extensive assist with bed mobility and incontinent care. R55 was on antipsychotics and antidepressants. In addition, R55 had diagnoses of diabetes, chronic end stage liver, heart disease, and dementia. R55 had a suprapubic catheter and was recently admitted to the facility for inpatient care and hospice care.

On 3/17/17, summary of the hospice visit indicated there was a small red open area mid spine. The hospitc visit notes indicated the nurse had come in and put a Mediplex dressing on it, and would leave a message for case manager (CM), there were no documented measurements. In addition, the notes indicated that on 3/17/17, there was a new open area on right ankle (no measurements).

A Progress Note dated 3/20/17, indicated the following: R55 had a mid-back open area 1 cm round, open but scabbed over. Covered with Mediplex, had a reddened coccyx with one open

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area but scabbed over 2 centimeters (cm) length X .5 cm width, had a right lateral ankle bone .5 cm circle open, covered with Band-Aid, scabbed over, and had a new left heel "mushy", non-blanching, dark colored area approximately 0.3 cm around non opened. Mepilex and heel protectors applied.

On 3/27/17, a hospice note indicated dressing change times for four areas on R55's back and the heel.

R55 had a Progress Note dated 3/29/17, entered as a Late Entry which documented the following: Dressing changes to all open or suspicious areas of skin on 3/28/17. Areas of concern were 1.) 2.2 cm open area on mid back; appears to be larger, dark open are. Cleansed, Mepilex applied. 2.) 2 cm x .5 cm open area on coccyx. Cleansed, Mediplex applied. 3.) Area to lateral right ankle bone healed. 4.) 2 cm unopened, non blanchable, dark circular area on right heel. Foam island dressing and sheepskin heel protectors on. The note the facility would continue to monitor.

R55's care plan revised on 2/26/17, indicated the resident had limited physical mobility related to terminal illness (cancer) evidenced by weakness, deconditioning, pain, impaired mobility and balance. Required staff assistance with mobility by placing equipment nearby and providing weight bearing support. The plan of care did not include interventions for treatment of the coccyx, the mid-back open area on the spine, not had it been updated to include the heel area. The plan of care did not indicate the resident refused cares.

The NA Kardex sheet undated, indicated the

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following: R55 was at high risk for skin injury, use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, keep skin clean and dry, use lotion on dry skin, do not apply on site of injury, and resident needs protection for the feet i.e. sheepskin boots, float heels. The Kardex did not indicate the resident refused to have the heels floated.

During an interview with RN-C on 3/29/17, at 7:14 a.m., R55 was on hospice care for malignant neoplasm of prostate and secondary malignant neoplasm of bone. R55 was admitted to the facility for palliative care on 2/15/17. R55's pain medications were adjusted one week ago by hospice. R55 did not verbalize any longer. R55 had a dressing to an open wound on his mid back over a kyphotic area, one dressing on the coccyx, and on the right heel which was dark in color. R55's dressings were changed on 3/28/17, and there was an order for dressing changes every three days and prn.

LPN-A was interviewed on 3/30/17, at 2:02 p.m. and indicated R55 was more alert that week than last week. When asked about floating the resident's heels, LPN-A stated the resident did not want his feet to float and that the resident liked to sit in the recliner a lot.

The NP-A was interviewed on 3/30/17, at 2:50 p.m. and indicated she had seen R55 for increased pain so she did know the resident. The NP-A was asked if the open areas were avoidable or non-avoidable and the NP indicated the resident started to decline on or about 3/15/17, due to poor nutrition, increased pain, and increased skin breakdown. The NP-A verified that

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R55 was admitted to the facility with no open areas.

The facility's policy on Skin Assessment, Pressure Ulcers, Prevention and Documentation requirements was revised on 4/16. The purpose of this policy were the following: to systematically assess residents with regard to risk of skin breakdown, to accurately document observations and assessments of residents, and to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. "When a pressure ulcer is present, daily monitoring (with accompanying documentation when complication or change is identified) should include the following:
- An evaluation of the ulcer, if no dressing is present
- An evaluation of the status of the dressing; if present (whether it is intact and whether draining, if present, is or is not leaking)
- The status of the area surrounding the ulcer (that can be observed without removing the dressing)
- The presence of possible complications, such as signs of increasing area of ulceration of soft tissue infection(for example, increased redness or swelling around the wound or increased drainage from the wound)."

The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound RN Assessment sheet. If the resident is on Medicare, document daily on the Wound Data Collection sheet with every treatment change. Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the

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F 314	Continued From page 48 following: Measurements - length, width, depth; Characteristics of ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin, etc.; Presence of pain; and Current treatments. Progress toward healing and any modifications to the plan of care/treatments should be assessed and evaluated by the registered nurse. The facility failed to implement interventions to prevent the potential development of pressure ulcers or worsening of the right ankle ulcer for R55. R181's significant change MDS dated 1/2/17, indicated R181 was cognitively intact and had not rejected cares during previous seven days. R181 required extensive assistance of one staff for bed mobility, transfers and toileting and identified R181 was continent of bowel and bladder. R181's MDS indicated R181 did not have any pressure ulcers but was at risk for developing pressure ulcers. R181's MDS indicated R181 had diagnosis of depression, ischemic cardiomyopathy and chronic obstructive pulmonary disease and required continuous oxygen. R181's MDS indicated R181 was on hospice. Progress Note dated 1/15/17, indicated staff, "...found a stage II pressure ulcer [partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater] on the left side of resident's coccyx. Area was cleansed and Mepilex dressing was applied to keep area clean and protected. Writer hss [sic] placed call to Total Care for seniors to report new open area and need for tx [treatment], voicemail was left and nursing is awaiting return call at this time."	F 314		

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F 314	Continued From page 49 The Care Area Assessment (CAA) dated 1/16/17, 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 due to declining health condition. CAA indicated R181 did not have a pressure ulcer. CAA indicated staff would proceed to care planning with goal to avoid complications and minimize risks of pressure ulcers. A Progress Note dated 1/20/17, at 12:42 p.m. indicated, "Writer also needs to update on new open area on coccyx. At this time there are a total of four open areas that are 0.25 x 0.25mm [millimeter] in size. Areas are free of s/sx [signs/symptoms] of infection. Writer has cleaned areas and applied Mepilex dressing to area to cover and keep clean. Resident is resistant to repositioning and will turn herself onto her back when in bed and frequently does not wish to get out of bed. Writer has notified RD [registered dietician] of open areas. Writer will request and air mattress for resident. Awaiting return call at this time." A Progress Note dated 1/20/17, at 1:50 p.m. indicated new orders received from hospice for an air mattress, heel protectors, reposition every one hour and the addition of barrier cream to open areas with dressing changes. The facility care plan printed 3/30/17, was reviewed for period of time from R181's admission on 12/6/16, until R181's death on 1/23/17. The care plan did not include identification of pressure ulcer risk or development of four stage II pressure ulcers. The	F 314		

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care plan lacked any interventions to prevent or treat pressure ulcers.

During interview on 3/30/17, at 3:10 p.m. registered nurse (RN)-B verified a stage II pressure ulcer was first documented on 1/15/17, and that on 1/20/17, three new stage II pressure ulcers were identified. RN-B verified there was no pressure ulcer care plan developed upon admission or when the staff identified the pressure ulcers on 1/15/17, or 1/20/17. RN-B stated an initial care plan would have been opened by the admissions nurse within 24 hours of admission. RN-B said the floor nurses were to update the care plan when they found open areas or risks on the Transitional Care unit. RN-B stated Hospice would typically do a paper care plan and then the facility would scan it into the chart. When asked what is part of the care plan? RN-B said, "The electronic care plan is the only care plan." RN-B said, "I would expect a Wound Data tool to be completed to at least get the assessment done."

During interview on 3/30/17, at 3:35 p.m. director of nurses (DON) said, "I would expect wound assessment to be completed for a patient with a pressure ulcer. I would expect the daily skill notes to reflect wound until healed." DON said, "If a patient is identified at risk for pressure ulcers would expect a care plan to be developed for prevention. I would expect there to be a care plan for a pressure ulcer. The care plan is the electronic one in PCC (an electronic health care record-PointClick Care)." When asked if the care plan includes any other sections of the chart DON said, "No just the care plan section. If they are on hospice I would expect an assessment and care plan. It gets harder to heal wounds if they are on

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hospice. I would expect the care plan to say pressure ulcers are present but not necessarily to indicate goal is to heal the pressure ulcers. The goal is individualized."

During interview on 3/31/17, at 8:51 a.m. RN-C said, "I found the pressure ulcer on January 15. It was a stage II. She was not eating." RN-C said, "It had started out as a reddened bottom because she would not get out of bed. Then she developed four very small open areas. There were two on either side of her coccyx. They were very small. As she got closer to death we did not expect the wounds to heal. I know we encouraged her to get out of bed and to eat but she would not." RN-C said, "I did not think to write the care plan, I was more focused on taking care of her." RN-C verified there should have been a care plan. RN-C said, "The wounds were pressure ulcers, they were over bony prominences." RN-C verified writing the progress notes but said, "I did not do a wound sheet."

During interview on 3/31/17, at 11:23 a.m. the DON said, "All of our mattress are pressure reducing and it will not be on the care plan. If someone is at risk for pressure ulcers we do a skin care plan." Requested DON to find any documentation of interventions to prevent pressure ulcers prior to R181's development of pressure ulcers

During interview on 3/31/17, at 11:54 a.m. the medical director stated physician orders are part of the care plan. The medical director said, "I do wound rounds on a monthly basis and am there weekly. It is unusual for me to be asked to look at pressure ulcers, because we do a good job preventing pressure ulcers."

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F 314	Continued From page 52 R181 was admitted to the facility without pressure ulcers but was identified as at risk for development of pressure ulcers. An individualized plan of care with interventions for prevention was not developed. The first pressure ulcer was identified on 1/15/17, but interventions for the prevention of pressure ulcers worsening or prevention of additional pressure ulcers were not implemented until 1/20/17, after the development of three additional ulcers. R200's admission MDS dated 12/11/16, indicated he required extensive assistance of two staff for bed mobility, transfers and toileting and identified R200 was frequently incontinent of bowel and bladder. A CAA dated 12/17/16, indicated R200 was at risk for pressure ulcers related to dependence on staff for mobility, weakness and frequent incontinence. The CAA did not identify a current pressure ulcer. R200's care plan identified limited physical mobility and an activity of daily living (ADL) self-care deficit and frequent loose stooling and a need for staff assistance. R200's care plan did not address skin condition. A Nursing Admit/ Re-admit Data Collection dated 12/4/16, identified a "red coccyx," but did not include a measurement or an indication if the area was blanchable. The data collection tool further indicated R200 had one of the following: pressure ulcer, venous ulcer, surgical wound, arterial ulcer, diabetic ulcer, surgical wound or suspected deep tissue injury, but did not identify which wound R200 had. A review of R200's Good Samaritan Society Specialty Care treatment record dated December 2016 identified the following treatments initiated on 12/10/16: Cleanse coccyx, pat dry and cover	F 314		

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F 314	Continued From page 53 with Mepiles [sic] Mepilex dressing (an absorbent dressing) daily in the morning for stage I skin breakdown prevention, Cleanse open area on spine with normal saline, pat dry and apply Mepilex dressing daily. A review of R200's Good Samaritan Society Specially Care Community Progress Notes dated 12/12/16 through 1/5/16, identified the following: 12/12/16 - Resident continued to receive skilled 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 1/2/16 - wound on coccyx is 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 cm x .75 cm, open to air and Other; mid back closed wound 0.25 cm x 0.5 cm, open to air.	F 314		

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F 314	Continued From page 54 During an interview on 3/29/17, at 1:37 p.m., RN-E stated residents receive a weekly skin check each week on their bath day. She stated if there was a skin concern, it would show up in an assessment on the electronic record. During an interview on 3/30/17, at 10:33 a.m., 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 have informed her of his skin condition because she was responsible for coding the MDS. The DON 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 and expect a care plan to be developed. While R200 had two separate pressure ulcers, there was no evidence the facility assessed the wounds to include: stage, size, characteristics of the wound bed, surrounding tissue, or progress toward healing, nor was there evidence the facility implemented interventions to prevent worsening of existing ulcers or prevention of new ones.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that -	F 323		5/15/17

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F 323	Continued From page 55 (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices 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 resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rails were assessed for use and maintained in a safe and functional manner for 1 of 3 residents (R243) reviewed for falls. Findings include: R243 was not assessed for the safe use of quarter side rails observed to be loose on the bed. On 3/27/17, at 5:03 p.m. the quarter siderails were observed to be loose on both upper ends of	F 323	On 3/29/2017 the siderails and bed for resident R243 were removed and replaced with a bed with secure pivot assist bar. All side rails and pivot assist bars attached to resident beds were inspected on 3/29/2017. Procedures for reporting equipment issues and completion of work orders will be reviewed with all staff. The Director of Nursing Services and/or	

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F 323	Continued From page 56 R243's bed. The siderails moved approximately 2 inches inward and were not secure to the bed. Review of a Falls Tool assessment dated 3/16/17, indicated R243 was at low risk for falls. R243's record lacked completion of any device assessment for the use of side rails and a medical doctor order indicating the quarter bilateral siderails were to be used for bed mobility. R243 was admitted on 3/16/17, and had diagnoses which included lumbar discitis (inflammation between discs in vertebra of the back), osteomyelitis and arthritis as indicated on the R243's Admission Minimum Data Set (MDS) dated 3/23/17. The MDS indicated R243 was cognitively intact and required assistance of two staff for bed mobility, transfers, toilet use and walking in the room. The Care Area Assessment dated 3/23/17, indicated R243 was at risk for falls due to weakness, deconditioning, and impaired mobility. R243's care plan with revision date of 3/27/17, indicated R243 was at risk for falls and had limited physical mobility due to deconditioning. The care plan directed staff to educate and instruct resident and family on safe use of assistive devices, remind resident not to bend over to pick up dropped items and to encourage R243 to use a grabber or to ask for assistance. During interview on 3/29/17, at 9:29 a.m. R243 stated he used the siderails to help sit up in bed, "but they're wobbly." During interview on 3/29/17, at 9:38 a.m. occupational therapist (OT) stated occupational	F 323	designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 323	Continued From page 57	F 323		

therapy would typically assess for any assistive devices but she did not see the siderails were loose, "I see your concern, and they are wobbly."

During interview on 3/29/17, at 9:41 a.m. registered nurse (RN)-A stated R243 requires and was assessed for a grab bar and will use it to sit up. RN-A stated the bed was in that room when he arrived and probably came with the siderails. At 10:17 a.m. RN-A verified the siderails were loose and moved at least two inches inward, stating "Oh my, that's not good, we will get them switched out immediately."

During interview on 03/29/2017, at 10:19 a.m. environmental assistant (EA)-A stated "Oh wow, that shouldn't be like that" when inspecting and moving both siderails. EA-A stated the bed had a "large frame" and the siderails shouldn't have been on the bed without an oversized mattress. EA-A stated he was not aware nor notified by nursing that the siderails were loose.

During interview on 3/29/17, at 12:06 p.m. the director of nursing (DON) stated "We don't consider it a restraint, its an assist bar" and verified both siderails were loose.

Review of the facility Bed Safety - Including Bed rails/Side Rails/Assist Bars policy with revision date of 11/16, indicated residents were to be assessed for the appropriateness of side rails/specialty mattress/overlays, usage will occur only when medical necessity is documented and that annual inspections will be conducted of all bedframes, mattresses and bed rails (side rails, assist bars and transfer devices) to identify and eliminate any potential entrapment issues and to ensure that bed rails are compatible with the bed

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F 323	Continued From page 58 frame and mattress.	F 323		
F 371 SS=E	483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve food in a sanitary manner for 2 of 6 dining rooms (Arrowhead and Woodlands), failed to follow food safety procedures to minimize the risk of food borne illness which had the potential to affect 84 of 88 residents who were served food out of the kitchen and lacked a system for checking expired	F 371	Dietary DA-A was reeducated on his responsibility for proper food handling and hand washing on 3/30/2017. On 3/27/2017 the uncovered dishes of peaches were disposed of. The drying fan was thrown out on 3/27/2017. The facility had no residents that were using the Two Cal HN, it was in our overflow	5/15/17

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F 371	Continued From page 59 enteral feeding products. Findings include: During observation of a meal service on the Arrowhead unit on 3/27/17, at 5:19 p.m., dietary aide (DA)-A reached into a bag of hamburger buns with his right, un-gloved hand. He then opened a cabinet with the same hand and again reached into the bag of buns, pulled one out and set it on a plate. At 5:28 p.m., DA-A wiped the sweat off his forehead with a rag, using his right hand, placed the rag on a counter and without washing his hands touched a hamburger bun on a resident's plate. During an interview on 3/27/17, at 5:40 p.m., DA-A stated, he had been at the facility for two years and had not been told he needed to wear gloves while serving unless he was serving fruits and vegetable. He then stated, "I'll keep in mind what I'm touching." On 3/29/17, at 8:22 a.m. breakfast service was observed on Arrowwood unit. The server was observed to be wearing a stocking cap, washed his hands prior to the start of the meal service, but during service he touched his apron over his stomach and pushed his glasses up on his face (both with left hand), opened the cabinet to get out foam bowls using both hands and then dished up food again, placing his thumb on the plate food surface. A dietary aide did not wash his hands after touching his apron, his glasses, or opening cupboards and getting out foam bowls prior to serving additional food. During an observation of the Boundary Waters unit on 3/29/17, at 8:27 a.m., DA-A prepared to	F 371	storage awaiting disposal. It was disposed of on 3/30/2017. All Dietary staff will be reeducated by the Director of Dietary Services on the GSS Food Handling Policy and Procedure, GSS Policy and Procedure for Dietary Services Handwashing Techniques, GSS Dining Service Standards Procedure and the GSS Food Transport Procedure. The procedure for Enteral Storage will be reviewed by the Director of Dietary Services with applicable staff. The Director of Dietary Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 371	Continued From page 60	F 371		

serve the breakfast meal. He washed his hands with soap and water, dried his hands on a paper towel, then used the same paper towel to wipe the sweat off his forehead. DA-A left the serving area through a door leading to an adjoining unit, returned, and without washing his hands, picked up a plate and began serving. He reached into a cabinet and pulled out a tray, he then reached into another cabinet and took out a yellow pate. He then wiped the sweat off of his forehead with the back of his hand and reached into another cabinet to get a white basket out. At 8:43 a.m., DA-A sneezed into his apron, holding the apron with his left hand, did not wash his hands, and continued plating food, touching the inside of bowels and holding onto plates with his left hand.

During an interview on 3/30/17, at 11:00 a.m., the director of food and nutrition stated he recently conducted a training on handwashing and cross contamination and stated staff should wash their hands prior to serving. He stated staff should re-wash hands if they leave the unit and come back, if they touch objects such as doors or drawers. The director of food and nutrition further stated staff should not be wiping the sweat off themselves and placing the rag on the counter and if they sneeze into their apron, staff should wash their hands and change their apron.

A facility policy titled Good Samaritan Society Handwashing Technique, dated February 2013, indicated staff will wash their hands as needed to safeguard the health of those who are dependent on their service. Wash hands: when reporting to work, after touching any contaminated object (face, hair, body or clothing), after coughing, sneezing or blowing nose.
Dessert/snack food improperly stored and

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F 371	Continued From page 61 expired tube feeding not properly disposed. During initial kitchen tour on 3/27/17, at 11:45 a.m. the following was observed and confirmed by the foodservice director (FD): A four tier food rack was positioned in the kitchen next to the cook's preparation table. Three of the four racks contained dishes of desserts, the second tier from the bottom contained uncovered dishes of peaches. A commercial speed dryer, heavily soiled with dirt, dust and dark particulate matter was positioned approximately four feet away on the floor, facing and blowing directly on the exposed tray of peaches. FD stated he had not seen the dryer before, "I don't know where it came from." FD verified the heavily soiled floor dryer should not have been blowing directly on the food rack, stating "all food should be covered with parchment paper, a pan or plastic wrap before going up to the floor, its policy." During followup kitchen tour on 3/30/17, at 10:11 a.m. with the FD, the following was observed: In the dry storage central supply room outside of the kitchen area eleven cans of Two Cal HN were observed to have an expiration date of December 2016. At the time of survey, there were four tube fed residents in the facility. FD stated he was not responsible for the enteral feedings in the facility, "I think nursing is." During interview on 3/30/17, at 1:20 p.m. registered nurse (RN)-D stated administration orders the product, she was not sure who was responsible for it, further stating "I think whoever takes in delivery should rotate it." RN-D verified both tube fed residents on the unit did not use the	F 371		

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F 371	Continued From page 62 product. During interview on 3/30/17, at 1:39 p.m. RN-E stated she stocks her own floors, administration orders the product and thought maintenance may put it away. RN-E stated she was not sure who was responsible, but "if I am getting the formula, I check the expiration date, if it's expired I take it off the shelf and get it destroyed." RN-E verified both tube fed residents on Boundary Waters unit did not use the product. During interview on 3/30/17, at 1:56 p.m. registered dietitian (RD) stated if she had a resident on a tube feeding she would go to the storeroom to look at the available tube feeding products and look at the expiration dates before it would go up to the floor. RD stated "we have checks and balances between myself and nursing managers", further stating "I understand" when told about the expired formula. Review of the facility Food Preparation policy dated February 2013 indicated the purpose was to ensure food is kept free of contamination and staff would practice techniques in food preparation that protect against food-borne illness. Review of the facility Food Transport policy with revision date of 2/16 indicated the purpose was to ensure safe practices when transporting food and fluids. The policy indicated "all food items will be covered, labeled and dated." A tube feeding formula policy was requested but not provided.	F 371		
F 431	483.45(b)(2)(3)(g)(h) DRUG RECORDS,	F 431		5/15/17

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F 431 SS=E	Continued From page 63 LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (g) Labeling of Drugs and Biologicals. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. (h) Storage of Drugs and Biologicals. (1) In accordance with State and Federal laws,	F 431		

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F 431	Continued From page 64 the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unauthorized personal were supervised in 1 of 6 medication rooms. This had the potential to affect all 16 residents residing on the unit. Findings include: During an observation on 3/29/17, at 9:09 a.m., registered nurse (RN)-F unlocked the Boundary Waters medication room to allow the environmental assistant (EA) to complete repairs. RN-A left the EA unattended in the medication room, with the door propped open until 9:44 a.m. An observation of the Boundary Waters medication room on 3/29/17, at 9:20 a.m. revealed medications left on baskets on the counter and unlocked in a refrigerator for all 16 residents residing on the unit. The medications accessible to the AE and others while the medication room was left unlocked and unsupervised included, but were not limited to:	F 431	RN-F was reeducated regarding her obligation to ensure the medication storage room is secure and ensure that unauthorized people do not have access on 3/29/2017. All applicable staff will be reeducated the GSS Procedure for Acquisition, Receiving, Dispensing and Storage of Medications. Environmental Services staff will be reeducated that they are only to have access to the medication storage areas in the presence of authorized staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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F 431	Continued From page 65 Seroquel (an atypical antipsychotic), haloperidol (an anti-psychotic medicine used to treat mental and mood disorders), Depakote (used to treat seizure disorders and certain psychiatric conditions), Effexor (an anti-depressant medication) and lorazepam (a benzodiazepine medication used treat anxiety disorders). During an interview on 3/29/17, at 1:11 p.m., RN-F stated only nurses and trained medication aides (TMAs) have access to the medication rooms. She stated non-medical staff should not be going in and out of med rooms or left unattended. RN-F stated she would have to check the regulation on whether or not the EA was allowed to be in the medication rooms. During an interview on 3/29/17, at 1:24 p.m., RN-E stated, only nurses and TMA's are allowed in the medication rooms unsupervised. She stated if a housekeeper goes in the room, nursing she be supervising them. RN-E stated unless supervised by a nurse, the EA should not be left alone in the medication rooms. A facility policy titled Good Samaritan Society Acquisition, Receiving, Dispensing and Storage of Medications, dated September 2016 was reviewed and indicated the following: Once medications are delivered, they will be secured in the appropriate storage area. Medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing the medications and the director of nursing services will be permitted to have access to the medication storage areas.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS	F 441		5/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	03/31/2017

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F 441	Continued From page 66 (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism	F 441		

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F 441	Continued From page 67 involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate hand washing and glove changes during a dressing change from dirty to clean area, and a clean barrier during dressing change for supplies. This practice had the potential to affect 1 of 1 resident (R55) who was observed during a dressing change. In addition, the facility failed to ensure that resident equipment was maintained to allow the surface to be cleaned and prevent potential infection for 1 of 1 resident (R116) that had black electrical tape on the siderails.	F 441	RN-C was reeducated on proper hand washing during treatments and Wound Dressing Change policy on 3/29/2017. The siderails with black electrical tape for resident R116 were removed on 3/30/2017. All side rails were inspected on 3/30/2017 for the presence of electrical tape, none were found. All staff will be reeducated on the policies	

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F 441	Continued From page 68 Findings include: Wound care: Registered nurse (RN)-C came into resident's room with a rolling computer on 3/29/17, at 9:53 a.m. RN-C explained to R55 that she was going to check the resident's back dressing first. The back dressing located over a kyphotic area was dry and intact, dated 3/28. RN-C checked heel left, no gloves used. No open areas. RN-C went into bathroom got one set of gloves. RN-C went to the dressing stand on wheels and got out dressings (gauge) and tape placed on the counter. RN-C then placed the wound cleanser on the resident's blanket. Nursing assistant (NA)-C cleaned out garbage bag that had discarded gloves and an incontinent brief. RN-C used hand sanitized and gloved. RN-C explained to the resident that she was going to do a dressing change to the suprapubic catheter. RN-C touched the outside of dressing package and tape after removing suprapubic catheter dressing which was urine soaked. RN-C did not remove gloves after removing the soiled dressing. RN-C used sterile saline wound cleaner to wipe around opening for catheter using a gauge. No redness noted. RN-C applied the cut dressing she removed from the package, checked tubing, urine started to flow. Gloves removed and placed in plastic lined garbage container. RN-C then took the wound cleansing solution and placed it on the rolling dressing cart. RN-C then left R55's room with the rolling dressing cart with the wound cleanser she used for R55. R55 had a Physician Order on 2/16/17 to change dressing to the suprapubic catheter every night	F 441	for Hand Washing and Wound Dressing Changes by the Director of Nursing Services and/or designee. All staff will be reeducated that black electrical tape is not allowed by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 441	Continued From page 69	F 441		

shift for Prostate cancer.

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 soaked 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 was to promote wound healing and that the wound would remain free of infection. The procedure was as follows:
Check physician's order; review previous assessment and notes; Position resident for comfort and to accommodate dressing change; Put on gloves; Loosen tape from resident's dressing or press down on surrounding skin gently and carefully lift one edge of the dressing from the skin. Continue to carefully lift the edge of the dressing from the skin by moving slowly around the ulcer margins until edges are free; Remove slowly, folding dressing over itself and pulling it in the direction of the hair growth. If the dressing is difficult to remove, loosen edges with a warm, wet cloth; Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene; Create field with equipment/dressing wrappers. Use sterile technique if required; Open all supplies and pour solutions if ordered; Put on gloves; Assess wound and surrounding area to ensure the selection of the appropriate-sized dressing; Cleanse the skin and wound thoroughly with normal saline using gauze wipes, wound

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F 441	Continued From page 70	F 441		

cleanser or ordered antiseptic solution. Clip excess hair at sites needed; Allow the skin to dry completely before applying the dressing. If the resident's skin is fragile, or drainage is expected to go beyond the wound edge, consider applying a skin protection preparation around the wound; Remove dressing from the inner wrapper; avoid finger contact with the dressing. Position the dressing over the wound and press down gently on the skin. Firmer pressure be used on edges depending upon skin condition. Sometimes a rolling motion is helpful. Avoid unnecessary stretching of the dressing; Place all disposable items in plastic bag with dressings, seal and discard according to procedure. Identify time, date, and initials on dressing; Chart dressing change and wound observation on the Wound Data Collection.

Eye drops:
On 3/29/17, at 10:01 a.m. RN-C stated to resident that she was going to put drops in R55's eyes. RN-C applied drops to left eye first which was dry and then put in drops times two to right eye that was reddened and had a buildup of a yellow substance. On 3/29/17, at 10:02 a.m. artificial tears were administered to R55 for eye moisture.

RN-C was interviewed immediately after the dressing change on 3/29/17, at 10:58 a.m. and confirmed RN-C did not wash their hands or utilize hand sanitizer after the wound care and before the eye drops were administered.

Wound cleanser:
RN-C came into resident's room with a rolling computer on 3/29/17, at 9:53 a.m. RN-C explained to R55 that she was going to check the resident's back dressing first. The back dressing

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F 441	Continued From page 71	F 441		

located over a kyphotic area was dry and intact, dated 3/28. RN-C checked heel left, no gloves used. No open areas. RN-C went into bathroom got one set of gloves. RN-C went to the dressing stand on wheels and got out dressings (gauge) and tape placed on the counter. RN-C then placed the wound cleanser on the resident's blanket.

RN-C was interviewed on 3/29/17, at 1:13 p.m. and confirmed that she had brought into R55's room a rolling dressing cart. RN-C said that the top shelf was set up for a computer and the lower shelf was used to put dressing and supplies on the shelf before entering the resident's room. The carts are not room specific. There are three carts but only two of the carts are used because each RN had a cart and there are only two RNs on during a shift. RN-C confirmed the same wound cleanser she used on R55 could be used on another resident because the skin cleanser was on the shelf for dressing change on the cart. The wound cleanser was not disinfected as RN-C had put the wound cleanser on R55's bed and then back on the cart without disinfecting the outside of the container.

Siderails:
R116's room was observed on 3/30/17, at 2:00 p.m. R116's bed had black electrical tape wrapped fully around the bilateral grab bars, which are a highly touched surface. The tape rendered the surface to be hygienically uncleanable.

The director of environmental services (EVS) and the facility administrator was along on the tour and both were not aware of the black electrical tape. It was verified by the administrator the

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F 441	Continued From page 72 surface was no longer a cleanable surface. The EVS the stated he had not been notified of the use of the electrical tape on the bilateral grab bars.	F 441		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 2GLR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245279**

2. STATE VENDOR OR MEDICAID NO. (L2) **138218700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMU**
(L4) **3815 WEST BROADWAY**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **03/31/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 05/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/22/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1985** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

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

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

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:

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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; OR
- 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) AND has a deficiency citation at level "F" or higher on its current health survey or "G" or higher for the current LSC survey.

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

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

- State Monitoring effective 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:

- 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.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	03/31/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 221 SS=D	483.10(e)(1), 483.12(a)(2) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS §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). 42 CFR §483.12, 483.12(a)(2) The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's symptoms. (a) The facility must-	F 221		5/15/17

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

Electronically 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.

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F 221	Continued From page 1 (1) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the use of a bilateral (bilat) thigh positioning device as a potential restraint for 1 of 3 residents (R40) reviewed for restraints. Findings include: On 3/29/17, at 7:20 a.m. R40 was observed seated in a Broda chair (tilt and recline positioning chair) in the hallway. Both of R40's legs were restrained by thigh straps that were secured behind the chair. R40 was leaning forward in the chair with elbows placed on his knees. At 8:41 a.m. trained medication aides (TMAs)-A and C were observed to take R40 to his room in the Broda chair and to readjust his clothing. R40's legs were released from the restraint as the restraint closure was located in the back of the wheelchair (W/C) where R40 could not release the restraint himself. Before taking R40 back out of the room in the Broda chair, the TMA re-applied the restraint to R40's legs. At 10:48 a.m., that same day, R40 was taken to his room again by TMA-A and TMA-C who assisted the resident with toileting and clothing adjustment. The restraint was again released from behind the	F 221	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F221 A Mobilization Data Collection Tool for resident R40 was completed on 4/28/2017 and Physical Device and Restraint Assessment on 5/1/2017 and the care plan updated as appropriate. Resident R40 was picked up on OT case load on 5/1/2017. All residents with bilateral thigh straps will	

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F 221	Continued From page 2 W/C during the care, but re-applied before R40 was taken back out of the room. R40 was admitted to the facility on 10/5/11, according to the Face Sheet, with diagnoses of schizophrenia, dementia with behavioral disturbances, supranuclear palsy (behavioral, cognitive, and gait disturbances). A Physician's Verbal Telephone Order dated 8/29/13, indicated the pelvic device was ok and had back latching for wheelchair safety/positioning. The facility was to discontinue OT (occupational Therapy) services. An OT evaluation dated 3/15/16, indicated R40 "in Broda chair with bilateral thigh pad postural support device which provides a neutral pelvis sitting position to promote independence with wheelchair mobility. Uses BLE [bilateral lower extremities] to propel wheelchair and forward flexion with upper body that results in anterior pelvic posture during wheelchair mobility. Bilateral thigh pads recommended to provide neutral pelvis sitting posture when in wheelchair and promotes upright visual alignment for interaction within environment." The Mobilization Support Data Collection Tool dated 2/25/17, indicated R40 was able to pull himself upright from lying to sitting. Did have enough torso strength to maintain an upright, seated position. R40 had the leg strength to transfer between surfaces, was able to push himself up and rise one to two inches. R40 could stand/sit/stand with limited support. "Used assistive device to transfer, stationary hand hold to pull self-up. Was unable to ambulate." A comment indicated R40 was able to pull self to	F 221	be reassessed by the Nurse Managers for restraint determination and care plans updated as appropriate. The GSS Policy & Procedure for Physical Restraints will be reviewed with all licensed nursing staff by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 221	Continued From page 3	F 221		

standing position when assessed, however staff report that his ability to pull self-upright was inconsistent, and often R40 will not pull himself up or will attempt to grab onto staff and hang on them or want them to lift him. "May need to utilize stand aid (mechanical transfer device) for transfers."

A Physical Devices and Restraint Review assessment dated 2/25/17, indicated: Thigh straps for Broda chair - assists resident in self-propelling chair w/out sliding out of it. A bolded note in the assessment indicated: "If the device, material or equipment cannot be removed easily by the resident and it restricts freedom of movement or normal access to one's own body, then it is a restraint. If the device does not meet this criteria, then it may be used." The facility assessment then asked "is this device a restraint for this resident?" and the facility checked no.

A Good Samaritan Society Specialty Care Community Progress Note dated 2/27/17, indicated R40 had declined in three areas of activities of daily living function since last review. He had been dependent with dressing, toileting and personal hygiene. A quarterly assessment dated 3/2/17, indicated R40 was assessed by physical therapy (PT), but was not felt to be appropriate for therapy. R40 did have a walking program in the past but refused to participate and it was discontinued. Soft back latching bilateral thigh straps to assist with positioning in the chair due to his forceful rocking back and forth using hand rail to propel himself in hallway.

A PT evaluation for patient and nursing safety dated 2/28/17, indicated R40 was assessed for increased difficulty with transfers. "Nonverbal and

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F 221	Continued From page 4	F 221		

non-ambulatory at baseline. Self-propels Broda chair in unit. Demonstrates decreased strength, activity tolerance, safety awareness, and balance affecting transfers and bed mobility. Educated patient and nursing staff on safety with transfers. Recommending use of EZ-Way transfer for safety due to decreased BUE [bilateral upper extremity] and BLE."

The significant change Minimum Data Set (MDS) dated 3/2/17, indicated R40 had no restraint use. R40 was noted to have severe cognitive loss, needed assist for transfers to and from the toilet and bed. R40 displayed behavioral symptoms of grabbing, hitting, and pacing in wheelchair. R40 was at risk for falls.

The care plan revised 3/28/17, (during survey), indicated R40 was resistive to care and had a history of striking out during cares. R40 was at risk for falls was impulsive and unaware of safety risks. Had impaired judgement, impaired sitting and standing balance, gait disturbance. Had a remote history of frequent falls, laying on landing strip (mat) next to bed and crawling on the floor. An intervention of Broda chair with bilateral thigh straps when up. R40 was dependent on staff for activities, cognitive stimulation, and social interaction. R40 had impaired cognitive function or impaired thought process, was unable to make needs known and wandered. R40 had bowel incontinence, irregular bowl habits and was unable to verbalize need to use toilet. R40 had a self-care deficit and needed assist for dressing, grooming, bathing, eating, bed mobility and transfers.

The nursing assistant (NA) care sheet printed 3/30/17, directed staff to use the Broda chair with

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F 221	Continued From page 5	F 221		

front, side, and rear tip bars, and bilateral thigh positioning device. Staff were to check every 30 minutes and release every two hours and off load/reposition and offer toileting.

On 3/29/17, at 2:10 p.m. registered nurse (RN)-F, indicated R40 used to propel himself by planting the heels and pulling forward, he was sliding around in his chair a lot, and kept falling out of chair. The thigh straps were considered a mobility aide, so he can self-propel without sliding out of the chair." RN-F reviewed the restraint form wording and stated "I was told therapy classified it as a positioning tool."

On 3/29/17, at 2:45 p.m. RN-E stated R40 used thigh straps for self-propelling in Broda chair. RN-E stated in the facility it was not considered a restraint because he cannot stand up by himself consistently. By having R40 use the thigh straps it afforded him a high level of mobility, the reason they were using the EZ stand was because he was pulling at staff, and the policy in the facility was safety of the staff as well. RN-E was asked if he could release the thigh straps himself and stated no, but it was not assessed as a restraint in the facility.

On 3/30/17, at 3:00 p.m. the director of nursing (DON) was interviewed and stated bilateral thigh straps were considered a positioning device.

The facility's Physical Restraints Procedure dated 11/16, included: "To ensure appropriate use of restraints: Physical Restraints - any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or

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F 221	Continued From page 6 normal access to one's own body. Physical restraints may include, but are not limited to, hand mitts soft ties, vests, lap cushions, lap trays and side rails that the resident cannot remove. Also included as restraints are location practices that meet the definition of a restraint, such as: Using devices in conjunction with a chair such as trays, tables and belts that prevent a resident from rising." R40 had both legs restrained and the facility did not assess the leg straps as a potential restraint.	F 221		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents choices for bathing preferences were honored for 1 of 3 residents (R246). Findings include:	F 242	Resident R246 no longer resides in the facility as of 4/11/2017. Systemic changes were made to ensure that bathing preferences are accurately transferred to bath schedules. And all applicable staff will be retrained on this	5/15/17

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F 242	Continued From page 7 R246 was admitted to the facilities post-acute care unit on 3/22/17, with diagnoses of spinal fracture with repair, insomnia, and recent fall per the Admission Face Sheet. A nursing admit-readmit Data Collection dated 3/22/17, indicated R246 would like to have two showers a week, during the day shift. A nursing assistant care sheet dated 3/22/17, indicated resident needed assist of one staff with bathing. An initial care plan dated 3/22/17, indicated R246 had a self-care performance deficit related to recent hospitalization, falls, subdural hematoma (blood between the brain and lining (dura), and spinal fracture at thoracic-8. R246 had poor balance and needed for brace when out of bed. An intervention of bathing assist of one staff, did not indicate how often R246 was to receive a shower. On 3/28/17, at 9:26 a.m. R246 was interviewed and stated he had not yet received a shower (six days after admission), and he had asked for two showers a week. On 3/30/17, at 8:38 a.m. registered nurse-G stated R246 was on the bath schedule for Wednesday's and was not scheduled for a second day. On 3/30/17, at 3:00 p.m. the director of nursing verified staff should be transferring data from the admission (nursing admission data collection) and R246 should have been scheduled for two showers a week.	F 242	process by the Director of Nursing Services and/or designee. The GSS Policy and Procedure regarding Resident Dignity will be reviewed with the appropriate staff by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 242	Continued From page 8 The policy Resident Dignity dated 2/17, indicated: Ideas for maintaining a resident's dignity may include, but not be limited to: "a. Grooming residents as they wish to be groomed."	F 242		
F 246 SS=D	483.10(e)(3) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES 483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: (e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure a call light was within reach for 1 of 35 residents (R243) who did not have the call light in reach, was dependent on staff to move in the room and was at risk for falls. In addition, the facility failed to ensure a helmet fit properly for 1 of 2 residents (R135) who was reviewed for use of helmet. Findings include: R243 was observed on 3/27/17, at 4:39 p.m. sitting upright in a recliner situated approximately four feet from the edge of R243's bed. The call light was lying across the bed. R243 was unable to reach the call light but stated he can and does use it when he needs help. R243's admission Minimum Data Set (MDS) dated 3/23/17, indicated R243 was cognitively	F 246	Call light for resident R243 was placed within reach on 3/27/17, upon notification by the surveyor. The helmet order for R135 was discontinued by the resident□s primary physician on 4/25/2017. All residents were reviewed for call light placement on 3/31/2017 and adjusted if needed. All residents were reviewed on 5/1/2017 and there are no other residents with helmets in the facility. All staff will be reeducated on call light procedure by Director of Nursing Services and/or designee. The Occupational therapy staff that are responsible for assessment of helmets will be reeducated by the Rehab Coordinator regarding their responsibility to assess for proper helmet fit and condition.	5/15/17

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F 246	Continued From page 9 intact and required assistance of two staff for bed mobility, transfers, toilet use and walking in the room. The Care Area Assessment (CAA) dated 3/23/17, indicated R243 was at risk for falls due to weakness, deconditioning, and impaired mobility. R243's care plan with revision date of 3/27/17, indicated R243 was at risk for falls and staff was to encourage R243 to use a grabber or to ask for assistance. During interview on 3/31/17, at 10:44 a.m. registered nurse (RN)-A stated R243 was "capable and does use the call light", but could not get up on his own to reach it if it was not near him. During interview on 3/31/17, at 10:50 a.m. the administrator stated it was an expectation that the call light would be within reach for any resident that needed it, unless they are capable of moving around the room on their own. The facility Call Light policy dated September 2012, indicated the purpose was to ensure resident always has a method of calling for assistance and directed staff "When leaving the room, place call light within easy reach of resident if in bed. If out of bed, stretch call light cord across bed so resident is able to reach it." R135 was observed on 3/27/17, at 5:27 p.m., sitting in a Broda chair at the dining room table before dinner wearing a pink helmet. The helmet was observed to fit so it was positioned down over the resident's eyes and R135 kept trying to push the helmet up. Due to continuous erratic movements with her hands and arms, the resident was unsuccessful. Prior to assistance with eating, trained medication aide (TMA)-D	F 246	The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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removed R135's helmet. After the evening meal was complete, TMA-D was observed to put the helmet back on R135 at 6:44 p.m. and once again, the helmet came down over the resident's eyes and R135 tried to unsuccessfully push the helmet up so it would not come down over the resident's eyes.

R135 was observed, 3/29/17, at 7:40 a.m., sitting in a Broda chair in the dining room. The pink helmet was attached to the back of the Broda chair. R135 was observed to have multiple uncontrolled movements with her legs and arms and moved her upper torso back and forth and her hands were in constant motion. R135 did not try to get out of the Broda chair.

R135 was observed throughout the day shifts on 3/29/17 and 3/30/17, sitting in a Broda chair with the pink helmet hooked to on the back of the Broda chair both at the dining room table and in her room. R135 did not wear the helmet and made no attempts to get out of the Broda chair.

R135 was observed on 3/31/17, at 9:48 a.m. in her room seated in the Broda chair, the pink helmet was hooked on the back of the chair. R135 was observed to have multiple arm and leg movements but did not attempt to get out of the chair.

A Physician's Order for R135's care dated 1/14/15, included "ok for soft helmet."

The care plan initiated on 1/14/15 and revised on 3/17/15, read R135 had limited physical mobility and risk for falls related to Huntington's, unsteady gait, and history of falls. The safety intervention was to apply a soft helmet, assist and encourage

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to wear.

The Progress Note, 3/6/17, for the MDS, "Does wear a soft helmet to help protect head." R135 has been seen 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 seen 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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F 246	Continued From page 12 initially but needed to be reassessed again. The occupational therapist-A was interviewed on 3/30/17, at 10:42 a.m. and confirmed R135 was admitted to the facility with a helmet. Occupational therapist-A shared the assessment that was completed by occupational therapy (OT) on admission. The OT assessment done on 12/18/20 (had year wiped out), indicated R135 wore a helmet and was a fall risk. The assessment failed to indicate the condition and fit of the helmet. TMA-C was interviewed on 3/31/17, at 9:52 a.m. and confirmed R135 can only push it up when it was covering her eyes. In addition, when the helmet touched the bridge of the nose, the nose will get red.	F 246		
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS (b) Comprehensive Assessments (1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural	F 272		5/15/17

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F 272	Continued From page 13 problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess the use of a bilateral (bilat) thigh 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.	F 272	A Mobilization Data Collection Tool for resident R40 was completed on 4/28/2017 and Physical Device and Restraint Assessment on 5/1/2017. Resident R40 was picked up on OT case load on 5/1/2017. Resident R243 had a Physical Device and Restraint Assessment done on 3/29/2017.	

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F 272	Continued From page 14 Findings include: Bilateral thigh device: R40 was admitted to the facility on 10/5/11, with admission diagnoses of schizophrenia, dementia with behavioral disturbances, supranuclear palsy (behavioral, cognitive, and gait disturbances). On 3/29/17, at 7:20 a.m. R40 was sitting in the hallway, both legs were restrained in a Broda chair (tilt and recline positioning wheelchairs (W/C), and he was leaning forward in the chair. On 3/29/17, at 8:41 a.m. trained medication aides (TMAs)-A and C took R40 to his room and readjusted the clothing. R40's legs were released from the restraint as the restraint closure was located in the back of the W/C where R40 could not reach the closure to release the restraint himself. Before R40 left the room the TMA re-applied the restraint. On 3/29/17, at 10:48 a.m. R40 was taken to his room By TMA-A and C for toileting and clothing adjustment. The restraint was again released from behind the W/C. Before R40 left the room the TMA re-applied the restraint. A Physician's Verbal Telephone Order dated 8/29/13, indicated a pelvic device was approved with a back latching for wheelchair safety/positioning. The facility was to discontinue OT (occupational Therapy) services. An OT evaluation dated 3/15/16, indicated R40 "in Broda chair with bilateral thigh pad postural support device which provides a neutral pelvis sitting position to promote independence with wheelchair mobility. Uses BLE [bilateral lower extremities] to propel wheelchair and forward flexion with upper body that results in anterior	F 272	All residents with bilateral thigh straps will be reassessed for restraint determination and care plans updated as appropriate by the Nurse Management staff. All residents with side rails will be reviewed by the Nurse Managers to ensure restraint determination and care plans are accurate. All staff with responsibility for MDS were retrained by the Director of Nursing Services on 4/25/2017. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations	

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pelvic posture during wheelchair mobility. Bilateral thigh pads recommended to provide neutral pelvis sitting posture when in wheelchair and promotes upright visual alignment for interaction within environment."

The Mobilization Support Data Collection Tool dated 2/25/17, indicated R40 was able to pull himself upright from lying to sitting. R40 did have enough torso strength to maintain an upright, seated position. R40 had the leg strength to transfer between surfaces, was able to push himself up and rise 1-2 inches. R40 could stand/sit/stand with limited support. "Used assistive device to transfer, stationary hand hold to pull self-up. Was unable to ambulate." A comment indicated R40 was able to pull self to standing position when assessed, however staff reported his ability to pull self-upright was inconsistent, and often R40 would not pull himself up or would attempt to grab onto staff and hang on them or want them to lift him. "May need to utilize stand aid for transfers."

A Physical Devices and Restraint Review assessment dated 2/25/17, indicated thigh straps for Broda chair - assists resident in self-propelling chair w/out sliding out of it. A bolded note in the assessment indicated: "If the device, material or equipment cannot be removed easily by the resident and it restricts freedom of movement or normal access to one's own body, then it is a restraint. If the device does not meet this criteria, then it may be used." The facility assessment then asked "is this device a restraint for this resident?" and the facility checked no. However the resident was not able to remove the thigh straps [restaint] himself.

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A Good Samaritan Society Specialty Care Community Progress Note dated 2/27/17, indicated R40 had declined in three areas of activities of daily living (ADL) function since last review. He had been dependent with dressing, toileting and personal hygiene. A quarterly assessment dated 3/2/17, indicated R40 was assessed by physical therapy (PT), but was not felt to be appropriate for therapy. R40 did have a walking program in the past but refused to participate and it was discontinued. Soft back latching bilateral thigh straps to assist with positioning in the chair due to his forceful rocking back and forth using hand rail to propel himself in hallway. Those remained appropriate.

A PT evaluation for patient and nursing safety dated 2/28/17, indicated R40 was assessed for increased difficulty with transfers. "Nonverbal and non-ambulatory at baseline. Self-propels Broda chair in unit. Demonstrates decreased strength, activity tolerance, safety awareness, and balance affecting transfers and bed mobility. Educated patient and nursing staff on safety with transfers. Recommending use of EZ-Way transfer for safety due to decreased BUE [bilateral upper extremity] and BLE."

The significant change Minimum Data Set (MDS) dated 3/2/17, indicated R40 had no restraint use. R40 was noted to have severe cognitive loss, needed assist for transfers to and from the toilet and bed. R40 displayed behavioral symptoms of grabbing, hitting, and pacing in wheelchair. R40 was at risk for falls.

The care plan revised 3/28/17, (during survey), indicated R40 was resistive to care and had a history of striking out during cares. R40 was at

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risk for falls was impulsive and unaware of safety risks. Had impaired judgement, impaired sitting and standing balance, gait disturbance. Had a remote history of frequent falls, laying on landing strip (mat) next to bed and crawling on the floor. An intervention listed of Broda chair with bilateral thigh straps when up.

The nursing assistant (NA) care sheet printed 3/30/17, directed staff to use the Broda chair with front, side, and rear tip bars, and bilateral thigh positioning device. Staff were to check every 30 minutes and "release every two hours" and off load/reposition and offer toileting.

On 3/29/17, at 2:10 p.m. registered nurse (RN)-F, indicated R40 used to propel himself by planting the heels and pulling forward, he was sliding around in his chair a lot, and kept falling out of chair. The thigh straps were considered a mobility aide, so he can self-propel without sliding out of the chair." RN-F reviewed the restraint form wording and stated "I was told therapy classified it as a positioning tool."

On 3/29/17, at 2:45 p.m. RN-E stated R40 used thigh straps for self-propelling in Broda chair, because he used to slide out of the W/C with his forceful movements. RN-E stated "in the facility it was not considered a restraint because he cannot stand up by himself consistently."By having R40 use the thigh straps it afforded him a high level of mobility. RN-E was asked if he could release the thigh straps himself and stated no, "but it was not assessed as a restraint in the facility."

On 3/30/17, at 3:00 p.m. the director of nursing (DON) was interviewed and stated bilateral thigh straps were considered a positioning device.

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The Physical Restraints Procedure dated 11/16, indicated, "To ensure appropriate use of restraints: Physical Restraints - any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove easily that restricts freedom of movement or normal access to one's own body. Physical restraints may include, but are not limited to, hand mitts soft ties, vests, lap cushions, lap trays and side rails that the resident cannot remove. Also included as restraints are location practices that meet the definition of a restraint, such as: Using devices in conjunction with a chair such as trays, tables and belts that prevent a resident from rising."

Siderails:
R243 was admitted on 3/16/17, and had diagnoses which included lumbar discitis (inflammation between discs in vertebra of the back), osteomyelitis and arthritis as indicated on the R243's admission MDS dated 3/23/17. The MDS indicated R243 was cognitively intact and required assistance of two staff for bed mobility, transfers, toilet use and walking in the room. The Care Area Assessment dated 3/23/17, indicated R243 was at risk for falls due to weakness, deconditioning, and impaired mobility. R243's medical lacked evidence of an assessment for siderails.

On 3/27/17, at 5:03 p.m. the quarter siderails were observed to be loose on both upper ends of R243's bed. The siderails moved approximately two inches inward and were not secure to the bed.

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F 272	Continued From page 19 R243's record lacked completion of any device assessment for the use of side rails and a medical doctor order indicating the quarter bilateral siderails were to be used for bed mobility. During interview on 3/29/17, at 9:38 a.m. OT stated occupational therapy would typically assess for any assistive devices but she did not see the siderails were loose, "I see your concern, and they are wobbly." During interview on 3/29/17, at 9:41 a.m. RN-A stated R243 required and was assessed for a grab bar and will use it to sit up. RN-A stated the bed was in that room when he arrived and probably came with the siderails. At 10:17 a.m. RN-A verified the siderails were loose and moved at least two inches inward, stating "oh my, that's not good, we will get them switched out immediately." During interview on 3/29/2017, at 10:19 a.m. environmental assistant (EA)-A stated "oh wow, that shouldn't be like that" when inspecting and moving both siderails. EA-A stated the bed had a "large frame" and the siderails shouldn't have been on the bed without an oversized mattress. EA-A stated he was not aware nor notified by nursing that the siderails were loose. During interview on 3/29/17, at 12:06 p.m. the DON stated "we don't consider it a restraint, it's an assist bar" and verified both siderails were loose and that there was no siderail assessment.	F 272		
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED	F 278		5/15/17

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F 278	Continued From page 20 (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (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 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure an accurate Minimum Data Set (MDS) was completed for 1 of 3 residents R200 reviewed for pressure ulcers.	F 278	Resident R200 was discharged from the facility on 1/14/2017. The MDS for resident R200 was modified on 4/28/2017 to include pressure ulcer.	

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F 278	Continued From page 21 Findings include: R200's admission MDS dated 12/11/16, indicated R200 did not have a pressure ulcer stage I or greater. A Care Area Assessment (CAA) dated 12/17/16, indicated R200 was at risk for pressure ulcers related to dependence on staff for mobility, weakness and frequent incontinence. The CAA did not identify a current pressure ulcer. A discharge - return anticipated MDS dated 12/20/17, indicated no pressure ulcers and an entry tracking record MDS dated 12/23/17 also indicated no pressure ulcers present. A discharge MDS dated 1/14/17, indicated R200 did not have a pressure ulcer, stage I or greater. A Nursing Admit/ Re-admit Data Collection dated 12/4/16, identified a "red coccyx." The data collection tool further indicated R200 had one of the following: pressure ulcer, venous ulcer, surgical wound, arterial ulcer, diabetic ulcer, surgical wound or suspected deep tissue injury, but did not identify which wound R200 had. A review of R200's Good Samaritan Society Specialty Care treatment record dated December 2016 identified the following treatments initiated on 12/10/16: Cleanse coccyx, pat dry and cover with Mepiles [sic] Mepilex dressing (an absorbent foam dressing) daily in the morning for stage I skin breakdown prevention, Cleanse open area on spine with normal saline, pat dry and apply Mepilex dressing daily. A review of R200's Good Samaritan Society Specially Care Community Progress Notes dated 12/12/16 through 1/5/16, identified the following: 12/12/16 - Resident continued to receive skilled	F 278	Documentation for all residents will be reviewed to ensure that identified pressure ulcers are appropriately assessed, documented and that information is coded accurately on the MDS by the Nurse Managers. All staff with responsibility for wound management will be retrained on the protocols for wound assessment and documentation by the Director of Nursing Services and/or designee. All staff with responsibility for completing the MDS were retrained by the Director of Nursing Services on 4/25/2017. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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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, 1/2/16 - 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 should have informed her of his skin condition 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

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F 278	Continued From page 23 and expect a care plan to be developed. While R200 had two separate pressure ulcers, one identified on admission and one identified on 12/10/16, both documented through the time of discharge, the facility coded the MDS inaccurately four separate times.	F 278		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not	F 279		5/15/17

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F 279	Continued From page 24 provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement interventions to prevent the development of pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for 1 of 1 resident (R181) identified as at risk for pressure ulcers.	F 279	Resident R181 is no longer in the facility as of 1/23/2017; during their stay, the plan of care was amended on 1/17/2017 to include a mepilex dressing, change every 3 days. And on 1/20/2017 to include the following interventions: a low-air loss mattress, heel protectors to wear at all times when in bed, reposition every hour as resident allows, cover open areas with	

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F 279	Continued From page 25 Findings include: R181's hospice care plan dated 12/28/16, did not address pressure ulcer risk or development but did instruct home health aide to, "Assist patient with lotion on body gentle massage to back feet and arms, observe and report skin changes, nail care and foot care." The Facility care plan printed 3/30/17, was reviewed for period of time from R181's admission on 12/6/16, until R181's death on 1/23/17. The care plan did not include identification of pressure ulcer risk or development of four stage II pressure ulcers (partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater). The care plan lacked any interventions to prevent or treat pressure ulcers. R181's admission Minimum Data Set (MDS) dated 12/13/17, indicated R181 was cognitively intact and had not rejected cares during previous seven days. R181 required extensive assistance of one staff for bed mobility, transfers and toileting and identified R181 was continent of bowel and bladder. R181's MDS indicated R181 did not have any pressure ulcers but was at risk for developing pressure ulcers. R181's MDS indicated R181 had diagnosis of depression, ischemic cardiomyopathy (decreased ability of the heart to pump blood to the body) and chronic obstructive pulmonary disease (a disease of the lungs that reduces air flow to the lungs) and required continuous oxygen. 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	F 279	small amount of barrier cream and apply mepilex dressing. Care plans for all residents with potential for skin integrity issues were reviewed and modified as needed by the Nurse Management staff on 4/28/2017. GSS Care Plan Policy and GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements will be reviewed by the with all appropriate staff by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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staff assistance with bed mobility. CAA indicated R181 did not have a pressure ulcer. The CAA indicated pressure ulcer care plan would be developed and R181 would continue to participate in therapy to become stronger with a goal of discharging home.

A Progress Note dated 1/15/17, indicated staff, "...found a stage II pressure ulcer on the left side of resident's coccyx. Area was cleansed and Mepilex dressing was applied to keep area clean and protected. Writer hss [sic] placed call to Total Care for seniors to report new open area and need for tx [treatment], voicemail was left and nursing is awaiting return call at this time."

A Progress Note dated 1/20/17, at 12:42 p.m. indicated, "writer also needs to update on new open area on coccyx. At this time there are a total of 4 open areas that are 0.25 x 0.25 mm [millimeter] in size. Areas are free of s/sx [signs/symptoms] of infection. Writer has cleaned areas and applied Mepilex dressing to area to cover and keep clean. Resident is resistant to repositioning and will turn herself onto her back when in bed and frequently does not wish to get out of bed. Writer has notified RD [registered dietician] of open areas. Writer will request and air mattress for resident. Awaiting return call at this time."

A Progress Note dated 1/20/17, at 13:50 p.m. indicated new orders received from hospice for an air mattress, heel protectors, reposition every one hour and the addition of barrier cream to open areas with dressing changes.

During interview on 3/30/17, at 3:10 p.m. registered nurse (RN)-B verified a stage II

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pressure ulcer was first documented on 1/15/17, and that on 1/2017, three new stage II pressure ulcers were identified. RN-B verified there was no pressure ulcer care plan developed upon admission or when the staff identified the pressure ulcers on 1/15/17, or 1/20/17. RN-B stated an initial care plan would have been opened by the admissions nurse with in 24 hours of admision. RN-B said the floor nurses were to update the care plan when they found open areas or risks on the Transitional Care unit. RN-B stated Hospice would typically do a paper care plan and then the facility would scan it into the chart. When asked what is part of the care plan? RN-B said, "The electronic care plan is the only care plan."

During interview on 3/30/17, at 3:35 p.m. director of nurses (DON) said, "If a patient is identified at risk for pressure ulcers would expect a care plan to be developed for prevention. I would expect there to be a care plan for a pressure ulcer. The care plan is the electronic one in PCC." When asked if the care plan includes any other sections of the chart DON said, "No just the care plan section. If they are on hospice I would expect an assessment and care plan. It gets harder to heal wounds if they are on hospice. I would expect the care plan to say pressure ulcers are present but not necessarily to indicate goal is to heal the pressure ulcers. The goal is individualized."

During interview on 3/31/17, at 8:51 a.m. RN-C said, "I found the pressure ulcer on January 15. It was a stage II. She was not eating." RN-C said, "It had started out as a reddened bottom because she would not get out of bed. Then she developed four very small open areas. There were two on either side of her coccyx. They were very small. As she got closer to death we did not

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F 279	Continued From page 28 expect the wounds to heal. I know we encouraged her to get out of bed and to eat but she would not." RN-C said, "I did not think to write the care plan, I was more focused on taking care of her." RN-C verified there should have been a care plan. RN-C said, "The wounds were pressure ulcers, they were over bony prominences." During interview on 3/31/17, at 11:23 a.m. the DON said, "All of our mattress are pressure reducing and it will not be on the care plan. If someone is at risk for pressure ulcers we do a skin care plan." During interview on 3/31/17, at 11:54 a.m. the medical director stated that physician orders are part of the care plan." The facility care plan printed 3/30/17, was reviewed for period of time from R181's admission on 12/6/16, until R181's death on 1/23/17. The care plan did not include identification of pressure ulcer risk or development of four stage II pressure ulcers. The care plan lacked any interventions to prevent or treat pressure ulcers.	F 279		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care.	F 282		5/15/17

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F 282	Continued From page 29 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 (R40) was kept free of nasal discharge and had his hands cleaned after personal self-touch and 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 dementia with behavioral symptoms. His quarterly Minimum Data Set (MDS) dated 12/29/16, indicated he was severely cognitively impaired and displayed behaviors directed toward others and verbal behavioral symptoms. R59 care plan dated 1/20/17, identified a sleep/wake cycle disturbance, and behaviors that included physical aggression, hitting, pushing and loud disruptive singing. The care plan directed staff to minimize behavior problems with the following interventions: If awake early, give R59 breakfast as soon as food was available, go to another unit if needed. The care plan further directed staff to offer music and the use of head phones as a diversion and administer medications as ordered. During observations on 3/29/17, at 7:26 a.m., R59 was seated in the dining room making intermittent non-sensical noises. At 7:57, R59 returned to the dining room table after getting dressed. He had a coffee cup in front of him, he	F 282	Resident R59 care plan was modified on 4/28/2017. Appropriate staff will be reeducated by the Director of Nursing Services and/or designee regarding following resident R59 care plan interventions and their responsibility to inform the Nurse Manager if and when those interventions are ineffective. Resident R40 has seasonal allergic rhinitis; his medication for allergies was changed to a more effective medication on 4/1/2017. NA-B and NA-C were reeducated regarding appropriate hand and face hygiene for resident R40 on 3/29/2017. Resident R55 no longer resides in the facility as of 4/12/2017. The care plans of all residents with dementia were reviewed by the Nurse Manager. Staff caring for patients with dementia were reeducated by the Nurse Manager regarding their obligation to follow care plan interventions and to inform the her if and when those interventions are ineffective. NA-B and NA-C were reeducated specifically on 5/1/2017 regarding pulling back the foreskin to wash the penis when performing male pericare. All staff will be reeducated on the GSS Care Plan Policy, staff obligation to respond appropriately to nasal discharge and the GSS Policy and Procedure for Perineal Care by the Director of Nursing Services and/or designee.	

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F 282	Continued From page 30 was clapping his hands and calling out, swearing repeatedly. At 7:59 a.m., a staff member ambulated past R59. R59 called out "hey," the staff member did not acknowledge R59 who then swore. At 3/29/17, at 8:18 a.m., R59 remained at the table singing, yelling out and swearing. At 8:33 a.m., staff began serving breakfast to other residents, however, R59 had not yet received any food. At 8:39 a.m., R59 continued to yell out and clap his hands. Staff served R59 his breakfast at 8:43 a.m., one hour and 27 minutes after R59 was seated at the table. R59 ate his breakfast quietly, calling out once for scrambled eggs. At 8:56 a.m., staff escorted R59 back to his room where he was yelling with the door shut. He continued to yell until 9:33 a.m. During a second observation on 3/29/17, at 1:19 p.m., R59 was in his room with the door open. He was calling out loudly. R59 was sitting on his bed, there was no music playing in his room and he was not wearing head phones as directed in his plan of care. During observations on 3/30/17, at 8:53 a.m., R59 sat at a table in the dining room yelling out and clapping his hands. Staff was setting up the meal, however R59 did not have any food. The residents on the adjoining unit had already eaten breakfast. At 9:09 a.m., R59 finished eating his meal and started yelling out, "hey." At 9:12 a.m., staff escorted R59 to his room where he continued to yell out. At 9:19 a.m., R59 was observed lying in bed. The lights were on and the blinds were open. No music was on and no head phones were present. He continued to yell out. During an interview on 3/30/17, at 9:23 a.m., nursing assistant (NA)-A stated R59 can be very agitated sometimes. She stated he gets very loud and was hard to re-direct. NA-A stated she	F 282	The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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brought R59 to his room, but he came right back out. She stated he has a radio in his room and staff are supposed to put music on for him and stated it calms him down. She stated she had not offered him any music that day.

During an interview on 3/30/17, at 9:43 a.m., registered nurse (RN)-F stated R59 made a lot of noise. She stated he wandered a lot and was difficult to re-direct. RN-F stated R59 would wake up too early and wanted breakfast right away. She stated he was usually up at 6:30 a.m., when she got there and stated she brought him coffee and if they have granola bars left over from the night before she would offer him one. She stated she was not aware staff were supposed to offer him breakfast as soon as it was available, but stated R59 liked music and sometimes staff would put it on for him. RN-f stated she did not think R59 head phones were working.

During an observation on 3/30/17, at 12:40 p.m., R59 was in the dining room. He was wearing his headphones and humming to himself while he ate his lunch. R59 displayed no signs of agitation.

During an interview on 3/30/17, at 2:46 a.m., RN-E stated R59 was up at 6:00 a.m., that morning and stated staff should offer him food when he was up early. She further stated when R59 was agitated staff should offer his headphones or music in his room. She stated even if the headphones were not working, they helped to cancel out excess noise.

During an interview on 3/30/17, at 2:46 a.m., the director of nursing (DON) stated staff should be using the interventions in place on the plan of care.

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A facility policy was requested but not received.
Hygiene:
R40 was observed on 3/29/17, at 7:20 a.m. sitting in the hallway, he was leaning forward in the chair, clear thick mucus was running out of his nose, and R40 pushed the mucous into his mouth. At 7:35 a.m. R40 was self-propelling across the unit. Mucous continued to drain from his nose. At 7:38 a.m. staff assisted R40 to eat, he continued to have mucous drain from his nose. At 8:41 a.m. NA-B and NA-C took R40 to his room, and released the restraint from behind the chair, assisted with brief using the EZ stand. R40 was able to pull himself upright without the assist of the EZ stand. R40 repeatedly removed his right hand from the EZ lift assist handle and pushed mucous into his mouth. When he was receiving peri-care R40 touched and scratched his penis, and then pulling mucous from his nose he put his hand into his mouth. At 10:48 a.m. R40 was taken to his room to change brief by NA-B and NA-C. Cares were provided, R40 again scratched his penis, and then lifted his hand to pull mucous from his nose and put his right hand into his mouth. NA-B said they would wash his hands when they get him back in the chair. R40 had his hands washed, NA-B and NA-C verified R40 had touched his penis, put his hand in his mouth, and that mucous draining was also being put into his mouth, NA-B and NA-C also verified he had done that in the cares provided at 8:41 a.m. as well. NA-C then washed his face.

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

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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 checked and found to be saturated with urine. The incontinent product under the resident was also wet and but absent of stool. NA-C ungloved and left the room to inform the nurse that the suprapubic catheter dressing was wet and the dressing needed to be changed. NAR-B got a wash cloth to clean the perineal and buttock area. NA-B only slightly washed over the penis and perineal area, she did not pull back the foreskin to wash. R55's penis was observed for

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reddened areas and open areas and there was none. The left hip area was reddened over the bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m.). NA-B removed her gloves and put a new set on before applying a barrier cream to scrotal area. The two NAs worked together to put the resident's brief put on.

R55's plan of care dated 2/16/17, indicated R55 was a total assist of one with hygiene.

R55's Minimum Data Set dated 2/22/17, indicated R55 recently had a urinary tract infection in the last thirty days and required extensive assistant with hygiene. R55 was also had severe memory impairment and had diagnoses of dementia and begin prostatic hyperplasia.

Registered nurse (RN)-C was interviewed immediately after the dressing change 3/29/17, at 10:58 a.m. and confirmed the NAs should have withdrew the foreskin to completely cleanse male genitals.

The director of nursing (DON) was interviewed on 3/30/17, at 10:00 a.m. and confirmed the aides are supposed to wash the penis and perineal area according to the facility's policy. If the aides are just washing over the area quickly that was not the correct way of washing a male patient.

The facility's policy on Perineal Care, revised 5/16 indicated the purpose of the procedure was to: keep the perineal area clean, to prevent infection and odors in the perineal area, to promote good perineal hygiene, and to observe perineal area. The procedure for male care read as follows: 'Grasp penis gently with one hand and wash.

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Begin at meatus and wash in a circular motion toward the base of the penis; If resident is not circumcised, draw foreskin back. Be sure entire penis is washed. Rinse thoroughly. Be careful to replace the foreskin to normal position; Wash scrotum. Lift scrotum and wash perineum; With a new wash cloth, remake mitt and rinse area just washed; Pat dry with towel. Reposition foreskin if necessary; Turn resident (both male and female) on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer to wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing." R55 was not assisted with total pericare as directed by the plan of care.

Pressure injury care:
R55 was observed during morning cares done by two nursing assistants (NAs)-B and NA-C on 3/29/17, at 9:40 a.m. The NAs 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 NA gloved after washing their hands in R55's bathroom. NA-B next removed pillows from between R55's legs. The right ankle had a loose dressing over a closed area which was pea size. 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 left hip area was reddened over the bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m. A pillow was positioned between the resident's legs, heels were not floating but resting on the pillow. The NAs did not float the resident's heels off a pillow which was in the resident's care plan.

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F 282	Continued From page 36 R55 had a Progress Note, 3/29/17, Late Entry which documented the following: Dressing changes to all open or suspicious areas of skin on 3/28/17. Areas of concern were 1. 2.2 cm open area on mid back; appears to be larger, dark open are. Cleansed, Mepilex applied. 2. 2.0 cm x 0.5 cm open area on coccyx. Cleansed, Mediplex applied. 3. Area to lateral right ankle bone healed. 4. 2.0 cm unopened, non blanchable, dark circular area on right heel. Foam island dressing and sheepskin heel protectors on. The note the facility would continue to monitor. The NA Kardex care sheet undated, indicated the following: R55 was at high risk for skin injury, use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, keep skin clean and dry, use lotion on dry skin, do not apply on site of injury, and resident needs protection for the feet i.e. sheepskin boots, float heels. The kardex did not indicate the resident refused to have the heels floated. Licensed practical nurse (LPN)-A was interviewed on 3/30/17, at 2:02 p.m. and indicated R55 was more alert this week than last week. When asked about floating the resident's heels, LPN-A stated the resident did not want his feet to float and that the resident liked to sit in the recliner a lot. R55 did not have the heels floated as directed per the plan of care.	F 282		
F 309 SS=E	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility	F 309		5/15/17

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F 309	Continued From page 37 residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to identify non-pressure related skin conditions for 3 of 4 residents (R244, R245, R116) with observed laceration and/or bruising reviewed for non-pressure related pressure conditions. In addition, the facility failed	F 309	An incident report was created for resident R244 on 3/29/2017 an RN assessed the laceration on 3/29/2017 and again on 3/30/2017. The care plan for resident R244 was modified on 3/31/2017. The laceration was assessed again the	

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F 309	Continued From page 38 to implement care planned interventions for 1 of 1 resident (R59) reviewed with dementia, who displayed behaviors during the survey. Findings include: R244 head laceration of unknown cause was not assessed nor monitored. R244 was admitted on 3/24/17, with diagnoses that included toxic encephalopathy, pneumonia and dementia obtained from the Admission Record dated 3/30/17. On 3/28/17, at 8:22 a.m. during interview, R244 was observed to have a laceration approximately one inch in length above his left eye. When asked how he had sustained the laceration, R244 stated that he fell and hit his head going into the bathroom. R244 stated it happened a "couple days ago, maybe yesterday." R244's Nursing Admit Re-Admit Data Collection dated 3/24/17, indicated R244 was oriented to person, place and time, had normal skin integrity and did not have any pressure, venous, arterial or diabetic ulcers, burns, deep tissue injury, and/or traumatic or surgical wounds. Review of the care plan with revision date 3/25/17, indicated R244 had impaired cognitive function or thought processes due to dementia, impaired decision making, had had an actual fall due to psychotropic medication use, weakness and deconditioning and required staff assist of one for ambulation and toileting. The care plan did not indicate any skin alterations. Review of nursing progress notes dated 3/24/17	F 309	following week on 4/3/2017. The resident left the facility on 4/5/2017. On 3/29/2017 weekly skin observation and monitoring UDA began for resident R245. Per our policy and procedure, an incident report for resident R245 was not needed in this situation; the resident is alert and oriented and the bruise was not suspicious in nature. Resident R116 right forearm skin tear was assessed and observed by an RN on 3/29/2017 and again on 3/30/2017 and 4/8/2017. Resident R59 care plan was modified on 4/28/2017. Appropriate staff will be reeducated by the Director of Nursing Services and/or designee regarding following resident R59 care plan interventions and their responsibility to inform the Nurse Manager if and when those interventions are ineffective. Documentation for all residents will be reviewed by Nurse Managers to ensure that any bruises/contusions/skin tears and abrasions are appropriately assessed and documented. RN-A was reeducation on her obligation to observe, report and monitor skin issues for all residents. Appropriate staff will be reeducated by the Nurse Manager, regarding following resident R59 care plan interventions and their responsibility to inform the Nurse Manager if and when those interventions are ineffective. All licensed staff will be reeducated on the GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements by the Director of Nursing Services and/or	

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F 309	Continued From page 39 through 3/28/17, revealed there was no documentation on the head laceration. During interview on 3/29/17, at 1:56 p.m. registered nurse (RN)-A stated R244 does self transfer and has some erratic behaviors. When asked if she was aware of the head laceration, RN-A stated "I've observed it, but am not his caregiver," further stating they did not have a report that he had fallen. RN-A verified that there was no monitoring of the laceration. During interview on 3/30/17, at 2:36 p.m. the director of nursing (DON) stated that R244 did not tell anyone that he fell and staff didn't notice the laceration. DON stated an incident report should have been started, "the nurses missed it." R245 bruise of unknown cause was not assessed nor monitored. R245 was admitted on 3/15/17, with diagnoses that included cellulitis of left lower limb, chronic atrial fibrillation and venous insufficiency obtained from the Admission Record dated 3/30/17. On 3/28/17, at 12:00 p.m. during interview, R245 was observed to have a large, purple, approximate 2" X 4" bruise on his upper left arm. R245 stated he did not know where it came from, "they know about it." R245's Nursing Admit Re-Admit Data Collection dated 3/15/17, indicated R245 was alert and oriented to person, place and time, had right and left lower leg ulcers and rashes on the upper body, however did not indicate any bruising.	F 309	designee. All nursing staff will be reeducated on daily skin observation and reporting procedures by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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Review of the Order Summary Report dated 3/30/17, indicated an international normalized ratio (INR-laboratory measurement of how long it takes blood to form a clot) was to be drawn every Friday until 3/31/17. An INR result dated 3/29/17, measured high at 4.1 (normal reference range 1.0 - 1.2).

Review of the care plan with revision date 3/30/17, indicated R245 had actual impairment to skin integrity due to cellulitis of left lower limb, anticoagulant use, increased risk for bruising and to observe for major or fatal bleeding. The care plan directed staff to monitor location, size and treatment of skin injury, to report abnormalities to the health care provider, and to conduct weekly skin observation by licensed nurse. The care plan did not indicate any upper arm bruising or monitoring.

Review of nursing progress notes dated 3/24/17 through 3/28/17, revealed there was no documentation on the upper arm bruise.

On 3/29/17, at 2:48 p.m. RN-B stated if unknown bruising was noted for a resident, nursing would investigate, and if an incident report wasn't necessary, nurses would document in the progress notes and monitor if "it got bigger or not." RN-B stated she was aware of the bruise, but did not document it and verified that monitoring was not completed.

On 3/30/17, at 2:36 a.m. DON stated she would have expected if someone saw the bruise they would tell a nurse who would fill out an incident report and if a nurse did know about it, "they should have documented and monitored it"

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R116's skin tear of unknown cause was not assessed nor monitored.

R116 was admitted on 1/24/17, with diagnoses that included sepsis, atrial fibrillation, cellulitis of lower limb and peripheral vascular disease cellulitis obtained from the Admission Record dated 3/30/17. The Admission Minimum Data Set (MDS) dated 1/31/17 indicated R116 was cognitively intact and had no open lesions, rashes, cuts or skin tears.

On 3/28/17, at 10:51 a.m. during interview, R116 was observed to have mid forearm discoloration/bruising with a 2" X 4" bandage above the area.

During observation on 3/29/17, at 10:13 a.m. R116 showed surveyor his right arm with the bandage on it and stated "my skin opened." R116 stated he bruises easily.

During observation on 3/30/17, at 9:28 a.m. R116's bandage on his right forearm was removed and replaced with steri strips.

Review of the Order Summary Report dated 3/30/17, indicated R116 was to receive warfarin sodium tablet (blood thinner) 3 mg (milligrams) one time a day.

Review of the care plan with revision date 1/29/17, indicated R116 had fragile skin, actual impairment to skin integrity due to lower extremity cellulitis with open areas and was on anticoagulant therapy. The care plan directed staff to monitor location, size and treatment of skin injury, report abnormalities to the health care provider. The care plan was updated on 3/30/17,

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directing staff to provide skin tear wound care per facility standing orders and indicated R116 was at high risk for skin injury and to use extra caution during transfers and bed mobility.

R116's Nursing Admit Re-Admit Data Collection dated 1/24/17, indicated R116 was alert and oriented to person and time, had lower extremity redness, ulcer and scab.

Review of Wound RN Assessments dated 1/24/17, 1/31/17 and 2/14/17, did not address any forearm injury and bandage.

Review of Wound Data Collection forms dated 2/15/17 addressed lower extremity skin injuries and did not address any forearm injury and bandage.

Review of nursing progress notes dated 1/24/17 through 3/28/17, revealed there was no documentation on the right forearm injury and bandage.

During interview on 3/29/17, at 2:46 p.m. RN-B stated she was aware R116's skin is fragile and discolored, but was not aware there was a skin issue on his forearm.

During interview on 3/30/17, at 2:36 p.m. DON stated staff should have documented and monitored the skin injury.

Review of the facility Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements policy with revision date of 4/16, indicated all residents will have a comprehensive skin inspection done by the licensed nurse on admission/readmission to identify any skin issues

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present including, but not limited to, pressure ulcers, and the results will be documented in PCC (computer program). Under the "Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions" section of the policy, if a bruise, contusion, abrasion or skin tear is observed on a resident, this should be reported to the nurse immediately, should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation sheet and on the resident's care plan.

R59's Admission Record Resident Information sheet indicated a diagnosis of dementia with behavioral symptoms. His quarterly MDS dated 12/29/16, indicated he was severely cognitively impaired and displayed behaviors directed toward others and verbal behavioral symptoms. R59 care plan dated 1/20/17, identified a sleep/wake cycle disturbance, and behaviors that included physical aggression, hitting, pushing and loud disruptive singing. The care plan directed staff to minimize behavior problems with the following interventions: If awake early, give R59 breakfast as soon as food is available, go to another unit if needed. The care plan further directed staff to offer music and the use of head phones as a diversion and administer medications as ordered.

During observations on 3/29/17, at 7:26 a.m., R59 was seated in the dining room making intermittent non-sensical noises. At 7:57, R59 returned to the dining room table after getting dressed. He had a coffee cup in front of him, he was clapping his hands and calling out, swearing repeatedly. At 7:59 a.m., a staff member ambulated past R59. R59 called out "hey," the staff member did not acknowledge R59 who then swore. At 3/29/17, at 8:18 a.m., R59 remained at

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the table singing, yelling out and swearing. At 8:33 a.m., staff began serving breakfast to other residents, however, R59 had not yet received any food. At 8:39 a.m., R59 continued to yell out and clap his hands. Staff served R59 his breakfast at 8:43 a.m., one hour and 27 minutes after R59 was seated at the table. R59 ate his breakfast quietly, calling out once for scrambled eggs. At 8:56 a.m., staff escorted R59 back to his room where he was yelling with the door shut. He continued to yell until 9:33 a.m. During a second observation on 3/29/17, at 1:19 p.m., R59 was in his room with the door open. He was calling out loudly. R59 was sitting on his bed, there was no music playing in his room and he was not wearing head phones as directed in his plan of care.

During observations on 3/30/17, at 8:53 a.m., R59 sat at a table in the dining room yelling out and clapping his hands. Staff was setting up the meal, however R59 did not have any food. The residents on the adjoining unit had already eaten breakfast. At 9:09 a.m., R59 finished eating his meal and started yelling out, "hey." At 9:12 a.m., staff escorted R59 to his room where he continued to yell out. At 9:19 a.m., R59 was observed lying in bed. The lights were on and the blinds were open. No music was on and no head phones were present. He continued to yell out.

During an interview on 3/30/17, at 9:23 a.m., nursing assistant (NA)-A stated R59 can be very agitated sometimes. She stated he gets very loud and is hard to re-direct. NA-A stated she brings R59 to his room, but he comes right back out. She stated he had a radio in his room and staff are supposed to put music on for him and stated it calmed him down. She stated she had not offered him any music that day.

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F 309	Continued From page 45 During an interview on 3/30/17, at 9:43 a.m., RN-F stated R59 makes a lot of noise. She stated he wandered a lot and was difficult to re-direct. RN-F stated R59 would wake up too early and wanted breakfast right away. She stated he was usually up at 6:30 a.m., when she got there and stated she brought him coffee and if they have granola bars left over from the night before she would offer him one. She stated she was not aware staff were supposed to offer him breakfast as soon as it was available, but stated R59 liked music and sometimes staff would put it on for him. RN-F stated she did not think R59 head phones were working. During an observation on 3/30/17, at 12:40 p.m., R59 was in the dining room. He was wearing his headphones and humming to himself while he ate his lunch. R59 displayed no signs of agitation. During an interview on 3/30/17, at 2:46 a.m., RN-E stated R59 was up at 6:00 a.m., that morning and stated staff should offer him food when he was up early. She further stated when R59 was agitated staff should offer his headphones or music in his room. She stated even if the headphones were not working, they helped to cancel out excess noise. During an interview on 3/30/17, at 2:46 a.m., the DON stated staff should be using the interventions in place on the plan of care. A facility policy was requested but not received.	F 309		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS	F 312		5/15/17

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F 312	Continued From page 46 (a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate perineal hygiene was provided for 1 of 3 residents (R55) observed to receive assistance with personal hygiene care. Findings include: 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 checked and found to be saturated with urine. The incontinent product under the resident was also wet and but absent of stool. NA-C ungloved and left the room to inform the nurse that the suprapubic catheter dressing was wet and the dressing needed to be changed. NAR-B got a wash cloth to clean the perineal and buttock area. NA-B only slightly washed over the penis and perineal area, she did not pull back the foreskin to wash. R55's penis was observed for reddened areas and open areas and there was none. The left hip area was reddened over the	F 312	Resident R55 no longer resides in the facility as of 4/12/2017. NA-B and NA-C were reeducated specifically on 5/1/2017 regarding pulling back the foreskin to wash the penis when performing male pericare. All staff will be reeducated on the Policy and Procedure for Perineal Care by 5/15/2017. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m.). NA-B removed her gloves and put a new set on before applying a barrier cream to scrotal area. The two NAs worked together to put the resident's brief put on.

R55's plan of care dated 2/16/17, indicated R55 was a total assist with hygiene.

R55's Minimum Data Set dated 2/22/17, indicated R55 recently had a urinary tract infection in the last thirty days and required extensive assistant with hygiene. R55 was also had severe memory impairment and had diagnoses of dementia and begin prostatic hyperplasia.

Registered nurse (RN)-C was interviewed immediately after the dressing change 3/29/17, at 10:58 a.m. and confirmed the NAs should have withdrew the foreskin to completely cleanse male genitals.

The director of nursing (DON) was interviewed on 3/30/17, at 10:00 a.m. and confirmed the aides are supposed to wash the penis and perineal area according to the facility's policy. If the aides are just washing over the area quickly that was not the correct way of washing a male patient.

The facility's policy on Perineal Care, revised 5/16 indicated the purpose of the procedure was to: keep the perineal area clean, to prevent infection and odors in the perineal area, to promote good perineal hygiene, and to observe perineal area. The procedure for male care read as follows: 'Grasp penis gently with one hand and wash. Begin at meatus and wash in a circular motion toward the base of the penis; If resident is not

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F 312	Continued From page 48 circumcised, draw foreskin back. Be sure entire penis is washed. Rinse thoroughly. Be careful to replace the foreskin to normal position; Wash scrotum. Lift scrotum and wash perineum; With a new wash cloth, remake mitt and rinse area just washed; Pat dry with towel. Reposition foreskin if necessary; Turn resident (both male and female) on side to wash, rinse and dry anal area. After removing soiled gloves, use hand sanitizer to wash with soap and water to cleanse hands. Put on clean gloves to put on clean pad and/or clothing."	F 312		
F 314 SS=G	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent the development of pressure ulcers (localized injury to the skin and/or	F 314	The facility has pressure redistribution mattresses as a standard intervention for all residents and was already in place for resident R55; then a low air loss mattress	5/15/17

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F 314	Continued From page 49 underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction.), for 2 of 3 residents (R55, R181) who had been identified as at risk for pressure ulcers. Lack of timely responsive care resulted in actual harm for R55 who had identified pressure ulcer on the heel. In addition, the facility failed to assess wounds to include: stage, size, characteristics of the wound bed, surrounding tissue, or progress toward healing for 1 of 3 residents (R200). Findings include: R55 was observed during morning cares done by two nursing assistants (NAs)-B and NA-C on 3/29/17, at 9:40 a.m. The NAs 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 NA gloved after washing their hands in R55's bathroom. NA-B next removed pillows from between R55's legs. The right ankle had a loose dressing over a closed area which was pea size. 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 left hip area was reddened over the bony prominence which the resident had been laying on (from 7:30 a.m. till 9:40 a.m. A pillow was positioned between the resident's legs, heels were not floating but resting on the pillow. The NAs did not float the resident's heels off a pillow which was in the resident's care plan. RN-C came into resident's room with a rolling computer on 3/29/17, at 9:53 a.m. RN-C explained to R55 that she was going to check the resident's back dressing first.	F 314	was put in place on 4/7/2017. Care plan for resident R55 was amended 3/29/2017. Wound RN Assessments began for resident R55 on 3/30/2017. Resident R181 no longer resided in the facility as of 1/23/2017. Resident R200 no longer resided in the facility as of 1/14/2017. Documentation for all residents will be reviewed by the Nurse Managers to ensure that identified pressure ulcers were appropriately assessed, documented and monitored by. Care plans for all residents with potential for skin integrity issues were reviewed and modified as needed. GSS Care Plan Policy and the GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements will be reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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The admission Minimum Data Set (MDS) dated 2/22/17, indicated R55 had no open areas. The Care Area Assessment (CAA) indicated R55 was at risk for developing pressure ulcers related to prostate cancer, pain, weakness, and deconditioning. R55 had impaired mobility and balance and needed assistance with transfers and ambulation. The CAA also indicated R55 was receiving hospice services for additional care during the end of life process. R55 required extensive assist with bed mobility and incontinent care. R55 was on antipsychotics and antidepressants. In addition, R55 had diagnoses of diabetes, chronic end stage liver, heart disease, and dementia. R55 had a suprapubic catheter and was recently admitted to the facility for inpatient care and hospice care.

On 3/17/17, summary of the hospice visit indicated there was a small red open area mid spine. The hospitc visit notes indicated the nurse had come in and put a Mediplex dressing on it, and would leave a message for case manager (CM), there were no documented measurements. In addition, the notes indicated that on 3/17/17, there was a new open area on right ankle (no measurements).

A Progress Note dated 3/20/17, indicated the following: R55 had a mid-back open area 1 cm round, open but scabbed over. Covered with Mediplex, had a reddened coccyx with one open area but scabbed over 2 centimeters (cm) length X .5 cm width, had a right lateral ankle bone .5 cm circle open, covered with Band-Aid, scabbed over, and had a new left heel "mushy", non-blanching, dark colored area approximately 0.3 cm around non opened. Mepilex and heel

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protectors applied.

On 3/27/17, a hospice note indicated dressing change times for four areas on R55's back and the heel.

R55 had a Progress Note dated 3/29/17, entered as a Late Entry which documented the following: Dressing changes to all open or suspicious areas of skin on 3/28/17. Areas of concern were 1.) 2.2 cm open area on mid back; appears to be larger, dark open are. Cleansed, Mepilex applied. 2.) 2 cm x .5 cm open area on coccyx. Cleansed, Mediplex applied. 3.) Area to lateral right ankle bone healed. 4.) 2 cm unopened, non blanchable, dark circular area on right heel. Foam island dressing and sheepskin heel protectors on. The note the facility would continue to monitor.

R55's care plan revised on 2/26/17, indicated the resident had limited physical mobility related to terminal illness (cancer) evidenced by weakness, deconditioning, pain, impaired mobility and balance. Required staff assistance with mobility by placing equipment nearby and providing weight bearing support. The plan of care did not include interventions for treatment of the coccyx, the mid-back open area on the spine, not had it been updated to include the heel area. The plan of care did not indicate the resident refused cares.

The NA Kardex sheet undated, indicated the following: R55 was at high risk for skin injury, use extra caution during transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface, keep skin clean and dry, use lotion on dry skin, do not apply on site of injury, and resident needs protection for the feet

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i.e. sheepskin boots, float heels. The Kardex did not indicate the resident refused to have the heels floated.

During an interview with RN-C on 3/29/17, at 7:14 a.m., R55 was on hospice care for malignant neoplasm of prostate and secondary malignant neoplasm of bone. R55 was admitted to the facility for palliative care on 2/15/17. R55's pain medications were adjusted one week ago by hospice. R55 did not verbalize any longer. R55 had a dressing to an open wound on his mid back over a kyphotic area, one dressing on the coccyx, and on the right heel which was dark in color. R55's dressings were changed on 3/28/17, and there was an order for dressing changes every three days and prn.

LPN-A was interviewed on 3/30/17, at 2:02 p.m. and indicated R55 was more alert that week than last week. When asked about floating the resident's heels, LPN-A stated the resident did not want his feet to float and that the resident liked to sit in the recliner a lot.

The NP-A was interviewed on 3/30/17, at 2:50 p.m. and indicated she had seen R55 for increased pain so she did know the resident. The NP-A was asked if the open areas were avoidable or non-avoidable and the NP indicated the resident started to decline on or about 3/15/17, due to poor nutrition, increased pain, and increased skin breakdown. The NP-A verified that R55 was admitted to the facility with no open areas.

The facility's policy on Skin Assessment, Pressure Ulcers, Prevention and Documentation requirements was revised on 4/16. The purpose

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of this policy were the following: to systematically assess residents with regard to risk of skin breakdown, to accurately document observations and assessments of residents, and to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for pressure ulcers. "When a pressure ulcer is present, daily monitoring (with accompanying documentation when complication or change is identified) should include the following:
- An evaluation of the ulcer, if no dressing is present
- An evaluation of the status of the dressing; if present (whether it is intact and whether draining, if present, is or is not leaking)
- The status of the area surrounding the ulcer (that can be observed without removing the dressing)
- The presence of possible complications, such as signs of increasing area of ulceration of soft tissue infection(for example, increased redness or swelling around the wound or increased drainage from the wound)."

The pressure ulcer should be assessed/evaluated at least weekly and documented on the Wound RN Assessment sheet. If the resident is on Medicare, document daily on the Wound Data Collection sheet with every treatment change. Observations of the ulcer's characteristics may be documented by a licensed nurse and should include at least the following: Measurements - length, width, depth; Characteristics of ulcer - including wound bed, undermining and tunneling, exudate, surrounding skin, etc.; Presence of pain; and Current treatments.

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Progress toward healing and any modifications to the plan of care/treatments should be assessed and evaluated by the registered nurse. The facility failed to implement interventions to prevent the potential development of pressure ulcers or worsening of the right ankle ulcer for R55. R181's significant change MDS dated 1/2/17, indicated R181 was cognitively intact and had not rejected cares during previous seven days. R181 required extensive assistance of one staff for bed mobility, transfers and toileting and identified R181 was continent of bowel and bladder. R181's MDS indicated R181 did not have any pressure ulcers but was at risk for developing pressure ulcers. R181's MDS indicated R181 had diagnosis of depression, ischemic cardiomyopathy and chronic obstructive pulmonary disease and required continuous oxygen. R181's MDS indicated R181 was on hospice.

Progress Note dated 1/15/17, indicated staff, "...found a stage II pressure ulcer [partial thickness skin loss involving epidermis, dermis, or both. The ulcer is superficial and presents clinically as an abrasion, blister, or shallow crater] on the left side of resident's coccyx. Area was cleansed and Mepilex dressing was applied to keep area clean and protected. Writer hss [sic] placed call to Total Care for seniors to report new open area and need for tx [treatment], voicemail was left and nursing is awaiting return call at this time."

The Care Area Assessment (CAA) dated 1/16/17, 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 due to declining

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health condition. CAA indicated R181 did not have a pressure ulcer. CAA indicated staff would proceed to care planning with goal to avoid complications and minimize risks of pressure ulcers.

A Progress Note dated 1/20/17, at 12:42 p.m. indicated, "Writer also needs to update on new open area on coccyx. At this time there are a total of four open areas that are 0.25 x 0.25mm [millimeter] in size. Areas are free of s/sx [signs/symptoms] of infection. Writer has cleaned areas and applied Mepilex dressing to area to cover and keep clean. Resident is resistant to repositioning and will turn herself onto her back when in bed and frequently does not wish to get out of bed. Writer has notified RD [registered dietician] of open areas. Writer will request and air mattress for resident. Awaiting return call at this time."

A Progress Note dated 1/20/17, at 1:50 p.m. indicated new orders received from hospice for an air mattress, heel protectors, reposition every one hour and the addition of barrier cream to open areas with dressing changes.

The facility care plan printed 3/30/17, was reviewed for period of time from R181's admission on 12/6/16, until R181's death on 1/23/17. The care plan did not include identification of pressure ulcer risk or development of four stage II pressure ulcers. The care plan lacked any interventions to prevent or treat pressure ulcers.

During interview on 3/30/17, at 3:10 p.m. registered nurse (RN)-B verified a stage II pressure ulcer was first documented on 1/15/17,

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and that on 1/20/17, three new stage II pressure ulcers were identified. RN-B verified there was no pressure ulcer care plan developed upon admission or when the staff identified the pressure ulcers on 1/15/17, or 1/20/17. RN-B stated an initial care plan would have been opened by the admissions nurse within 24 hours of admission. RN-B said the floor nurses were to update the care plan when they found open areas or risks on the Transitional Care unit. RN-B stated Hospice would typically do a paper care plan and then the facility would scan it into the chart. When asked what is part of the care plan? RN-B said, "The electronic care plan is the only care plan." RN-B said, "I would expect a Wound Data tool to be completed to at least get the assessment done."

During interview on 3/30/17, at 3:35 p.m. director of nurses (DON) said, "I would expect wound assessment to be completed for a patient with a pressure ulcer. I would expect the daily skill notes to reflect wound until healed." DON said, "If a patient is identified at risk for pressure ulcers would expect a care plan to be developed for prevention. I would expect there to be a care plan for a pressure ulcer. The care plan is the electronic one in PCC (an electronic health care record-PointClick Care)." When asked if the care plan includes any other sections of the chart DON said, "No just the care plan section. If they are on hospice I would expect an assessment and care plan. It gets harder to heal wounds if they are on hospice. I would expect the care plan to say pressure ulcers are present but not necessarily to indicate goal is to heal the pressure ulcers. The goal is individualized."

During interview on 3/31/17, at 8:51 a.m. RN-C

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said, "I found the pressure ulcer on January 15. It was a stage II. She was not eating." RN-C said, "It had started out as a reddened bottom because she would not get out of bed. Then she developed four very small open areas. There were two on either side of her coccyx. They were very small. As she got closer to death we did not expect the wounds to heal. I know we encouraged her to get out of bed and to eat but she would not." RN-C said, "I did not think to write the care plan, I was more focused on taking care of her." RN-C verified there should have been a care plan. RN-C said, "The wounds were pressure ulcers, they were over bony prominences." RN-C verified writing the progress notes but said, "I did not do a wound sheet."

During interview on 3/31/17, at 11:23 a.m. the DON said, "All of our mattress are pressure reducing and it will not be on the care plan. If someone is at risk for pressure ulcers we do a skin care plan." Requested DON to find any documentation of interventions to prevent pressure ulcers prior to R181's development of pressure ulcers

During interview on 3/31/17, at 11:54 a.m. the medical director stated physician orders are part of the care plan. The medical director said, "I do wound rounds on a monthly basis and am there weekly. It is unusual for me to be asked to look at pressure ulcers, because we do a good job preventing pressure ulcers."

R181 was admitted to the facility without pressure ulcers but was identified as at risk for development of pressure ulcers. An individualized plan of care with interventions for prevention was not developed. The first pressure ulcer was

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
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identified on 1/15/17, but interventions for the prevention of pressure ulcers worsening or prevention of additional pressure ulcers were not implemented until 1/20/17, after the development of three additional ulcers.
R200's admission MDS dated 12/11/16, indicated he required extensive assistance of two staff for bed mobility, transfers and toileting and identified R200 was frequently incontinent of bowel and bladder. A CAA dated 12/17/16, indicated R200 was at risk for pressure ulcers related to dependence on staff for mobility, weakness and frequent incontinence. The CAA did not identify a current pressure ulcer. R200's care plan identified limited physical mobility and an activity of daily living (ADL) self-care deficit and frequent loose stooling and a need for staff assistance. R200's care plan did not address skin condition.

A Nursing Admit/ Re-admit Data Collection dated 12/4/16, identified a "red coccyx," but did not include a measurement or an indication if the area was blanchable. The data collection tool further indicated R200 had one of the following: pressure ulcer, venous ulcer, surgical wound, arterial ulcer, diabetic ulcer, surgical wound or suspected deep tissue injury, but did not identify which wound R200 had.

A review of R200's Good Samaritan Society Specialty Care treatment record dated December 2016 identified the following treatments initiated on 12/10/16: Cleanse coccyx, pat dry and cover with Mepiles [sic] Mepilex dressing (an absorbent dressing) daily in the morning for stage I skin breakdown prevention, Cleanse open area on spine with normal saline, pat dry and apply Mepilex dressing daily.

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A review of R200's Good Samaritan Society Specially Care Community Progress Notes dated 12/12/16 through 1/5/16, identified the following:

12/12/16 - Resident continued to receive skilled 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

1/2/16 - wound on coccyx is 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 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 3/29/17, at 1:37 p.m., RN-E stated residents receive a weekly skin check each week on their bath day. She stated if there was a skin concern, it would show up in an assessment on the electronic record.

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F 314	Continued From page 60 During an interview on 3/30/17, at 10:33 a.m., 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 have informed her of his skin condition because she was responsible for coding the MDS. The DON 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 and expect a care plan to be developed. While R200 had two separate pressure ulcers, there was no evidence the facility assessed the wounds to include: stage, size, characteristics of the wound bed, surrounding tissue, or progress toward healing, nor was there evidence the facility implemented interventions to prevent worsening of existing ulcers or prevention of new ones.	F 314		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents.	F 323		5/15/17

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F 323	Continued From page 61 (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 resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure side rails were assessed for use and maintained in a safe and functional manner for 1 of 3 residents (R243) reviewed for falls. Findings include: R243 was not assessed for the safe use of quarter side rails observed to be loose on the bed. On 3/27/17, at 5:03 p.m. the quarter siderails were observed to be loose on both upper ends of R243's bed. The siderails moved approximately 2 inches inward and were not secure to the bed. Review of a Falls Tool assessment dated 3/16/17, indicated R243 was at low risk for falls. R243's record lacked completion of any device	F 323	On 3/29/2017 the siderails and bed for resident R243 were removed and replaced with a bed with secure pivot assist bar. All side rails and pivot assist bars attached to resident beds were inspected on 3/29/2017. Procedures for reporting equipment issues and completion of work orders will be reviewed with all staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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assessment for the use of side rails and a medical doctor order indicating the quarter bilateral siderails were to be used for bed mobility.

R243 was admitted on 3/16/17, and had diagnoses which included lumbar discitis (inflammation between discs in vertebra of the back), osteomyelitis and arthritis as indicated on the R243's Admission Minimum Data Set (MDS) dated 3/23/17. The MDS indicated R243 was cognitively intact and required assistance of two staff for bed mobility, transfers, toilet use and walking in the room. The Care Area Assessment dated 3/23/17, indicated R243 was at risk for falls due to weakness, deconditioning, and impaired mobility.

R243's care plan with revision date of 3/27/17, indicated R243 was at risk for falls and had limited physical mobility due to deconditioning. The care plan directed staff to educate and instruct resident and family on safe use of assistive devices, remind resident not to bend over to pick up dropped items and to encourage R243 to use a grabber or to ask for assistance.

During interview on 3/29/17, at 9:29 a.m. R243 stated he used the siderails to help sit up in bed, "but they're wobbly."

During interview on 3/29/17, at 9:38 a.m. occupational therapist (OT) stated occupational therapy would typically assess for any assistive devices but she did not see the siderails were loose, "I see your concern, and they are wobbly."

During interview on 3/29/17, at 9:41 a.m. registered nurse (RN)-A stated R243 requires and

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F 323	Continued From page 63 was assessed for a grab bar and will use it to sit up. RN-A stated the bed was in that room when he arrived and probably came with the siderails. At 10:17 a.m. RN-A verified the siderails were loose and moved at least two inches inward, stating "Oh my, that's not good, we will get them switched out immediately." During interview on 03/29/2017, at 10:19 a.m. environmental assistant (EA)-A stated "Oh wow, that shouldn't be like that" when inspecting and moving both siderails. EA-A stated the bed had a "large frame" and the siderails shouldn't have been on the bed without an oversized mattress. EA-A stated he was not aware nor notified by nursing that the siderails were loose. During interview on 3/29/17, at 12:06 p.m. the director of nursing (DON) stated "We don't consider it a restraint, its an assist bar" and verified both siderails were loose. Review of the facility Bed Safety - Including Bed rails/Side Rails/Assist Bars policy with revision date of 11/16, indicated residents were to be assessed for the appropriateness of side rails/specialty mattress/overlays, usage will occur only when medical necessity is documented and that annual inspections will be conducted of all bedframes, mattresses and bed rails (side rails, assist bars and transfer devices) to identify and eliminate any potential entrapment issues and to ensure that bed rails are compatible with the bed frame and mattress.	F 323		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION 483.35	F 356		5/15/17

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F 356	Continued From page 64 (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	F 356		

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F 356	Continued From page 65 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. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to post nurse staffing hours that were accessible to residents, family, and visitors. This had the potential to affect 88 of 88 residents, families, and visitors to the facility. Findings include: The posted nurse staffing hours were not posted at a height where everyone could view the posting. During the initial tour of the facility on 3/27/17, at 12:00 p.m., the posted nurse staffing was posted to the right of the elevators on first floor in a glass enclosed case for 3/27/17. However, the posting was very high up in the case and one would have to stand on their tip toes and stretch their neck to read the posting. During all days of the survey, the posted nurse staff remained posted high up in the glass enclosed case. The director of nursing (DON) was interviewed on 3/30/17, at 10:45 a.m. and confirmed that wheelchair residents would not be able to view the posted nurse staffing nor would someone of a short stature. The DON confirmed the posted nurse staff should be lowered to a height where all could view the posting.	F 356	The sign was lowered on 5/1/2017. Staff with responsibility for posting the sign will be reeducated on placing it lower. The Administrator and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 371 SS=E	Continued From page 66 483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY (i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. (i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. (i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to serve food in a sanitary manner for 2 of 6 dining rooms (Arrowhead and Woodlands), failed to follow food safety procedures to minimize the risk of food borne illness which had the potential to affect 84 of 88 residents who were served food out of the kitchen and lacked a system for checking expired enteral feeding products.	F 371	Dietary DA-A was reeducated on his responsibility for proper food handling and hand washing on 3/30/2017. On 3/27/2017 the uncovered dishes of peaches were disposed of. The drying fan was thrown out on 3/27/2017. The facility had no residents that were using the Two Cal HN, it was in our overflow storage awaiting disposal. It was disposed of on 3/30/2017.	5/15/17

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F 371	Continued From page 67 Findings include: During observation of a meal service on the Arrowhead unit on 3/27/17, at 5:19 p.m., dietary aide (DA)-A reached into a bag of hamburger buns with his right, un-gloved hand. He then opened a cabinet with the same hand and again reached into the bag of buns, pulled one out and set it on a plate. At 5:28 p.m., DA-A wiped the sweat off his forehead with a rag, using his right hand, placed the rag on a counter and without washing his hands touched a hamburger bun on a resident's plate. During an interview on 3/27/17, at 5:40 p.m., DA-A stated, he had been at the facility for two years and had not been told he needed to wear gloves while serving unless he was serving fruits and vegetable. He then stated, "I'll keep in mind what I'm touching." On 3/29/17, at 8:22 a.m. breakfast service was observed on Arrowwood unit. The server was observed to be wearing a stocking cap, washed his hands prior to the start of the meal service, but during service he touched his apron over his stomach and pushed his glasses up on his face (both with left hand), opened the cabinet to get out foam bowls using both hands and then dished up food again, placing his thumb on the plate food surface. A dietary aide did not wash his hands after touching his apron, his glasses, or opening cupboards and getting out foam bowls prior to serving additional food. During an observation of the Boundary Waters unit on 3/29/17, at 8:27 a.m., DA-A prepared to serve the breakfast meal. He washed his hands with soap and water, dried his hands on a paper	F 371	All Dietary staff will be reeducated by the Director of Dietary Services on the GSS Food Handling Policy and Procedure, GSS Policy and Procedure for Dietary Services Handwashing Techniques, GSS Dining Service Standards Procedure and the GSS Food Transport Procedure. The procedure for Enteral Storage will be reviewed by the Director of Dietary Services with applicable staff. The Director of Dietary Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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towel, then used the same paper towel to wipe the sweat off his forehead. DA-A left the serving area through a door leading to an adjoining unit, returned, and without washing his hands, picked up a plate and began serving. He reached into a cabinet and pulled out a tray, he then reached into another cabinet and took out a yellow pate. He then wiped the sweat off of his forehead with the back of his hand and reached into another cabinet to get a white basket out. At 8:43 a.m., DA-A sneezed into his apron, holding the apron with his left hand, did not wash his hands, and continued plating food, touching the inside of bowels and holding onto plates with his left hand.

During an interview on 3/30/17, at 11:00 a.m., the director of food and nutrition stated he recently conducted a training on handwashing and cross contamination and stated staff should wash their hands prior to serving. He stated staff should re-wash hands if they leave the unit and come back, if they touch objects such as doors or drawers. The director of food and nutrition further stated staff should not be wiping the sweat off themselves and placing the rag on the counter and if they sneeze into their apron, staff should wash their hands and change their apron.

A facility policy titled Good Samaritan Society Handwashing Technique, dated February 2013, indicated staff will wash their hands as needed to safeguard the health of those who are dependent on their service. Wash hands: when reporting to work, after touching any contaminated object (face, hair, body or clothing), after coughing, sneezing or blowing nose.
Dessert/snack food improperly stored and expired tube feeding not properly disposed.

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F 371	Continued From page 69 During initial kitchen tour on 3/27/17, at 11:45 a.m. the following was observed and confirmed by the foodservice director (FD): A four tier food rack was positioned in the kitchen next to the cook's preparation table. Three of the four racks contained dishes of desserts, the second tier from the bottom contained uncovered dishes of peaches. A commercial speed dryer, heavily soiled with dirt, dust and dark particulate matter was positioned approximately four feet away on the floor, facing and blowing directly on the exposed tray of peaches. FD stated he had not seen the dryer before, "I don't know where it came from." FD verified the heavily soiled floor dryer should not have been blowing directly on the food rack, stating "all food should be covered with parchment paper, a pan or plastic wrap before going up to the floor, its policy." During followup kitchen tour on 3/30/17, at 10:11 a.m. with the FD, the following was observed: In the dry storage central supply room outside of the kitchen area eleven cans of Two Cal HN were observed to have an expiration date of December 2016. At the time of survey, there were four tube fed residents in the facility. FD stated he was not responsible for the enteral feedings in the facility, "I think nursing is." During interview on 3/30/17, at 1:20 p.m. registered nurse (RN)-D stated administration orders the product, she was not sure who was responsible for it, further stating "I think whoever takes in delivery should rotate it." RN-D verified both tube fed residents on the unit did not use the product.	F 371		

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F 371	Continued From page 70 During interview on 3/30/17, at 1:39 p.m. RN-E stated she stocks her own floors, administration orders the product and thought maintenance may put it away. RN-E stated she was not sure who was responsible, but "if I am getting the formula, I check the expiration date, if it's expired I take it off the shelf and get it destroyed." RN-E verified both tube fed residents on Boundary Waters unit did not use the product. During interview on 3/30/17, at 1:56 p.m. registered dietitian (RD) stated if she had a resident on a tube feeding she would go to the storeroom to look at the available tube feeding products and look at the expiration dates before it would go up to the floor. RD stated "we have checks and balances between myself and nursing managers", further stating "I understand" when told about the expired formula. Review of the facility Food Preparation policy dated February 2013 indicated the purpose was to ensure food is kept free of contamination and staff would practice techniques in food preparation that protect against food-borne illness. Review of the facility Food Transport policy with revision date of 2/16 indicated the purpose was to ensure safe practices when transporting food and fluids. The policy indicated "all food items will be covered, labeled and dated." A tube feeding formula policy was requested but not provided.	F 371		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS	F 431		5/15/17

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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 71	F 431		

The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable.

(h) Storage of Drugs and Biologicals.
(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature

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F 431	Continued From page 72 controls, and permit only authorized personnel to have access to the keys. (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure unauthorized personal were supervised in 1 of 6 medication rooms. This had the potential to affect all 16 residents residing on the unit. Findings include: During an observation on 3/29/17, at 9:09 a.m., registered nurse (RN)-F unlocked the Boundary Waters medication room to allow the environmental assistant (EA) to complete repairs. RN-A left the EA unattended in the medication room, with the door propped open until 9:44 a.m. An observation of the Boundary Waters medication room on 3/29/17, at 9:20 a.m. revealed medications left on baskets on the counter and unlocked in a refrigerator for all 16 residents residing on the unit. The medications accessible to the AE and others while the medication room was left unlocked and unsupervised included, but were not limited to: Seroquel (an atypical antipsychotic), haloperidol (an anti-psychotic medicine used to treat mental	F 431	RN-F was reeducated regarding her obligation to ensure the medication storage room is secure and ensure that unauthorized people do not have access on 3/29/2017. All applicable staff will be reeducated the GSS Procedure for Acquisition, Receiving, Dispensing and Storage of Medications. Environmental Services staff will be reeducated that they are only to have access to the medication storage areas in the presence of authorized staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 431	Continued From page 73 and mood disorders), Depakote (used to treat seizure disorders and certain psychiatric conditions), Effexor (an anti-depressant medication) and lorazepam (a benzodiazepine medication used treat anxiety disorders). During an interview on 3/29/17, at 1:11 p.m., RN-F stated only nurses and trained medication aides (TMAs) have access to the medication rooms. She stated non-medical staff should not be going in and out of med rooms or left unattended. RN-F stated she would have to check the regulation on whether or not the EA was allowed to be in the medication rooms. During an interview on 3/29/17, at 1:24 p.m., RN-E stated, only nurses and TMA's are allowed in the medication rooms unsupervised. She stated if a housekeeper goes in the room, nursing she be supervising them. RN-E stated unless supervised by a nurse, the EA should not be left alone in the medication rooms. A facility policy titled Good Samaritan Society Acquisition, Receiving, Dispensing and Storage of Medications, dated September 2016 was reviewed and indicated the following: Once medications are delivered, they will be secured in the appropriate storage area. Medications will be stored in a locked medication cart, drawer or cupboard. Only the person passing the medications and the director of nursing services will be permitted to have access to the medication storage areas.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		5/15/17

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F 441	Continued From page 74 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the	F 441		

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F 441	Continued From page 75 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate hand washing and glove changes during a dressing change from dirty to clean area, and a clean barrier during dressing change for supplies. This practice had the potential to affect 1 of 1 resident (R55) who was observed during a dressing change. In addition, the facility failed to ensure that resident equipment was maintained to allow the surface to be cleaned and prevent potential infection for 1 of 1 resident (R116) that had black electrical tape on the siderails. Findings include:	F 441	RN-C was reeducated on proper hand washing during treatments and Wound Dressing Change policy on 3/29/2017. The siderails with black electrical tape for resident R116 were removed on 3/30/2017. All side rails were inspected on 3/30/2017 for the presence of electrical tape, none were found. All staff will be reeducated on the policies for Hand Washing and Wound Dressing Changes by the Director of Nursing	

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F 441	Continued From page 76 Wound care: Registered nurse (RN)-C came into resident's room with a rolling computer on 3/29/17, at 9:53 a.m. RN-C explained to R55 that she was going to check the resident's back dressing first. The back dressing located over a kyphotic area was dry and intact, dated 3/28. RN-C checked heel left, no gloves used. No open areas. RN-C went into bathroom got one set of gloves. RN-C went to the dressing stand on wheels and got out dressings (gauge) and tape placed on the counter. RN-C then placed the wound cleanser on the resident's blanket. Nursing assistant (NA)-C cleaned out garbage bag that had discarded gloves and an incontinent brief. RN-C used hand sanitized and gloved. RN-C explained to the resident that she was going to do a dressing change to the suprapubic catheter. RN-C touched the outside of dressing package and tape after removing suprapubic catheter dressing which was urine soaked. RN-C did not remove gloves after removing the soiled dressing. RN-C used sterile saline wound cleaner to wipe around opening for catheter using a gauge. No redness noted. RN-C applied the cut dressing she removed from the package, checked tubing, urine started to flow. Gloves removed and placed in plastic lined garbage container. RN-C then took the wound cleansing solution and placed it on the rolling dressing cart. RN-C then left R55's room with the rolling dressing cart with the wound cleanser she used for R55. R55 had a Physician Order on 2/16/17 to change dressing to the suprapubic catheter every night shift for Prostate cancer.	F 441	Services and/or designee. All staff will be reeducated that black electrical tape is not allowed by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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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 soaked 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 was to promote wound healing and that the wound would remain free of infection. The procedure was as follows:
Check physician's order; review previous assessment and notes; Position resident for comfort and to accommodate dressing change; Put on gloves; Loosen tape from resident's dressing or press down on surrounding skin gently and carefully lift one edge of the dressing from the skin. Continue to carefully lift the edge of the dressing from the skin by moving slowly around the ulcer margins until edges are free; Remove slowly, folding dressing over itself and pulling it in the direction of the hair growth. If the dressing is difficult to remove, loosen edges with a warm, wet cloth; Remove soiled dressing and discard in plastic bag, avoiding contact and thus contamination of other surfaces. Remove gloves and discard in same plastic bag. Perform hand hygiene; Create field with equipment/dressing wrappers. Use sterile technique if required; Open all supplies and pour solutions if ordered; Put on gloves; Assess wound and surrounding area to ensure the selection of the appropriate-sized dressing; Cleanse the skin and wound thoroughly with normal saline using gauze wipes, wound cleanser or ordered antiseptic solution. Clip excess hair at sites needed; Allow the skin to dry

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F 441	Continued From page 78	F 441		

completely before applying the dressing. If the resident's skin is fragile, or drainage is expected to go beyond the wound edge, consider applying a skin protection preparation around the wound; Remove dressing from the inner wrapper; avoid finger contact with the dressing. Position the dressing over the wound and press down gently on the skin. Firmer pressure be used on edges depending upon skin condition. Sometimes a rolling motion is helpful. Avoid unnecessary stretching of the dressing; Place all disposable items in plastic bag with dressings, seal and discard according to procedure. Identify time, date, and initials on dressing; Chart dressing change and wound observation on the Wound Data Collection.

Eye drops:
On 3/29/17, at 10:01 a.m. RN-C stated to resident that she was going to put drops in R55's eyes. RN-C applied drops to left eye first which was dry and then put in drops times two to right eye that was reddened and had a buildup of a yellow substance. On 3/29/17, at 10:02 a.m. artificial tears were administered to R55 for eye moisture.

RN-C was interviewed immediately after the dressing change on 3/29/17, at 10:58 a.m. and confirmed RN-C did not wash their hands or utilize hand sanitizer after the wound care and before the eye drops were administered.

Wound cleanser:
RN-C came into resident's room with a rolling computer on 3/29/17, at 9:53 a.m. RN-C explained to R55 that she was going to check the resident's back dressing first. The back dressing located over a kyphotic area was dry and intact, dated 3/28. RN-C checked heel left, no gloves

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F 441	Continued From page 79	F 441		

used. No open areas. RN-C went into bathroom got one set of gloves. RN-C went to the dressing stand on wheels and got out dressings (gauge) and tape placed on the counter. RN-C then placed the wound cleanser on the resident's blanket.

RN-C was interviewed on 3/29/17, at 1:13 p.m. and confirmed that she had brought into R55's room a rolling dressing cart. RN-C said that the top shelf was set up for a computer and the lower shelf was used to put dressing and supplies on the shelf before entering the resident's room. The carts are not room specific. There are three carts but only two of the carts are used because each RN had a cart and there are only two RNs on during a shift. RN-C confirmed the same wound cleanser she used on R55 could be used on another resident because the skin cleanser was on the shelf for dressing change on the cart. The wound cleanser was not disinfected as RN-C had put the wound cleanser on R55's bed and then back on the cart without disinfecting the outside of the container.

Siderails:
R116's room was observed on 3/30/17, at 2:00 p.m. R116's bed had black electrical tape wrapped fully around the bilateral grab bars, which are a highly touched surface. The tape rendered the surface to be hygienically uncleanable.

The director of environmental services (EVS) and the facility administrator was along on the tour and both were not aware of the black electrical tape. It was verified by the administrator the surface was no longer a cleanable surface. The EVS the stated he had not been notified of the

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F 441	Continued From page 80 use of the electrical tape on the bilateral grab bars.	F 441		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS -2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED AT VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 29, 2017. At the time of this survey, Good Samaritan Society-Specialty Care Community was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR	K 000	EPOC	

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us Angela. Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building with a basement was constructed in 2012 and determined to be Type II (111) construction. The building has a garage, kitchen and mechanical equipment in the basement, long-term care and transitional care on the first floor, long-term care on the second floor and long-term care on the third floor utilizing special locking arrangements for memory care. The building is fire sprinkler protected throughout. The building has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 90 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 521 SS=F	NFPA 101 HVAC HVAC	K 521		5/15/17

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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	**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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 521	Continued From page 2 Heating, ventilation, and air conditioning shall comply with 9.2 and shall be installed in accordance with the manufacturer's specifications. 18.5.2.1, 19.5.2.1, 9.2 This STANDARD is not met as evidenced by: Based on observation and a staff interview, it could not be verified whether the facility's general ventilating and air conditioning system (HVAC) was maintained in accordance with NFPA 101 (2000) Chapter 19, Section 19.5.2.1 and Chapter 9, Section 9.1 and NFPA 90A. In a fire emergency, a noncompliant HVAC system could adversely affect all residents. FINDINGS INCLUDE: On 03/29/2017 at 1:55 PM, during an interview with facility staff, it was confirmed the HVAC system does contain one or more fire/smoke dampers, however, no fire/smoke dampers were inspected and tested within the previous 4 years, in accordance with NFPA 90A [1999] Chapter 3, Section 3-4.7. This finding was confirmed with the chief building engineer.	K 521	The smoke dampers were inspected on 4/4/2017. The Environmental Services Director was retrained on the GSS Policy and Procedure for Extinguishment and Fire Suppression System Requirements on 3/30/2017. The smoke damper testing was added to The Equipment Lifecycle System (TELS)to provide reminders for testing every 4 years. The Administrator and/or designee will be responsible to ensure compliance through random audits. Audit results will be taken to the QAPI committee for further recommendations.	