Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 22, 2024

Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: December 28, 2023

Dear Administrator:

On December 28, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by March 28, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by June 28, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

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Administrator
Good Samaritan Society - Comforcare
1201 17th Street Ne
Austin, MN 55912

Re: State Nursing Home Licensing Orders
Event ID: 2KDF11

Dear Administrator:

The above facility was surveyed on December 26, 2023 through December 28, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING ______ B. WING ______	C 12/28/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 12/26/23 to 12/28/23, a survey for compliance with CMS Appendix Z, the Emergency Preparedness Requirements, was conducted during a standard recertification survey. Good Samaritan Society - Comforcare was found not in compliance with the requirements. 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. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 007 SS=C	EP Program Patient Population CFR(s): 483.73(a)(3) §403.748(a)(3), §416.54(a)(3), §418.113(a)(3), §441.184(a)(3), §460.84(a)(3), §482.15(a)(3), §483.73(a)(3), §483.475(a)(3), §484.102(a)(3), §485.68(a)(3), §485.542(a)(3), §485.625(a)(3), §485.727(a)(3), §485.920(a)(3), §491.12(a)(3), §494.62(a)(3). [(a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least every 2 years. The plan must do the following:] (3) Address [patient/client] population, including, but not limited to, persons at-risk; the type of services the [facility] has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession	E 007		1/31/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 01/26/2024

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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E 007	Continued From page 1 plans.** *[For LTC facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following: (3) Address resident population, including, but not limited to, persons at-risk; the type of services the LTC facility has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans. *NOTE: ["Persons at risk" does not apply to: ASC, hospice, PACE, HHA, CORF, CMCH, RHC/FQHC, or ESRD facilities.] This REQUIREMENT is not met as evidenced by: Based on an interview and document review, the facility failed to address in their emergency preparedness plan, the resident population including, but not limited to, the residents most at-risk and the type of services the facility could provide these populations in an emergency. This had the potential to affect all 35 residents residing in the facility. Findings include: A review of the facility's Emergency Management Plan dated 5/9/23, lacked components regarding the resident populations including the persons at risk and the type of services the facility could provide them in an emergency. During an interview on 12/28/23 at 11:00 a.m., the director of nursing (DON) stated that the facility would have to run an electronic medical record	E 007	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. E007 EP Program Patient Population- 1. During survey it was noted that there was not a patient population of residents	

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E 007	Continued From page 2 report to inform them of their current resident population if an emergency occurred. The DON confirmed that the emergency plan did not include the specifics about their resident population, the persons at risk, and the types of services the facility could provide them in an emergency. A review of the facility Emergency Management Plan policy dated 7/22/22, did not indicate how the facility was to address the residents most at-risk; the type of services the facility had the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans in their emergency preparedness plan.	E 007	with special needs in the emergency management plan. A resident population table was developed by the DON to be added into the emergency management plan. 2. All residents have the potential to be affected by this deficient practice. Specifically resident with potential needs of special medical treatments. On January 24, 2024 the DON completed the special resident population and submitted it to the emergency management plan. 3. To ensure systemic changes are sustained, the DON or designee will review the resident population annual with the administrator during the annual review of the emergency management plan. Also, education was provided to staff the importance of having a resident population table to ensure proper care of residents during the all staff meeting on January 18, 2024 in the case of an emergency or evacuation. 4. The Administrator or designee will conduct quarterly audits of the Emergency Management Binder to ensure resident population still reflects residents residing in the care center. 5. The correction of the deficiency will be completed by the administrator by January 31, 2024.	
F 000	INITIAL COMMENTS On 12/26/23 to 12/28/23, a standard recertification survey was conducted by surveyors from the Minnesota Department of Health (MDH). In addition, a complaint investigation was also completed. Good Samaritan Society -	F 000		

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F 000	Continued From page 3 Comforcare was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was reviewed with no associated deficiencies cited: H53178078C (MN95201) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult	F 578		1/31/24

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F 578	Continued From page 4 residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure wishes and directives for emergency treatment (i.e., cardio-pulmonary resuscitation) were obtained upon admission and kept readily-accessible to ensure appropriate care would be provided for 1 of 1 resident (R96) reviewed for advanced directives. Findings Include: R96's admission Minimum Data Set (MDS) assessment, dated 12/17/23, indicated R96 had impaired cognition and diagnoses included hypertension (high blood pressure), mild cognitive	F 578	F578 Request/Refuse/Discontinue Treatment; Advance Directive- 1. Resident R96 was identified to not have documented wishes and directives for emergency treatment. A review of R96s chart was immediately completed on 12/26/2023 and code status/advanced directives were entered into the EMR system based on resident wishes and clinical documentation from residents hospital medical record. A POLST was filled out by nursing staff and resident. The medical provider then signed the POLST and it was submitted to be	

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F 578

Continued From page 5

impairment, shortness of breath, anemia (low red blood cells), and gastrointestinal hemorrhage (a bleed in the digestive tract). Further, the MDS indicated he was independent with mobility, personal hygiene, and eating; and admitted to the care center on 12/11/23.

Review of R96's physician orders on 12/26/23, lacked evidence of a code status (type of emergent treatment a person would or would not receive if their heart or breathing were to stop) for R96. In addition, R96's care plan, dated 12/28/23, and his electronic medical record (EMR) both also lacked evidence of R96 health care wishes being addressed or listed (i.e., code status). The EMR had a banner along the top which listed R96's name, date of birth, and age along with a space which read, "Code Status:," however, this space was left blank.

R96's medical record was reviewed and lacked evidence to ensure R96's wishes and directives were assessed upon admission. There was no evidence the facility had assessed R96 to determine what, if any, measures he would want implemented during an emergency situation. Further, the record lacked any scanned information or physical order for a code status which could be easily identified should an emergent situation happen and R96 would be unable to speak for himself.

During interview on 12/26/23, at 3:01 p.m., registered nurse unit manager (RN)-A verified in the EMR there is no code status listed for R96. RN-A stated if a code status is not listed, then the facility would do CPR and start compressions. RN-A indicated there is a red-colored folder with "code status" for each person listed, but upon

F 578

scanned into the residents EMR code status was entered into EMR as soon as resident made wishes know.

2. All residents have the potential to be affected by the deficient practice. All resident medical records were reviewed by DON or nurse manager on 12/26/2023 and showed that code status/advanced directives were entered into the electronic medical record for all other residents.

3. To ensure that our systemic changes are sustained the DON provided education to nurses, nurse managers, social services, and HIM on entry of code status/advance directives using the Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) Policy and Procedure and the Advance Care Planning Policy and Procedure on January 18, 2024 in an all staff meeting.

4. The DON, administrator, or designee will perform audits on resident code status/advance directive to verify it is entered into the EMR twice a week for four weeks and weekly for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.

5. The date of correction will be January 31, 2024 with the DON, Administrator, or designee verifying correction of deficiency.

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F 578	Continued From page 6	F 578		

review then verified that R96 was not listed and again stated they would start CPR. Registered nurse (RN)-C then joined the interview and indicated the nurse who does admission should complete POLST (physician order for life-sustaining treatment: a form which residents complete to ensure their healthcare wishes are upheld), question a resident code status and record it in EMR so it shows on banner. RN-A and RN-C indicated the code status is likely not in progress note but directly on banner at the top of the EMR and reiterated the "admission nurse" should have "conversation with them" on admission about this, and record it directly into the EMR banner and medical record.

On 12/26/23, at 3:15 p.m., RN-A reviewed EMR and was unable to locate code status via hospital, verified R96 was cognitively impaired, and no health care directive listed. RN-A then started to review a complied stack of paperwork in the nurses' station which had multiple residents, including R96's, information within. RN-C verified would check EMR banner if a resident is found unresponsive, if the banner is blank, would start CPR. RN-C stated if unable or poor cognition to verify code status, then would visit with family and paperwork placed in charting room until scanned. RN-C verified R96 admitted 12/11/23, and the code status remains blank adding "it shouldn't be". RN-C verified if a resident was DNR (do not resuscitate) then would get CPR which could possibly be "against their wishes". RN-C reviewed hospital paperwork and unable to locate code status.

During interview on 12/26/23 at 3:19 p.m., R96 indicated that he "of course" would want CPR done if unresponsive. R96 was unable to recall if

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F 578		F 578		

Continued From page 7
the facility asked about his wishes. R96 stated his son was "so-so" involved.

On 12/26/23, at 3:21 p.m., RN-A presented back to the surveyor and reported they had found and provided a hospital report that listed R96 as a Full code status. RN-A verified it was located after doing extensive review of the stack of paperwork and other binders in the office and was not located in a "typical" place a nurse would check for a code status and verified it should be in the EMR.

During an interview on 12/27/23, at 1:37 p.m., family member (FM)-A stated that the facility had not consulted with them on health care directive or code status of their family member. They stated that R96 was their own person, and the code status should be what R96 wants. FM-A stated they are working on making a legal document (health care directive) with a lawyer on January 5th.

During an interview on 12/27/23, at 2:37 p.m., director of nursing (DON) stated the admission nurse reviews a resident's code status, discusses a resident wish, and have the resident or representative sign a POLST which then goes to the physician to sign. This occurs on the day of admission. DON stated the code status is entered into the EMR.

During an interview on 12/28/23, at 8:33 a.m., licensed practical nurse (LPN)-A stated residents code statuses are discussed upon admission. The code statuses are entered into the EMR system. LPN-A verified code statuses are verified in the EMR prior to administering CPR.

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F 578	Continued From page 8 The facility policy titled Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator, dated 8/1/23, was provided. The policy indicated the purpose is to provide each resident the opportunity to make decisions related to medical care and select a provide and to define a process to make resident decisions known.	F 578		
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the significant change in status Minimum Data Set (MDS; i.e., a comprehensive assessment) was completed in a thorough manner to ensure areas of cognition and depressive symptoms were fully evaluated for 1 of 4 residents (R13) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services	F 637	F637 □ Comprehensive Assessment After Significant Change Resident R13 had blank MDS Sections from C0200 to C1000, Section D was left blank from D0150 to D0600 during a SCSA MDS with an ARD from 11/11/23 to 11/18/23. 1. Resident R13□s MDS was reviewed and noted to have incomplete sections on 12/27/2023. The needed assessments were reviewed and competed if resident was able to respond to questions or still	1/31/24

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F 637	Continued From page 9 (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual included a section labeled, "Comprehensive Assessments," which included a significant change in status (SCSA) and outlined such assessments would yield corresponding CAA(s) to be completed which were triggered from conditions and responses marked on the MDS. The manual included a section labeled, "SECTION C: COGNITIVE PATTERNS," which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, "These items are crucial factors in many care-planning decisions;" with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, "SECTION D: MOOD," which outlined the section would be used to help address mood distress and social isolation adding, "Mood distress is a serious condition that is under diagnosed and under treated in the nursing home and is associated with significant morbidity," and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R13's significant change MDS, dated 11/18/23, identified R13 admitted to the care center in 12/2022 and had several medical diagnoses including renal disease, high blood pressure, and a history of stroke. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed Brief Interview for Mental Status	F 637	available for interview. 2. All residents could be affected by the deficient practice. Specifically, resident who recently had a significant change in status and needed to have a new MDS completed. All residents who could be affected by this were reviewed by the MDS nurse and verified to be completed correctly. 3. To ensure systemic changes are sustained, education was provided to MDS Nurse on 12/27/2024 using the MDS 3.0 RAI Policy and Procedure. The DON provided education to the social worker using the MDS 3.0 RAI Policy and Procedure on January 24, 2024. All staff were notified of this deficiency and education was provided on completing UDAs to ensure completion of the MDS in a timely manner on January 18, 2024 in an all staff meeting. The DON, Social Worker, Dietary Manager, Activities Director, and MDS nurse will meet weekly to ensure MDS assessments are completed and ready for submission. 4. MDS assessments will be audited by the DON, Administrator, or designee twice a week for four weeks and weekly for eight weeks. Audit results will be reviewed by the QAPI committed with the appropriate follow-up initiated to ensure compliance is sustained. 5. The correction of this deficiency will be conducted the DON and will have a date of correction on January 31, 2024.	

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(BIMS) was left blank and not completed and, in addition, the subsequent section for the staff assessment (used if the resident is rarely or never understood) was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment (also used if the resident is rarely or never understood) was left blank and not completed. In total, section D0150 to D0600 was left blank and not completed or addressed.

R13's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the SCSA assessment reference date (ARD; from 11/11/23 to 11/18/23) to determine what, if any, complications or issues R13 demonstrated with those corresponding areas.

On 12/27/23 at 12:34 p.m., registered nurse (RN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R13's medical record, including the SCSA MDS (dated 11/18/23), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility' did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. RN-B stated, as a result, they had to dash the corresponding MDS areas. RN-B expressed they had not delegated any of these

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F 637	Continued From page 11	F 637		

assessments to the floor nurses' to complete, either, adding, "I don't know if we could or not." RN-B stated an MDS not completed thoroughly, including the applicable evaluations for mental status and mood, could cause various CAA items to not trigger adding, "It might." Further, RN-B stated "going forward" they were going to "block out" more time to get the evaluations completed for the MDS' and expressed it was important to ensure MDS(s) were completed accurately and thoroughly so "we know where their [resident] cognitive levels are."

When interviewed on 12/27/23 at 12:51 p.m., the director of nursing (DON) stated he was aware RN-B being pulled to work on other things (i.e., the floor) was "slowing [them] down" on MDS' workload, however, he was unaware they were just being dashed and not thoroughly completed as a result. DON stated they had recently hired a social worker who was "still in training" and were hopeful such hire would improve the situation. However, DON stated it was important to ensure all areas on the MDS were thoroughly completed as they help determine "how we care for our patients" and they help "develop better care plans," too.

A provided MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) - Rehab/Skilled & Therapy and Rehab policy, dated 6/2023, identified a purpose to complete the RAI within the federally mandated timeline(s). The policy outlined, "The interviews must be conducted during the designated observation period. The [BIMS] ... will be completed during the observation period. The [PHQ-9] and Pain Assessment are preferably completed the day before or day of the ARD. Complete means that

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F 637	Continued From page 12 the interview questions have been saved, signed and locked." Further, the policy outlined, "If any discipline is unable to complete its section ..., the RN coordinator will assign another person to complete this section within the time frame."	F 637		
F 638 SS=D	Qrtly Assessment at Least Every 3 Months CFR(s): 483.20(c) §483.20(c) Quarterly Review Assessment A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quarterly Minimum Data Set (MDS) was completed in a thorough manner to ensure areas of cognition and depressive symptoms were screened and, if needed, fully evaluated for 2 of 4 residents (R3, R28) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined a quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident' status between comprehensive assessments " ... to ensure critical indicators of	F 638	F638- Quarterly Review Assessment at Least Every 3 Months-Residents R3 and R28 were identified to have section C0200 to C1000 and Section D0150 to D0600 blank on their MDS assessments. 1. These residents MDS sections were reviewed by the MDS nurse, the MDS nurse coordinated the completion of these sections in the MDS for residents R3 and R28. 2. All residents have the potential to be affected by the deficient practice. All resident MDS sections were reviewed by the MDS nurse to ensure that they are completed in a timely manner. 3. To ensure systemic changes are sustained, the DON provided education to MDS Nurse on 12/27/2024 using the MDS 3.0 RAI Policy and Procedure. The DON provided education to the social worker using the MDS 3.0 Policy and Procedure on January 24, 2024. All staff were notified of this deficiency and education	1/31/24

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F 638	Continued From page 13 gradual change in a resident's status are monitored." The manual included a section labeled, "SECTION C: COGNITIVE PATTERNS," which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, "These items are crucial factors in many care-planning decisions;" with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, "SECTION D: MOOD," which outlined the section would be used to help address mood distress and social isolation adding, "Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity," and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R3's quarterly MDS, dated 12/7/23, identified R3 had several medical conditions including high blood pressure, depression, and a history of stroke. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed Brief Interview for Mental Status (BIMS) was left blank and not completed and, in addition, the subsequent section for the staff assessment (used if the resident is rarely or never understood) was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment (also used if the resident is rarely or never understood) was left blank and not completed. In total, section D0150	F 638	was provided on completing UDAs to ensure completion of the MDS in a timely manner on January 18, 2024. The DON, Social Worker, and MDS nurse will meet weekly to ensure MDS assessments are completed and ready for submission. 4. MDS assessments will be audited by the DON, Administrator, or designee twice a week for four weeks and weekly for eight weeks. Audit results will be reviewed by the QAPI committed with the appropriate follow-up initiated to ensure compliance is sustained. 5. The correction of this deficiency will be conducted the DON and will have a date of correction on January 31, 2024.	

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F 638	Continued From page 14	F 638		

to D0600 was left blank and not completed or addressed.

R3's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the quarterly assessment reference date (ARD; from 12/1/23 to 12/7/23) to determine what, if any, complications or issues R3 demonstrated with those corresponding areas.

R28's quarterly MDS, dated 11/29/23, identified R28 had several medical conditions including history of stroke. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed BIMS was left blank and not completed and, in addition, the subsequent section for the staff assessment was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment was left blank and not completed. In total, section D0150 to D0600 was left blank and not completed or addressed.

R28's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the quarterly ARD (from 11/22/23 to 11/29/23) to determine what, if any, complications or issues R28 demonstrated with those corresponding areas.

On 12/27/23 at 12:34 p.m., registered nurse

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(RN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R3 and R28 medical record, including the completed MDS(s), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility' did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. RN-B stated, as a result, they had to dash the corresponding MDS areas. RN-B expressed they had not delegated any of these assessments to the floor nurses' to complete, either, adding, "I don't know if we could or not." Further, RN-B stated "going forward" they were going to "block out" more time to get the evaluations completed for the MDS' and expressed it was important to ensure MDS(s) were completed accurately and thoroughly so "we know where their [resident] cognitive levels are."

When interviewed on 12/27/23 at 12:51 p.m., the director of nursing (DON) stated he was aware RN-B being pulled to work on other things (i.e., the floor) was "slowing [them] down" on MDS' workload, however, he was unaware they were just being dashed and not thoroughly completed as a result. DON stated they had recently hired a social worker who was "still in training" and were hopeful such hire would improve the situation. However, DON stated it was important to ensure all areas on the MDS were thoroughly completed as they help determine "how we care for our patients" and they help "develop better care plans," too.

A provided MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) -

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F 638	Continued From page 16 Rehab/Skilled & Therapy and Rehab policy, dated 6/2023, identified a purpose to complete the RAI within the federally mandated timeline(s). The policy outlined, "The interviews must be conducted during the designated observation period. The [BIMS] ... will be completed during the observation period. The [PHQ-9] and Pain Assessment are preferably completed the day before or day of the ARD. Complete means that the interview questions have been saved, signed and locked." Further, the policy outlined, "If any discipline is unable to complete its section ..., the RN coordinator will assign another person to complete this section within the time frame."	F 638		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(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 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	F 656		1/31/24

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F 656	Continued From page 17 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. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed to reflect resident' condition with assessed bowel incontinence and consumed, high-risk medications to promote continuity of care and reduce the risk of complication for 1 of 2 residents (R95) reviewed for care planning. Findings include: R95's Medicare - 5 Day Minimum Data Set (MDS), dated 11/17/23, identified sections to record R95's cognition, however, these were left	F 656	F656- Develop/Implement Comprehensive Care Plans-Residents R95 Comprehensive Care Plan did not show high-risk medication, bowel incontinence. 1. On 12/27/2023 it was noted that the care plan for resident R95 was lacking information regarding high-risk medications and bowel incontinence. The Nurse Manager for R95 reviewed the care plan and added section information on high-risk medications including the observation of side-effects and psychotropic medication use monitoring	

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blank and not completed (see F637, F638).

On 12/26/23 at 11:27 a.m., R95 was interviewed and expressed concerns over his bowels adding, "I haven't had a regular bowel movement in months." R95 stated his bowel movements, as of late, had been "very loose" and he had "no control over it" so staff were changing his incontinence products often.

R95's most recent Bowel Evaluation, dated 12/20/23, identified R95 had been assessed as having bowel incontinence which existed for "months" with a listed frequency, "Daily, but some control is present." The sections to record history, contributing factors, and cognition were left blank and not completed. Further, the assessment listed a section labeled, "Care Planning," with corresponding options to check to represent what, if any, problem statements or goals or interventions would be completed or implemented for R95's incontinence; however, these were all left blank and not completed.

R95's POC (Point of Care) Response History, printed 12/28/23, identified a 14-day look back period and recorded R95's bowel continence episodes. This identified R95 had 10 episodes of bowel incontinence recorded during the period.

R95's Order Summary Report, printed 12/28/23, identified R95's had several medical conditions including anemia, diabetes mellitus, atrial fibrillation, and chronic kidney disease. The report listed R95's physician-ordered medications which included apixaban (an anti-coagulant medication), lorazepam (an anti-anxiety medication) bumetanide (a diuretic medication), mirtazapine (an anti-depressant medication), oxycodone (a

F 656

and triggered monitoring questions into the electronic medical record. A toileting program was developed in the Care Plan to provide resident R95 with appropriate bowel incontinence care/prevention.
2. All residents have the potential to be affected by the deficient practice. Specifically, residents who are taking high-risk medications and have bowel/bladder incontinence. A review of all residents care plans was completed by the nurse managers and DON to ensure these items were in resident care plans including interventions and goals. On 12/28/2024 The DON provided education to the nurse managers using the Comprehensive Care Plan and Care Conference Policy and Procedure to ensure understanding.
3. To ensure systemic changes are sustained, all nursing staff were educated on comprehensive care plans on January 18, 2024 during and all staff meeting using the Comprehensive Care Plan and Care Conference Policy and procedure.
4. The DON or designee will complete audits on random resident care plans twice a week for four weeks and then weekly for eight weeks specifically for hazards medications and Bowel incontinence. Audit results will be reviewed by the QAPI committee and appropriate follow-up initiated to ensure compliance is sustained.
5. The DON will assure correction of this deficiency by January 31, 2024

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F 656	Continued From page 19	F 656		

narcotic medication), and senna-docusate sodium (a laxative medication).

However, R95's care plan, dated 12/26/23, identified R95 admitted to the care center on 12/20/23 but lacked any identified problem statements, goals, or subsequent interventions for R95's bowel incontinence or consumed high-risk medications (i.e., side effect monitoring, associated risk factors). Further, the medical record, including Treatment Administration Record (TAR), was reviewed and lacked evidence of ongoing psychotropic medication use monitoring or how such would be completed (i.e., care planned); in addition, the medical record lacked evidence a baseline care plan had been completed or initiated upon R95's re-admission nearly a week prior.

On 12/27/23 at 2:25 p.m., nursing assistant (NA)-B was interviewed and verified they had worked with R95 prior. NA-B explained R95 was "most of the time" in bed and rarely used the toilet so, as a result, would call for staff assistance when he was incontinence of bowel. NA-B stated R95's stool were "putty like" most of the time, however, they never report that to the nurses rather "just charted it." NA-B stated they were unaware what, if any, other interventions for R95's bowel were being done aside from just checking and changing him with each incontinence episode. Further, NA-B stated they had not noticed or seen by behavior issues or depressive symptoms from R95 to their recall.

On 12/28/23 at 8:34 a.m., registered nurse unit manager (RN)-B was interviewed and verified they had reviewed R95's medical record. RN-B explained R95 had originally been admitted back

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F 656	Continued From page 20 in November 2023; however, he was then re-hospitalized and the family elected to not hold the bed so, as a result, on 12/20/23 he was considered a new admission adding R95 had a primary diagnosis of cancer and anemia and, as a result of those, would get routine blood transfusions. RN-B explained a "24 hour" care plan was developed upon admission which included basic information for the NA(s) to use for care with evaluations are completed. RN-B verified a formal 'baseline care plan' was not done, rather the care center just started building the comprehensive care plan right away and added to it as things were evaluated. RN-B reviewed R95's care plan and verified it lacked problem statements, goals, or interventions for R95's assessed bowel incontinence or what, if any, interventions or monitoring would be completed for the high-risk medication consumption (i.e., any psychotropic medication monitoring). RN-B stated they were going to repeat the bowel evaluation as they "want to do the full assessment" since the nurse who completed the original one (dated 12/20/23) "obviously didn't complete everything." RN-B acknowledge the information on the care plan pulled to the NA kardex (tool used to know what cares to provide) and expressed they were going to add certain items to help guide R95's care (i.e., monitor for bruising, depression symptoms). RN-B stated it was important to ensure a care plan was developed as "it helps address what you're [staff] actually doing through your assessment." A policy on care plan development was requested, however, none was received.	F 656		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices	F 689		1/31/24

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F 689	Continued From page 21 CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate interventions and supervision for 1 of 1 residents (R96) after found smoking in the facility. Findings include: R96's Admission Record printed 12/28/23, indicated R96 was admitted on 12/11/23, and R96's diagnoses included tobacco use, mild cognitive impairment, shortness of breath, and hypertension (high blood pressure). R96's admission Minimum Data Set (MDS) assessment dated 12/17/23, indicated R96 had impaired cognition. R96's MDS indicated R96 wanders daily and places resident at significant risk of getting into a potentially dangerous place. R96's MDS indicated that a current tobacco user, independent with mobility, personal hygiene, and eating. A Nursing Admit Re-Admit Data Collection assessment, dated 12/11/23, indicated R96 was a current tobacco user. Assessment indicated resident received education, cognitive barriers to	F 689	F689- Fee of Accident/Hazards/Supervision/Devices-Resident R96 had history of tobacco use and was observed smoking in care center on December 25, 2023. Resident was observed with pack of Marlboro cigarettes in the pocket of his shirt by surveyors on December 27, 2024 1. Cigarettes were removed form resident R96s room on December 27, 2023 to ensure resident did not smoke in their room. Resident was reminded that the care center was a smoke free facility and that tobacco use was prohibited to be used by anyone inside the building. 2. All residents have potential to be affected by the deficient practice. Specifically, those residents who are identified to use tobacco products. A review of residents who use tobacco products was complete by the DON on January 24, 2024 and assessments and care plans were reviewed to ensure all items were addressed. 3. To ensure systemic changes are sustained all staff were given education on the Smoking and Tobacco Use Policy	

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F 689	Continued From page 22 learning and resident outcome was "unable to understand". A Tobacco Use Evaluation, dated 12/16/23, was completed. It indicated that R96 was a current everyday tobacco (smoking/vaping) user, current using 10+ times per day, and uses throughout the day. Evaluation identified R96 is severely impaired, and "resident is unable to know that he can't smoke in the building". Evaluation indicated that resident "has exit seeking behaviors ...does not understand where he is ...confused/agitated." R96's care plan, dated 12/28/23, identified R96 wished to quit smoking and to apply nicotine patch per physician order on 12/26/23. R96's care plan lacked any evidence for interventions related to smoking, cigarettes, or recent use or interventions. R96's Order Summary, dated 12/28/23, indicated an order for Nicoderm CQ Transdermal Patch 21 mg (milligram)/24 hour: Apply 1 patch transdermally (via skin) one time a day for smoking cessation and remove per schedule. The order had a start date of 12/14/23, which was 3 days after admission. The orders lacked any order for any non-pharmalogical intervention for smoking cessation. A progress note, dated 12/25/23, indicated R96 was found smoking in his room. The note further indicates the cigarette was put out ...resident educated can't smoke in facility .... confiscated lighter ...placed in locked med drawer .... opened window ....notified director of nursing ....notified R96's son ...explained R96 can't have lighter in facility.	F 689	and Procedure during an all staff meeting on January 18, 2024. A review of what to do if a resident is found smoking within the care center was completed and included: verbal reminder that resident is not allowed to smoke in the building, notify nearest nurse that a resident is smoking in the building, remove smoking items from the area (cigarettes, vapes, lighters, matches), nurses are to complete a tobacco assessment if a resident is caught smoking in the building, and the care plan should be updated with appropriate interventions. 4. The DON or designee will complete audits on tobacco assessments if resident uses tobacco products, will also audit care plan twice a week for four weeks and then weekly for eight weeks. The audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The DON will ensure correction of deficiency by January 31, 2024	

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F 689	Continued From page 23	F 689		

Review of electronic medical record (EMR) through 12/27/23, lacked evidence of any additional assessments, progress notes or follow up related to tobacco use.

On 12/27/23, at 8:25 a.m., R96 was observed sitting on the edge of his bed with an empty breakfast tray. R96 had a pack of Marlboro cigarettes in the pocket of his shirt.

During an interview on 12/27/23, at 11:08 a.m., R96 indicated that he had one cigarette in the facility since he had been there. R96 indicated he understands that he can not do that since there is oxygen and it is a fire hazard. R96 stated he has smoked for many years. He stated he is wearing a nicotine patch but isn't sure if it is helpful. It is observed that he has a pack of Marlboro cigarettes in his shirt pocket during the interview.

During an interview with licensed practical nurse (LPN)-A, they indicated that a smoking assessment is completed upon admission, and this is a smoke free facility. If a resident is a "smoker", they must be able to independently leave the property and smoke safely. They indicated that smoking cessation is encouraged with nicotine patches or nicotine inhalers. They stated that if a resident brings tobacco products in the facility, the tobacco products and lighters are locked in the medication drawer. They stated it is important to properly assess residents as "we" don't want residents to accidentally burn themselves or start a fire. They indicated that if a resident was found smoking in the facility, they would immediately stop the resident, lock up the contraband, notify management (director of nursing and administer), do a tobacco use assessment and put in a progress note. They

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F 689	Continued From page 24 indicated management would follow up as well with the resident and family. LPN-A stated that more cigarettes were found on R96 as they are sitting on the nursing desk. It is unknown when they were obtained from R96. LPN-A indicated they are not aware of R96 having a lighter or matches. During an interview on 12/28/23 at 9:26 a.m., with director of nursing (DON) indicated it was a smoke free facility and residents must leave the property to smoke. He stated that if residents bring tobacco products into the facility, the lighter and cigarettes are locked in the medication drawer and the admissions agreement is reviewed. He stated that a smoking assessment is completed upon admission to assess a resident need. He stated if a resident is found smoking on the grounds or within the facility, the administer would follow up after the issue was immediately addressed. He stated the family would be notified and a tobacco assessment would be completed as soon as possible. He indicated it would be added to the care plan and ensure that smoking cessation is offered, and education provided. DON verified that a follow up tobacco assessment had not been completed for R96 after he was found smoking. DON verified no additional progress notes or additional information/interventions in the EMR was available regarding tobacco use for R96. A facility policy titled Smoking and Tobacco use, dated 10/11/23, was provided. The policy indicated all residents/clients who smoke or use tobacco products will be assessed and care plans will be updated as needed.	F 689		
F 732 SS=C	Posted Nurse Staffing Information	F 732		1/31/24

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F 732		F 732		

Continued From page 25
CFR(s): 483.35(g)(1)-(4)

§483.35(g) Nurse Staffing Information.
§483.35(g)(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.

§483.35(g)(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.

§483.35(g)(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.

§483.35(g)(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.

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F 732	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the required nurse staffing information was posted on a daily basis. This had the potential to affect all 35 residents residing in the facility and/or visitors who may wish to view the information. Findings include: During observation, document review, and interview on 12/26/23 at 10:10 a.m., the nursing staff posting was observed in the main lobby near the entrance and was dated 12/19/23 with a resident population of 36. The staff posting indicated the morning shift began at 6:00 a.m. The staffing coordinator (SC) stated she had not updated the nursing staff posting for the day yet. During an interview on 12/28/23 at 10:26 a.m., the SC stated she oversaw the staff posting and had not updated the staff posting over the weekend or the holiday. The SC stated she updated the staff postings when she arrived at 9:30 a.m., but she did not have a process to update the staff posting at the beginning of the morning shift. The SC stated during the weekend and the holidays, the facility did not have a process to update the staff posting, but this would have been helpful. During an interview on 12/28/23 at 10:34 a.m., the director of nursing (DON) stated that the SC oversaw staffing and would better answer questions regarding this top but, he expected the staffing coordinator to update the staff posting every day in the morning when she arrived.	F 732	F732Posted Nurse Staffing Information- 1. Upon surveyor entry on 12/26/2023 surveyors noted the daily nurse schedule hours were noted to be dated 12/19/2023. The schedule was updated and posted on 12/26/2023 and following days during the survey process 2. All residents have the potential to be affected by the deficient practice. The nurse hour schedule was posted correctly when the scheduler arrived to the care center and completed the necessary corrections to it. 3. To ensure systemic changes are sustained the scheduler received education and procedure changes via email on January 23, 2024 to ensure that a correct nurse hours schedule is posted for the day. A message was sent to all LPN and RN staff stating the new procedure for the posting of nursing schedule hours on January 26, 2024 via the OnShift application. The scheduler will post daily schedule and keep a binder of past schedules available for staff, residents, and guests to review. 4. The DON, Administrator, or designee will audit the posted schedule twice a week for four weeks and then weekly for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The DON will ensure correction of deficiency by January 31, 2024	

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F 732	Continued From page 27 A facility policy regarding the nursing staff posting was not provided.	F 732		
F 804 SS=E	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 2 of 2 residents (R95, R100) reviewed on the short-term stay (i.e., TCU) unit. This had potential to affect a total 11 of 11 residents identified to reside on the unit where the meals were served. Findings include: A provided Resident Listing Report, printed 12/26/23, identified all residents and their room number within the care center. This outlined a total of 11 residents, including R95 and R100, resided on the TCU. R95's Daily Skilled Note - V2, dated 12/24/23, identified multiple sections to recorded R95's various health issues or concerns. This note included a section labeled, "Summary of Skilled Services," which identified R95 was alert and	F 804	F804- Nutritive Value/Appearance, Palatable/Prefer Temperature- 1. On 12/26/2023 it was noted that room tray food was not seasoned, room temperature and could be warmer 2. All residents have the potential to be affected by the deficient practice. Dietary staff received education from the Nutrition and Food Service Supervisor using the Food Preparation-Food and Nutrition Policy and Procedure on January 24, 2024. 3. To ensure systemic changes are sustained the Nutrition and Food Service Supervisor will have all cooks complete the ServSafe Training on January 29, 2024. The Nutrition and Food Service Supervisor is also going to implement an additional dietary meeting with residents monthly which began on January 22, 2024. 4. The Nutrition and Food Service	1/31/24

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F 804

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oriented to person, place, and time.

On 12/26/23 at 11:07 a.m., R95 was interviewed. R95 stated he didn't care for the meal service at the care center. R95 stated he was rarely, if ever, allowed to have a choice on the meal served and expressed the only meal he enjoyed was the breakfast meal. R95 explained the rest of the meals, such as lunch and supper, were typically lacking in flavor and cool when served to him in the room. R95 added, "Both [taste and temperature] are very unsatisfying." R95 stated he had not reported this to anyone at the care center but rather was just trying to eat a bigger breakfast meal so there was "one meal that more or less satisfies me."

R100's admission Minimum Data Set (MDS) dated 12/12/2023, which indicated she was cognitively intact and independent with eating after set-up.

On 12/26/23 at 1:19 p.m., R100 stated that the food is always cold when it is served. She stated she eats meals her meals in her room.

On 12/27/23, the following observations were made:
-11:36 a.m. steam table arrives to Healing Grace Unit. The staff set up empty trays in preparation for the food to be plated to be served to rooms. The items on the steam table are covered with tin foil which included pizza slices (pepperoni and hamburger) and cut up lettuce (for salad).
-11:39 a.m. two residents in the dining room waiting for lunch to be served
-11:41 a.m. the staff asked both residents sitting in the dining room what type of pizza they want and were served lunch

F 804

Supervisor or designee will audit food palatability/temperature two times a week and then weekly for eight weeks.
5. The Administrator or designee will ensure correction of deficiency by January 31, 2024.

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F 804	Continued From page 29	F 804		

-11:45 a.m. the food was plated onto the trays and two unidentified nursing staff delivered the food trays resident rooms. The food items (two pieces of pieces and lettuce) are placed onto a plate and then covered with a plate cover. The plate is then placed on the tray.
-11:52 a.m. the last resident tray finished being plated
-11:52 a.m. a sample plate was requested from the steam table
-11:54 a.m. the sample tray was sampled by nursing assistant (NA)-A who stated there is "not much seasoning" "room temperature" "could be warmer". NA-A stated the sample tray was "mediocre".

During interview on 12/27/23, at 12:27 p.m., NA-A stated there have been "some" complaints from resident about the temperature, flavor, and amount of food. The complaints are written down and given to the dietary manager and director of nursing for follow up.

During interview on 12/27/23, at 12:36 p.m., dietary manager (DM) stated he had received complaints about flavoring about food and is addressing it. DM stated they got a new steam table a couple of weeks ago to help ensure temperatures are holding as he had received complaints. He stated they are monitoring food temperatures. DM stated that when he receives a complaint, he follows up on the complaint by meeting with the resident to see how it can be addressed.

On 12/27/23 at 2:28 p.m., director of nursing (DON) stated that complaints regarding food get passed along to dietary and the administrator will follow up when needed. DON indicated he

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(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 804	Continued From page 30 provides education when needed if it is related to a health concern or impacting a resident's health. A facility policy titled, Dining Service Standard-Food and Nutrition Services, review date of 7/21/23 was provided. It indicated that residents will be provided meals that are nourishing, attractive, and palatable and are served at a safe and appetizing temperature.	F 804		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.	F 883		1/31/24

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F 883	Continued From page 31 §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 2 of 5 residents (R13, R27) reviewed for immunizations. Findings include: A CDC Pneumococcal Vaccine Timing for Adults	F 883	F883- Influenza and Pneumococcal Immunizations- It was found that resident R13 and R27 had not received pneumococcal immunizations during the survey process. 1. The DON provided education to the IP nurse using the Immunization/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other Policy and Procedure on December 28, 2024. The IP nurse reviewed the	

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F 883

Continued From page 32

feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions (i.e., PPSV23, PCV13, PCV20) of the pneumococcal vaccine. The graph labeled, "Adults 19-64 years old with specified immunocompromising conditions ...," listed multiple columns to reference with which vaccine(s) had already been given and, from that, which were now recommended. The graph contained various conditions which were considered immunocompromising including, "Chronic renal failure," and the graph identified with a previous administration of PPSV23, to wait at least one year then provide either a PCV15 or PCV20 vaccine.

R13's significant change Minimum Data Set (MDS), dated 11/18/23, identified R13 admitted to the nursing home in December 2022, was less than 65 years old, and had several medical conditions including anemia and chronic kidney disease (CKD). However, the section to record R13's cognition was left blank and not completed (see F637, F638).

R13's Vaccine Consent - Multiple Vaccines form, illegibly (handwritten) dated, identified multiple vaccines listed with a corresponding space to circle consent or refusal via a "yes" or "no" response. This identified a space which read, "Pneumococcal (PCV15, PCV20; PPSV23)" with the affirmative response (i.e., yes) circled as his choice. However, there were no written date of administration listed as there were with the other recorded vaccines.

R13's electronic medical record (EMR) Immunizations listing, undated, identified all of R13's complete immunizations per the care

F 883

electronic medical record and consent forms for residents R13 and R27 then provided education and consent to the residents before proceeding with immunizations.

2. All residents have the potential to be affected by the deficient practice. A comprehensive review of all resident Influenza and Pneumococcal Immunizations was completed by the IP nurse. Education, consent, or refusal of immunization was given/acquired from resident or resident representative and documented in the electronic medical record. Those who gave consent to be immunized received the appropriate immunization and this was documented in the electronic medical record.

3. To ensure systemic changes are sustained all nursing staff received education on Immunization/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other Policy and Procedure on January 18, 2024. Immunization education will be provided to all new admissions to care center, and consent or refusal of immunization will be obtained from resident or resident representative. Appropriate immunizations will then be given to those who have consented to them. These items will be document in the electronic medical record.

4. The DON or designee will complete audits of random resident immunization information in the electronic medical record two times a week for four weeks and then weekly for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up

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F 883	Continued From page 33 center' record. This included a PPSV23 vaccine on 11/2008 with dictation, "Historical," however, lacked evidence any of the other pneumococcal immunizations were offered, provided or refused. Further, R13's entire medical record, including the scanned Minnesota Immunization Information Connect (MIIC) information, was reviewed and lacked evidence any of the other pneumococcal vaccinations, including PCV15 or PCV20, had been offered, refused or provided despite being recommended due to history of CKD. When interviewed on 12/27/23 at 11:04 a.m., R13 stated he was unable to recall if anyone, including his physician, had ever discussed the subsequent vaccinations with him adding, "I don't remember." R13 verified he had CKD and diabetes and voiced he was open to getting the vaccinations, if needed. A CDC Pneumococcal Vaccine Timing for Adults feature, dated 3/2023, identified several tables with corresponding recommendations when to receive various versions of the pneumococcal vaccine. The graph labeled, "Adults 19-64 years old with chronic health conditions ...," listed multiple columns to reference with which vaccine(s) had already been given and, from that, which were now recommended. The graph contained various health conditions which were considered chronic (i.e., high risk) including diabetes mellitus and cigarette smoking, and the graph identified with a previous administration of PCV13, to wait at least one year then provide either a PCV20 or PPSV23 with dictation, "Review pneumococcal vaccine recommendations again when your patient turns 65 years old."	F 883	initiated to ensure compliance is sustained. 5. The DON will ensure correction of deficiency by January 31, 2024.	

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F 883	Continued From page 34	F 883		

R27's quarterly MDS, dated 12/6/23, identified R27 had diabetes mellitus. However, the section to record R27's cognition was left blank and not completed (see F637, F638).

R27's Vaccine Consent - Multiple Vaccines form, dated 12/28/23, identified R27 was less than 65 years old and outlined multiple vaccines with a corresponding space to circle consent or refusal via a "yes" or "no" response. This identified a space which read, "Pneumococcal (PCV15, PCV20; PPSV23)" with the affirmative response (i.e., yes) circled as his choice.

R27's EMR Immunizations listing, undated, identified all of R27's complete immunizations per the care center' record. This included a PCV13 on 8/2015 with dictation, "Historical," however, lacked evidence any of the other pneumococcal immunizations were offered, provided or refused. Further, R27's entire medical record, including the scanned Minnesota Immunization Information Connect (MIIC) information, was reviewed and lacked evidence any of the other pneumococcal vaccinations, including PPSV23 or PCV20, had been offered, refused or provided prior to the recertification survey when his consent was obtained (dated 12/28/23) despite being recommended due to a history of diabetes.

When interviewed on 12/27/23 at 11:06 a.m., R27 stated he had diabetes and was a current smoker. R27 stated he was unable to recall anyone from the care center, including his physician, discussing the subsequent pneumococcal vaccinations with him and added he was open to discussing them further, if needed.

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F 883	Continued From page 35 On 12/28/23 at 9:20 a.m., registered nurse unit manager (RN)-A was interviewed and verified they were the infection preventionist (IP) for the campus. RN-A explained immunizations were discussed upon admission but admitted the process had "kind of varied" lately with personnel whom were responsible to do it. RN-A stated they typically reviewed EPIC (hospital charting) and the MIIC for data and, based on those sources, would offer applicable vaccines as needed adding the process was "kind of like a group effort." RN-A reviewed R13 and verified his medical conditions. RN-A stated R13 had signed a consent previously in November 2023 for the subsequent pneumococcal vaccine but there had been a delay in getting it due to a needed "prior authorization" from an insurance payer then an illness-related episode happened so they were going to wait awhile before giving it. As a result, RN-A stated they had just given R13 the vaccine last evening (on 12/27/23) after being questioned about it by the surveyor, and acknowledged the medical record lacked any information explaining the delay in administration. RN-A then reviewed R27 and verified his medical conditions and being a current smoker. RN-A stated the facility had just recently ordered more PCV20 doses and had received them to provide to residents, including R27, however, had not done so yet. RN-A stated they were unsure why there was such a delay in offering any of the subsequent vaccines (i.e., PPSV23) to R27 since he had admitted several months prior. As a result, RN-A stated they had just discussed the remaining series of vaccines with R27 the day prior (on 12/27/23) after being questioned about it by the surveyor, and verified R27 did indeed want the vaccination. RN-A stated the lack of timely administration was "very frustrating" and attributed it to being short-staffed	F 883		

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F 883	Continued From page 36 and, subsequently, constantly being pulled to work the floor adding the immunization process, as a whole, was still a "work in progress" and they were working with an outside group to help them streamline it for the better. However, RN-A stated it was important to ensure the timely administration of vaccines "to protect them [residents]"." A facility' provided Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other policy, dated 3/2022, identified each new admission to the care center would be given the Vaccination Information Statements (VIS) for influenza and pneumococcal vaccines. If they consented, then a physician order and written consent would be obtained, and the vaccine administered. The policy outlined a section labeled, "Pneumococcal Vaccination," which outlined directions for adults 65 years or older, however lacked information on recommendations for adults less than 65 years of age.	F 883		

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 12/27/2023. At the time of this survey, GOOD SAMARITAN SOCIETY COMFORTCARE was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code.

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/26/2024

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 IS NOT REQUIRED. Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GOOD SAMARITAN SOCIETY COMFORTCARE is a 1 story building, with no basement The building was constructed was constructed in 2007 and was determined to be of Type II (111) construction.	K 000		

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K 000	Continued From page 2 The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 45 beds and had a census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 324 SS=D	Cooking Facilities CFR(s): NFPA 101 Cooking Facilities Cooking equipment is protected in accordance with NFPA 96, Standard for Ventilation Control and Fire Protection of Commercial Cooking Operations, unless: * residential cooking equipment (i.e., small appliances such as microwaves, hot plates, toasters) are used for food warming or limited cooking in accordance with 18.3.2.5.2, 19.3.2.5.2 * cooking facilities open to the corridor in smoke compartments with 30 or fewer patients comply with the conditions under 18.3.2.5.3, 19.3.2.5.3, or * cooking facilities in smoke compartments with 30 or fewer patients comply with conditions under 18.3.2.5.4, 19.3.2.5.4. Cooking facilities protected according to NFPA 96 per 9.2.3 are not required to be enclosed as hazardous areas, but shall not be open to the corridor. 18.3.2.5.1 through 18.3.2.5.4, 19.3.2.5.1 through 19.3.2.5.5, 9.2.3, TIA 12-2	K 324		1/31/24

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K 324	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observation, documentation review, and staff interview, the facility failed to maintain proper safety and security measures related to a cooking device in a resident accessible corridor in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.3.2.5.3(9). This deficient condition could have a isolated impact on the residents within the facility. Findings Include: On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the cooking device located in the Physical / Occupational Area did not have the proper lock-out, timeout, and disconnect hardware connected to the device. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 324	K324 Cooking Facilities- Cooking device without proper safety and security measures On December 27, 2023 it was found that the cooking device in the therapy room did not have a proper safety and security measure device installed. The Environmental Services Director contacted Austin Electric (electrician) to install a new safety/security device on the cooking device on January 10, 2024. The electrician ordered the appropriate supplies and installed the proper safety equipment on January 26, 2024. All other cooking devices that are accessible to residents will continue to be disconnected and will have notices placed on them to notify staff, resident, and visitors that they are disconnected. The Environmental Services Director or designee will audit cooking devices twice a week for four weeks and then weekly time eight weeks to ensure compliance.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per	K 374		1/31/24

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K 374	Continued From page 4 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: 1. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the Lodge Wing - smoke compartment doors upon testing exhibited a final door-to-door gap opening greater than 1/8 inch. Protective hardware was incorrectly mounted to the doors. 2. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the Garden Wing - smoke compartment doors upon testing exhibited a final door-to-door gap opening greater than 1/8 inch. Protective hardware was incorrectly mounted to the doors. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 374	K374-Subdivision of Building-Smoke Barrier On December 27, 2023 it was noted that the fire doors on the Lodge and Garden had incorrectly mounted protective hardware on them causing a gap. . The Environmental Services Director mounted protective hardware for smoke doors for both the Lodge and Garden on January 10, 2024 so that they were mounted in the correct position. The facility will verify correct hardware mounting if fire doors are replaced in the future. The Administrator or designee will audit fire doors two times a week for four weeks and then weekly for eight weeks to ensure there is no gap greater than 1/8 of an inch while they are closed.	
K 741 SS=C	Smoking Regulations CFR(s): NFPA 101 Smoking Regulations Smoking regulations shall be adopted and shall	K 741		1/31/24

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	**1201 17TH STREET NE** **AUSTIN, MN 55912**

(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 741	Continued From page 5 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: Based on review of available documentation and staff interview, the facility failed to implement and maintain proper documentation associated to facility smoking regulations per NFPA 101 (2012 edition), Life Safety Code , section 19.7.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 12/27/2023 between 9:30 AM and 1:30 PM, it	K 741	K741 Smoking Regulation On December 27, 2023 it was found that the care center did not have a designated smoking area for staff within its smoking policy. The care center will initiate an addendum to the smoking policy to clearly describe the location of the designated smoking area for the staff to prevent this from happening in the future, policy will be reviewed annually to ensure compliance.	

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K 741	Continued From page 6 was revealed by review of available documentation that the facility smoking policy did not identify location(s) where staff and/or clients are allowed to smoke. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 741	On January 24, 2023 the addendum was printed and placed in the fire safety book by the DON and Environmental Services Director to ensure that it was completed.	
K 753 SS=F	Combustible Decorations CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: o Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. o Decorations meet NFPA 701. o Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. o Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). o The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain and inspect the facility to be in accordance with NFPA 101 (2012 edition), Life Safety Code, section 19.7.5, 19.7.5.6. This deficient finding could have a patterned impact on the residents within the facility. Findings include:	K 753	K753 Combustible Decorations On December 27, 2023 it was found that two resident rooms had over 90% of their doors covered by holiday decorations. These items were removed from the doors on December 27, 2023. Education about decorations using the Life Safety Code Resource Packet will be provided to staff via message using the	1/31/24

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K 753	Continued From page 7 On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that the following resident / client room doors were 90% covered with combustible seasonal decoration(s): RM 413, RM 419. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 753	OnShift application on January 24, 2024. Residents and families will receive education on decorations upon admission and annually. The Administrator, Environmental Services Director, and DON will provide education to staff, families, and residents by January 31, 2024. The Environmental Services Director or designee will audit all doors for compliance of decorations two times a week for four weeks and then weekly for eight weeks to ensure facility remains in compliance. The Administrator will ensure correction of deficiency by January 31, 2024.	
K 920 SS=E	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the	K 920		1/31/24

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K 920	Continued From page 8 conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to properly manage the implementation and usage of power strips in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6, 10.2.4 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8, 590.3(D). These deficient finds could have a patterned impact on the residents within the facility. Findings include: 1. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the Admin. Office that a relocatable power tap was connected to an extension cord 2. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the Social Services Office that a relocatable power tap was connected to an extension cord An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 920	K920 Electrical Equipment Power Cords and Extens On December 27, 2023 it was found that extension cords were being used in Administrator office and Social Services Office. The extension cords were removed on December 31, 2023. Staff education will be provided using the Electrical Systems Resource Packet via the OnShift application on January 24, 2024. The Environmental Services Director or designee will audit for use of extension cords two times a week for four weeks and then weekly for eight weeks. The Administrator will ensure correction of deficiency by January 31, 2024.	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet	K 923		1/31/24

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K 923	Continued From page 9 Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited-combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier. Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper medical gas storage and management per NFPA 99 (2012 edition), Health Care Facilities Code, sections 9.3.7, 9.3.7.5.3, 11.6.5. These deficient findings could have a widespread impact on the residents	K 923	K923-Gas Equipment-Cylinder and Container Storage On December 27, 2023 there was mixed storage of empty and full cylinders in the Oxygen Supply Room. On December 27, 2023 the cylinders in question were placed	

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K 923	Continued From page 10 within the facility. Findings include: 1. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in the Healing Grace Wing and the Main - Med Gas (O2) Storage Rooms that there was mixed storage of empty / full cylinders. 2. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation in the Main - Med Gas (O2) Storage Room that there was storage of combustible materials. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 923	into the correct storage rack showing they were either empty or full. All staff received education on the Medical Gas Protection, Including Oxygen-Life Safety Code Policy and Procedure on January 18, 2024. The DON or designee will audit oxygen storage twice a week for four weeks and then weekly for eight weeks. The DON will correct area of deficiency by January 31, 2024 On December 27, 2023 it was found that there was combustible materials stored in the Oxygen Storage room. On January 18, 2024 combustible materials were removed from the oxygen storage room. All staff received education on the Oxygen Policy and Procedure on January 18, 2024. The DON or designee will audit the Oxygen Storage Rooms for combustible items two times a week for four weeks and then weekly for eight weeks. The DON will ensure correction of the area of deficiency by January 31, 2024.	

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	00967	A. BUILDING: ______ B. WING ______	12/28/2023

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2 000	Initial Comments	2 000		

Initial Comments

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
On 12/26/23 to 12/28/23, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the MN State Licensure requirements. In addition, a complaint investigation was completed.

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The following complaints were reviewed with no licensed orders associated: H53178078C (MN95201)

As a result of the survey, the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

The MDH is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the significant change in status Minimum Data Set (MDS; i.e., a comprehensive assessment) was completed in a thorough manner to ensure areas of cognition and depressive symptoms were fully evaluated for 1 of 4 residents (R13) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual,	2 545	□ Comprehensive Assessment After Significant Change Resident R13 had blank MDS Sections from C0200 to C1000, Section D was left blank from D0150 to D0600 during a SCSA MDS with an ARD from 11/11/23 to 11/18/23. 1. Resident R13□s MDS was reviewed and noted to have incomplete sections on 12/27/2023. The needed assessments were reviewed and competed if resident was able to respond to questions or still available for interview. 2. All residents could be affected by the	1/31/24

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2 545	Continued From page 3 dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual included a section labeled, "Comprehensive Assessments," which included a significant change in status (SCSA) and outlined such assessments would yield corresponding CAA(s) to be completed which were triggered from conditions and responses marked on the MDS. The manual included a section labeled, "SECTION C: COGNITIVE PATTERNS," which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, "These items are crucial factors in many care-planning decisions;" with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, "SECTION D: MOOD," which outlined the section would be used to help address mood distress and social isolation adding, "Mood distress is a serious condition that is under diagnosed and under treated in the nursing home and is associated with significant morbidity," and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R13's significant change MDS, dated 11/18/23, identified R13 admitted to the care center in 12/2022 and had several medical diagnoses including renal disease, high blood pressure, and a history of stroke. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed Brief Interview for Mental Status (BIMS) was left blank and not completed and, in addition, the subsequent section for the staff assessment (used if the resident is rarely or	2 545	deficient practice. Specifically, resident who recently had a significant change in status and needed to have a new MDS completed. All residents who could be affected by this were reviewed by the MDS nurse and verified to be completed correctly. 3. To ensure systemic changes are sustained, education was provided to MDS Nurse on 12/27/2024 using the MDS 3.0 RAI Policy and Procedure. The DON provided education to the social worker using the MDS 3.0 RAI Policy and Procedure on January 24, 2024. All staff were notified of this deficiency and education was provided on completing UDAs to ensure completion of the MDS in a timely manner on January 18, 2024 in an all staff meeting. The DON, Social Worker, Dietary Manager, Activities Director, and MDS nurse will meet weekly to ensure MDS assessments are completed and ready for submission. 4. MDS assessments will be audited by the DON, Administrator, or designee twice a week for four weeks and weekly for eight weeks. Audit results will be reviewed by the QAPI committed with the appropriate follow-up initiated to ensure compliance is sustained. 5. The correction of this deficiency will be conducted the DON and will have a date of correction on January 31, 2024.	

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2 545	Continued From page 4	2 545		

never understood) was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment (also used if the resident is rarely or never understood) was left blank and not completed. In total, section D0150 to D0600 was left blank and not completed or addressed.

R13's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the SCSA assessment reference date (ARD; from 11/11/23 to 11/18/23) to determine what, if any, complications or issues R13 demonstrated with those corresponding areas.

On 12/27/23 at 12:34 p.m., registered nurse (RN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R13's medical record, including the SCSA MDS (dated 11/18/23), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility' did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. RN-B stated, as a result, they had to dash the corresponding MDS areas. RN-B expressed they had not delegated any of these assessments to the floor nurses' to complete, either, adding, "I don't know if we could or not." RN-B stated an MDS not completed thoroughly, including the applicable evaluations for mental

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status and mood, could cause various CAA items to not trigger adding, "It might." Further, RN-B stated "going forward" they were going to "block out" more time to get the evaluations completed for the MDS' and expressed it was important to ensure MDS(s) were completed accurately and thoroughly so "we know where their [resident] cognitive levels are."

When interviewed on 12/27/23 at 12:51 p.m., the director of nursing (DON) stated he was aware RN-B being pulled to work on other things (i.e., the floor) was "slowing [them] down" on MDS' workload, however, he was unaware they were just being dashed and not thoroughly completed as a result. DON stated they had recently hired a social worker who was "still in training" and were hopeful such hire would improve the situation. However, DON stated it was important to ensure all areas on the MDS were thoroughly completed as they help determine "how we care for our patients" and they help "develop better care plans," too.

A provided MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) - Rehab/Skilled & Therapy and Rehab policy, dated 6/2023, identified a purpose to complete the RAI within the federally mandated timeline(s). The policy outlined, "The interviews must be conducted during the designated observation period. The [BIMS] ... will be completed during the observation period. The [PHQ-9] and Pain Assessment are preferably completed the day before or day of the ARD. Complete means that the interview questions have been saved, signed and locked." Further, the policy outlined, "If any discipline is unable to complete its section ..., the RN coordinator will assign another person to complete this section within the time frame."

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	00967	A. BUILDING: ______ B. WING ______	12/28/2023

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 545	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure accuracy, educate floor staff and/or consulting staff on expectations for the timely completion of the MDS, and then audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: 21 Days	2 545		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quarterly Minimum Data Set (MDS) was completed in a thorough manner to ensure areas of cognition and depressive symptoms were screened and, if needed, fully evaluated for 2 of 4 residents (R3, R28) reviewed for MDS accuracy. Findings include: The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument (RAI) 3.0 User's Manual, dated 10/2023, identified the RAI consists of three basic components including the MDS, the Care Area Assessment (CAA) and the utilization	2 550	Quarterly Review Assessment at Least Every 3 Months-Residents R3 and R28 were identified to have section C0200 to C1000 and Section D0150 to D0600 blank on their MDS assessments. 1. These residents MDS sections were reviewed by the MDS nurse, the MDS nurse coordinated the completion of these sections in the MDS for residents R3 and R28. 2. All residents have the potential to be affected by the deficient practice. All resident MDS sections were reviewed by the MDS nurse to ensure that they are completed in a timely manner. 3. To ensure systemic changes are	1/31/24

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2 550	Continued From page 7 guidelines and this process (i.e., use of the entire RAI) was mandated by CMS. The manual outlined a quarterly assessment was a non-comprehensive assessment which was to be completed every 92 days and was used to track a resident' status between comprehensive assessments " ... to ensure critical indicators of gradual change in a resident's status are monitored." The manual included a section labeled, "SECTION C: COGNITIVE PATTERNS," which outlined the section would be used to help determine the resident's attention, orientation and ability to register or recall information adding, "These items are crucial factors in many care-planning decisions;" with provided methods and instructions to ensure accurate, thorough coding of the MDS. Further, the manual included another section labeled, "SECTION D: MOOD," which outlined the section would be used to help address mood distress and social isolation adding, "Mood distress is a serious condition that is underdiagnosed and undertreated in the nursing home and is associated with significant morbidity," and again, the manual provided methods and instructions to ensure the comprehensive evaluation of these conditions. R3's quarterly MDS, dated 12/7/23, identified R3 had several medical conditions including high blood pressure, depression, and a history of stroke. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed Brief Interview for Mental Status (BIMS) was left blank and not completed and, in addition, the subsequent section for the staff assessment (used if the resident is rarely or never understood) was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a	2 550	sustained, the DON provided education to MDS Nurse on 12/27/2024 using the MDS 3.0 RAI Policy and Procedure. The DON provided education to the social worker using the MDS 3.0 Policy and Procedure on January 24, 2024. All staff were notified of this deficiency and education was provided on completing UDAs to ensure completion of the MDS in a timely manner on January 18, 2024. The DON, Social Worker, and MDS nurse will meet weekly to ensure MDS assessments are completed and ready for submission. 4. MDS assessments will be audited by the DON, Administrator, or designee twice a week for four weeks and weekly for eight weeks. Audit results will be reviewed by the QAPI committed with the appropriate follow-up initiated to ensure compliance is sustained. 5. The correction of this deficiency will be conducted the DON and will have a date of correction on January 31, 2024.	

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2 550	Continued From page 8	2 550		

mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment (also used if the resident is rarely or never understood) was left blank and not completed. In total, section D0150 to D0600 was left blank and not completed or addressed.

R3's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the quarterly assessment reference date (ARD; from 12/1/23 to 12/7/23) to determine what, if any, complications or issues R3 demonstrated with those corresponding areas.

R28's quarterly MDS, dated 11/29/23, identified R28 had several medical conditions including history of stroke. The 'Section C - Cognitive Patterns' was reviewed and the spacing to record a completed BIMS was left blank and not completed and, in addition, the subsequent section for the staff assessment was also left blank and not completed. In total, section C0200 to C1000 was left blank and not completed. The 'Section D - Mood' was reviewed and the spacing to record a mood interview, including with symptom presence of frequency of depression, was left blank and not completed and, in addition, the subsequent section for the staff assessment was left blank and not completed. In total, section D0150 to D0600 was left blank and not completed or addressed.

R28's medical record was reviewed and lacked evidence either of these sections and corresponding evaluations (i.e., BIMS, PHQ-9) had been completed during the quarterly ARD

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2 550		2 550		

Continued From page 9

(from 11/22/23 to 11/29/23) to determine what, if any, complications or issues R28 demonstrated with those corresponding areas.

On 12/27/23 at 12:34 p.m., registered nurse (RN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R3 and R28 medical record, including the completed MDS(s), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility' did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. RN-B stated, as a result, they had to dash the corresponding MDS areas. RN-B expressed they had not delegated any of these assessments to the floor nurses' to complete, either, adding, "I don't know if we could or not." Further, RN-B stated "going forward" they were going to "block out" more time to get the evaluations completed for the MDS' and expressed it was important to ensure MDS(s) were completed accurately and thoroughly so "we know where their [resident] cognitive levels are."

When interviewed on 12/27/23 at 12:51 p.m., the director of nursing (DON) stated he was aware RN-B being pulled to work on other things (i.e., the floor) was "slowing [them] down" on MDS' workload, however, he was unaware they were just being dashed and not thoroughly completed as a result. DON stated they had recently hired a social worker who was "still in training" and were hopeful such hire would improve the situation. However, DON stated it was important to ensure all areas on the MDS were thoroughly completed as they help determine "how we care for our patients" and they help "develop better care

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2 550	Continued From page 10 plans," too. A provided MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) - Rehab/Skilled & Therapy and Rehab policy, dated 6/2023, identified a purpose to complete the RAI within the federally mandated timeline(s). The policy outlined, "The interviews must be conducted during the designated observation period. The [BIMS] ... will be completed during the observation period. The [PHQ-9] and Pain Assessment are preferably completed the day before or day of the ARD. Complete means that the interview questions have been saved, signed and locked." Further, the policy outlined, "If any discipline is unable to complete its section ..., the RN coordinator will assign another person to complete this section within the time frame." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure timely and full MDS completion; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 550		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are	2 560		1/31/24

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2 560	Continued From page 11 identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a comprehensive care plan was developed to reflect resident' condition with assessed bowel incontinence and consumed, high-risk medications to promote continuity of care and reduce the risk of complication for 1 of 2 residents (R95) reviewed for care planning. Findings include: R95's Medicare - 5 Day Minimum Data Set (MDS), dated 11/17/23, identified sections to record R95's cognition, however, these were left blank and not completed (see F637, F638). On 12/26/23 at 11:27 a.m., R95 was interviewed and expressed concerns over his bowels adding, "I haven't had a regular bowel movement in months." R95 stated his bowel movements, as of late, had been "very loose" and he had "no control over it" so staff were changing his incontinence products often. R95's most recent Bowel Evaluation, dated 12/20/23, identified R95 had been assessed as having bowel incontinence which existed for "months" with a listed frequency, "Daily, but some control is present." The sections to record history, contributing factors, and cognition were left blank and not completed. Further, the assessment listed a section labeled, "Care Planning," with	2 560	Develop/Implement Comprehensive Care Plans-Residents R95 Comprehensive Care Plan did not show high-risk medication, bowel incontinence. 1. On 12/27/2023 it was noted that the care plan for resident R95 was lacking information regarding high-risk medications and bowel incontinence. The Nurse Manager for R95 reviewed the care plan and added section information on high-risk medications including the observation of side-effects and psychotropic medication use monitoring and triggered monitoring questions into the electronic medical record. A toileting program was developed in the Care Plan to provide resident R95 with appropriate bowel incontinence care/prevention. 2. All residents have the potential to be affected by the deficient practice. Specifically, residents who are taking high-risk medications and have bowel/bladder incontinence. A review of all residents care plans was completed by the nurse managers and DON to ensure these items were in resident care plans including interventions and goals. On 12/28/2024 The DON provided education to the nurse managers using the Comprehensive Care Plan and Care Conference Policy and Procedure to ensure understanding.	

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2 560	Continued From page 12 corresponding options to check to represent what, if any, problem statements or goals or interventions would be completed or implemented for R95's incontinence; however, these were all left blank and not completed. R95's POC (Point of Care) Response History, printed 12/28/23, identified a 14-day look back period and recorded R95's bowel continence episodes. This identified R95 had 10 episodes of bowel incontinence recorded during the period. R95's Order Summary Report, printed 12/28/23, identified R95's had several medical conditions including anemia, diabetes mellitus, atrial fibrillation, and chronic kidney disease. The report listed R95's physician-ordered medications which included apixaban (an anti-coagulant medication), lorazepam (an anti-anxiety medication) bumetanide (a diuretic medication), mirtazapine (an anti-depressant medication), oxycodone (a narcotic medication), and senna-docusate sodium (a laxative medication). However, R95's care plan, dated 12/26/23, identified R95 admitted to the care center on 12/20/23 but lacked any identified problem statements, goals, or subsequent interventions for R95's bowel incontinence or consumed high-risk medications (i.e., side effect monitoring, associated risk factors). Further, the medical record, including Treatment Administration Record (TAR), was reviewed and lacked evidence of ongoing psychotropic medication use monitoring or how such would be completed (i.e., care planned); in addition, the medical record lacked evidence a baseline care plan had been completed or initiated upon R95's re-admission nearly a week prior.	2 560	3. To ensure systemic changes are sustained, all nursing staff were educated on comprehensive care plans on January 18, 2024 during and all staff meeting using the Comprehensive Care Plan and Care Conference Policy and procedure. 4. The DON or designee will complete audits on random resident care plans twice a week for four weeks and then weekly for eight weeks specifically for hazards medications and Bowel incontinence. Audit results will be reviewed by the QAPI committee and appropriate follow-up initiated to ensure compliance is sustained. 5. The DON will assure correction of this deficiency by January 31, 2024	

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2 560	Continued From page 13 On 12/27/23 at 2:25 p.m., nursing assistant (NA)-B was interviewed and verified they had worked with R95 prior. NA-B explained R95 was "most of the time" in bed and rarely used the toilet so, as a result, would call for staff assistance when he was incontinence of bowel. NA-B stated R95's stool were "putty like" most of the time, however, they never report that to the nurses rather "just charted it." NA-B stated they were unaware what, if any, other interventions for R95's bowel were being done aside from just checking and changing him with each incontinence episode. Further, NA-B stated they had not noticed or seen by behavior issues or depressive symptoms from R95 to their recall. On 12/28/23 at 8:34 a.m., registered nurse unit manager (RN)-B was interviewed and verified they had reviewed R95's medical record. RN-B explained R95 had originally been admitted back in November 2023; however, he was then re-hospitalized and the family elected to not hold the bed so, as a result, on 12/20/23 he was considered a new admission adding R95 had a primary diagnosis of cancer and anemia and, as a result of those, would get routine blood transfusions. RN-B explained a "24 hour" care plan was developed upon admission which included basic information for the NA(s) to use for care with evaluations are completed. RN-B verified a formal 'baseline care plan' was not done, rather the care center just started building the comprehensive care plan right away and added to it as things were evaluated. RN-B reviewed R95's care plan and verified it lacked problem statements, goals, or interventions for R95's assessed bowel incontinence or what, if any, interventions or monitoring would be completed for the high-risk medication consumption (i.e., any psychotropic medication	2 560		

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2 560	Continued From page 14 monitoring). RN-B stated they were going to repeat the bowel evaluation as they "want to do the full assessment" since the nurse who completed the original one (dated 12/20/23) "obviously didn't complete everything." RN-B acknowledge the information on the care plan pulled to the NA kardex (tool used to know what cares to provide) and expressed they were going to add certain items to help guide R95's care (i.e., monitor for bruising, depression symptoms). RN-B stated it was important to ensure a care plan was developed as "it helps address what you're [staff] actually doing through your assessment." A policy on care plan development was requested, however, none was received. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure timely evaluation and careplanning for identified problem areas; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 560		
2 620	MN Rule 4658.0445 Subp. 4 A-N Clinical Record; Admission Information Subp. 4. Admission information. Identification information must be collected and maintained for each resident upon admission and must include, at a minimum: A. the resident's legal name and preferred name; B. previous address;	2 620		1/31/24

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2 620	Continued From page 15 C. social security number; D. gender; E. marital status; F. date and place of birth; G. date and hour of admission; H. advance directives, & Do Not Resuscitate (DNR) & Do Not Intubate (DNI) status, if any; I. name, address, and telephone number of designated relative or significant other, if any; J. name, address, and telephone number of person to be notified in an emergency; legal representative, designated representative, or representative payee, if any; K. legal representative, designated representative, or representative payee, if any; L. religious affiliation, place of worship, and clergy member; M. hospital preference; and N. name of attending physician. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure wishes and directives for emergency treatment (i.e., cardio-pulmonary resuscitation) were obtained upon admission and kept readily-accessible to ensure appropriate care would be provided for 1 of 1 resident (R96) reviewed for advanced directives. Findings Include: R96's admission Minimum Data Set (MDS) assessment, dated 12/17/23, indicated R96 had impaired cognition and diagnoses included hypertension (high blood pressure), mild cognitive	2 620	1. Resident R96 was identified to not have documented wishes and directives for emergency treatment. A review of R96s chart was immediately completed on 12/26/2023 and code status/advanced directives were entered into the EMR system based on resident wishes and clinical documentation from residents hospital medical record. A POLST was filled out by nursing staff and resident. The medical provider then signed the POLST and it was submitted to be scanned into the residents EMR code status was entered into EMR as soon as resident	

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2 620	Continued From page 16 impairment, shortness of breath, anemia (low red blood cells), and gastrointestinal hemorrhage (a bleed in the digestive tract). Further, the MDS indicated he was independent with mobility, personal hygiene, and eating; and admitted to the care center on 12/11/23. Review of R96's physician orders on 12/26/23, lacked evidence of a code status (type of emergent treatment a person would or would not receive if their heart or breathing were to stop) for R96. In addition, R96's care plan, dated 12/28/23, and his electronic medical record (EMR) both also lacked evidence of R96 health care wishes being addressed or listed (i.e., code status). The EMR had a banner along the top which listed R96's name, date of birth, and age along with a space which read, "Code Status:," however, this space was left blank. R96's medical record was reviewed and lacked evidence to ensure R96's wishes and directives were assessed upon admission. There was no evidence the facility had assessed R96 to determine what, if any, measures he would want implemented during an emergency situation. Further, the record lacked any scanned information or physical order for a code status which could be easily identified should an emergent situation happen and R96 would be unable to speak for himself. During interview on 12/26/23, at 3:01 p.m., registered nurse unit manager (RN)-A verified in the EMR there is no code status listed for R96. RN-A stated if a code status is not listed, then the facility would do CPR and start compressions. RN-A indicated there is a red-colored folder with "code status" for each person listed, but upon review then verified that R96 was not listed and	2 620	made wishes know. 2. All residents have the potential to be affected by the deficient practice. All resident medical records were reviewed by DON or nurse manager on 12/26/2023 and showed that code status/advanced directives were entered into the electronic medical record for all other residents. 3. To ensure that our systemic changes are sustained the DON provided education to nurses, nurse managers, social services, and HIM on entry of code status/advance directives using the Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) Policy and Procedure and the Advance Care Planning Policy and Procedure on January 18, 2024 in an all staff meeting. 4. The DON, administrator, or designee will perform audits on resident code status/advance directive to verify it is entered into the EMR twice a week for four weeks and weekly for eight weeks. Audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained. 5. The date of correction will be January 31, 2024 with the DON, Administrator, or designee verifying correction of deficiency.	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 620	Continued From page 17	2 620		

again stated they would start CPR. Registered nurse (RN)-C then joined the interview and indicated the nurse who does admission should complete POLST (physician order for life-sustaining treatment: a form which residents complete to ensure their healthcare wishes are upheld), question a resident code status and record it in EMR so it shows on banner. RN-A and RN-C indicated the code status is likely not in progress note but directly on banner at the top of the EMR and reiterated the "admission nurse" should have "conversation with them" on admission about this, and record it directly into the EMR banner and medical record.

On 12/26/23, at 3:15 p.m., RN-A reviewed EMR and was unable to locate code status via hospital, verified R96 was cognitively impaired, and no health care directive listed. RN-A then started to review a complied stack of paperwork in the nurses' station which had multiple residents, including R96's, information within. RN-C verified would check EMR banner if a resident is found unresponsive, if the banner is blank, would start CPR. RN-C stated if unable or poor cognition to verify code status, then would visit with family and paperwork placed in charting room until scanned. RN-C verified R96 admitted 12/11/23, and the code status remains blank adding "it shouldn't be". RN-C verified if a resident was DNR (do not resuscitate) then would get CPR which could possibly be "against their wishes". RN-C reviewed hospital paperwork and unable to locate code status.

During interview on 12/26/23 at 3:19 p.m., R96 indicated that he "of course" would want CPR done if unresponsive. R96 was unable to recall if the facility asked about his wishes. R96 stated his son was "so-so" involved.

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	00967	A. BUILDING: ______ B. WING ______	12/28/2023

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GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912

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On 12/26/23, at 3:21 p.m., RN-A presented back to the surveyor and reported they had found and provided a hospital report that listed R96 as a Full code status. RN-A verified it was located after doing extensive review of the stack of paperwork and other binders in the office and was not located in a "typical" place a nurse would check for a code status and verified it should be in the EMR.

During an interview on 12/27/23, at 1:37 p.m., family member (FM)-A stated that the facility had not consulted with them on health care directive or code status of their family member. They stated that R96 was their own person, and the code status should be what R96 wants. FM-A stated they are working on making a legal document (health care directive) with a lawyer on January 5th.

During an interview on 12/27/23, at 2:37 p.m., director of nursing (DON) stated the admission nurse reviews a resident's code status, discusses a resident wish, and have the resident or representative sign a POLST which then goes to the physician to sign. This occurs on the day of admission. DON stated the code status is entered into the EMR.

During an interview on 12/28/23, at 8:33 a.m., licensed practical nurse (LPN)-A stated residents code statuses are discussed upon admission. The code statuses are entered into the EMR system. LPN-A verified code statuses are verified in the EMR prior to administering CPR.

The facility policy titled Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator, dated

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2 620	Continued From page 19 8/1/23, was provided. The policy indicated the purpose is to provide each resident the opportunity to make decisions related to medical care and select a provide and to define a process to make resident decisions known. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure code status is clarified on admission; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 620		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide	2 830	1. Cigarettes were removed form resident R96�s room on December 27, 2023 to ensure resident did not smoke in	1/31/24

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2 830

Continued From page 20

adequate interventions and supervision for 1 of 1 residents (R96) after found smoking in the facility.

Findings include:

R96's Admission Record printed 12/28/23, indicated R96 was admitted on 12/11/23, and R96's diagnoses included tobacco use, mild cognitive impairment, shortness of breath, and hypertension (high blood pressure).

R96's admission Minimum Data Set (MDS) assessment dated 12/17/23, indicated R96 had impaired cognition. R96's MDS indicated R96 wanders daily and places resident at significant risk of getting into a potentially dangerous place. R96's MDS indicated that a current tobacco user, independent with mobility, personal hygiene, and eating.

A Nursing Admit Re-Admit Data Collection assessment, dated 12/11/23, indicated R96 was a current tobacco user. Assessment indicated resident received education, cognitive barriers to learning and resident outcome was "unable to understand".

A Tobacco Use Evaluation, dated 12/16/23, was completed. It indicated that R96 was a current everyday tobacco (smoking/vaping) user, current using 10+ times per day, and uses throughout the day. Evaluation identified R96 is severely impaired, and "resident is unable to know that he can't smoke in the building". Evaluation indicated that resident "has exit seeking behaviors ...does not understand where he is ...confused/agitated."

R96's care plan, dated 12/28/23, identified R96 wished to quit smoking and to apply nicotine patch per physician order on 12/26/23. R96's care

2 830

their room. Resident was reminded that the care center was a smoke free facility and that tobacco use was prohibited to be used by anyone inside the building.

2. All residents have potential to be affected by the deficient practice. Specifically, those residents who are identified to use tobacco products. A review of residents who use tobacco products was complete by the DON on January 24, 2024 and assessments and care plans were reviewed to ensure all items were addressed.

3. To ensure systemic changes are sustained all staff were given education on the Smoking and Tobacco Use Policy and Procedure during an all staff meeting on January 18, 2024. A review of what to do if a resident is found smoking within the care center was completed and included: verbal reminder that resident is not allowed to smoke in the building, notify nearest nurse that a resident is smoking in the building, remove smoking items from the area (cigarettes, vapes, lighters, matches), nurses are to complete a tobacco assessment if a resident is caught smoking in the building, and the care plan should be updated with appropriate interventions.

4. The DON or designee will complete audits on tobacco assessments if resident uses tobacco products, will also audit care plan twice a week for four weeks and then weekly for eight weeks. The audit results will be reviewed by the QAPI committee with appropriate follow-up initiated to ensure compliance is sustained.

5. The DON will ensure correction of deficiency by January 31, 2024

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plan lacked any evidence for interventions related to smoking, cigarettes, or recent use or interventions.

R96's Order Summary, dated 12/28/23, indicated an order for Nicoderm CQ Transdermal Patch 21 mg (milligram)/24 hour: Apply 1 patch transdermally (via skin) one time a day for smoking cessation and remove per schedule. The order had a start date of 12/14/23, which was 3 days after admission. The orders lacked any order for any non-pharmalogical intervention for smoking cessation.

A progress note, dated 12/25/23, indicated R96 was found smoking in his room. The note further indicates the cigarette was put out ...resident educated can't smoke in facility .... confiscated lighter ...placed in locked med drawer .... opened window ....notified director of nursing ....notified R96's son ...explained R96 can't have lighter in facility.

Review of electronic medical record (EMR) through 12/27/23, lacked evidence of any additional assessments, progress notes or follow up related to tobacco use.

On 12/27/23, at 8:25 a.m., R96 was observed sitting on the edge of his bed with an empty breakfast tray. R96 had a pack of Marlboro cigarettes in the pocket of his shirt.

During an interview on 12/27/23, at 11:08 a.m., R96 indicated that he had one cigarette in the facility since he had been there. R96 indicated he understands that he can not do that since there is oxygen and it is a fire hazard. R96 stated he has smoked for many years. He stated he is wearing a nicotine patch but isn't sure if it is helpful. It is

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2 830	Continued From page 22	2 830		

observed that he has a pack of Marlboro cigarettes in his shirt pocket during the interview.

During an interview with licensed practical nurse (LPN)-A, they indicated that a smoking assessment is completed upon admission, and this is a smoke free facility. If a resident is a "smoker", they must be able to independently leave the property and smoke safely. They indicated that smoking cessation is encouraged with nicotine patches or nicotine inhalers. They stated that if a resident brings tobacco products in the facility, the tobacco products and lighters are locked in the medication drawer. They stated it is important to properly assess residents as "we" don't want residents to accidentally burn themselves or start a fire. They indicated that if a resident was found smoking in the facility, they would immediately stop the resident, lock up the contraband, notify management (director of nursing and administer), do a tobacco use assessment and put in a progress note. They indicated management would follow up as well with the resident and family. LPN-A stated that more cigarettes were found on R96 as they are sitting on the nursing desk. It is unknown when they were obtained from R96. LPN-A indicated they are not aware of R96 having a lighter or matches.

During an interview on 12/28/23 at 9:26 a.m., with director of nursing (DON) indicated it was a smoke free facility and residents must leave the property to smoke. He stated that if residents bring tobacco products into the facility, the lighter and cigarettes are locked in the medication drawer and the admissions agreement is reviewed. He stated that a smoking assessment is completed upon admission to assess a resident need. He stated if a resident is found

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2 830	Continued From page 23 smoking on the grounds or within the facility, the administer would follow up after the issue was immediately addressed. He stated the family would be notified and a tobacco assessment would be completed as soon as possible. He indicated it would be added to the care plan and ensure that smoking cessation is offered, and education provided. DON verified that a follow up tobacco assessment had not been completed for R96 after he was found smoking. DON verified no additional progress notes or additional information/interventions in the EMR was available regarding tobacco use for R96. A facility policy titled Smoking and Tobacco use, dated 10/11/23, was provided. The policy indicated all residents/clients who smoke or use tobacco products will be assessed and care plans will be updated as needed. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures to ensure the timely and comprehensive reassessment of someone identified to be smoking; then educate staff and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 830		
2 960	MN Rule 4658.0600 Subp. 1 Dietary Service - Food Quality Subpart 1. Food quality. Food must have taste, aroma, and appearance that encourages resident consumption of food.	2 960		1/31/24

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2 960	Continued From page 24 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure meals were served in a warm, palatable manner to promote quality of life and nutritional intake for 2 of 2 residents (R95, R100) reviewed on the short-term stay (i.e., TCU) unit. This had potential to affect a total 11 of 11 residents identified to reside on the unit where the meals were served. Findings include: A provided Resident Listing Report, printed 12/26/23, identified all residents and their room number within the care center. This outlined a total of 11 residents, including R95 and R100, resided on the TCU. R95's Daily Skilled Note - V2, dated 12/24/23, identified multiple sections to recorded R95's various health issues or concerns. This note included a section labeled, "Summary of Skilled Services," which identified R95 was alert and oriented to person, place, and time. On 12/26/23 at 11:07 a.m., R95 was interviewed. R95 stated he didn't care for the meal service at the care center. R95 stated he was rarely, if ever, allowed to have a choice on the meal served and expressed the only meal he enjoyed was the breakfast meal. R95 explained the rest of the meals, such as lunch and supper, were typically lacking in flavor and cool when served to him in the room. R95 added, "Both [taste and temperature] are very unsatisfying." R95 stated he had not reported this to anyone at the care center but rather was just trying to eat a bigger breakfast meal so there was "one meal that more	2 960	1. On 12/26/2023 it was noted that room tray food was not seasoned, room temperature and could be warmer 2. All residents have the potential to be affected by the deficient practice. Dietary staff received education from the Nutrition and Food Service Supervisor using the Food Preparation-Food and Nutrition Policy and Procedure on January 24, 2024. 3. To ensure systemic changes are sustained the Nutrition and Food Service Supervisor will have all cooks complete the ServSafe Training on January 29, 2024. The Nutrition and Food Service Supervisor is also going to implement an additional dietary meeting with residents monthly which began on January 22, 2024. 4. The Nutrition and Food Service Supervisor or designee will audit food palatability/temperature two times a week and then weekly for eight weeks. 5. The Administrator or designee will ensure correction of deficiency by January 31, 2024.	

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or less satisfies me."

R100's admission Minimum Data Set (MDS) dated 12/12/2023, which indicated she was cognitively intact and independent with eating after set-up.

On 12/26/23 at 1:19 p.m., R100 stated that the food is always cold when it is served. She stated she eats meals her meals in her room.

On 12/27/23, the following observations were made:
-11:36 a.m. steam table arrives to Healing Grace Unit. The staff set up empty trays in preparation for the food to be plated to be served to rooms. The items on the steam table are covered with tin foil which included pizza slices (pepperoni and hamburger) and cut up lettuce (for salad).
-11:39 a.m. two residents in the dining room waiting for lunch to be served
-11:41 a.m. the staff asked both residents sitting in the dining room what type of pizza they want and were served lunch
-11:45 a.m. the food was plated onto the trays and two unidentified nursing staff delivered the food trays resident rooms. The food items (two pieces of pieces and lettuce) are placed onto a plate and then covered with a plate cover. The plate is then placed on the tray.
-11:52 a.m. the last resident tray finished being plated
-11:52 a.m. a sample plate was requested from the steam table
-11:54 a.m. the sample tray was sampled by nursing assistant (NA)-A who stated there is "not much seasoning" "room temperature" "could be warmer". NA-A stated the sample tray was "mediocre".

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During interview on 12/27/23, at 12:27 p.m., NA-A stated there have been "some" complaints from resident about the temperature, flavor, and amount of food. The complaints are written down and given to the dietary manager and director of nursing for follow up.

During interview on 12/27/23, at 12:36 p.m., dietary manager (DM) stated he had received complaints about flavoring about food and is addressing it. DM stated they got a new steam table a couple of weeks ago to help ensure temperatures are holding as he had received complaints. He stated they are monitoring food temperatures. DM stated that when he receives a complaint, he follows up on the complaint by meeting with the resident to see how it can be addressed.

On 12/27/23 at 2:28 p.m., director of nursing (DON) stated that complaints regarding food get passed along to dietary and the administrator will follow up when needed. DON indicated he provides education when needed if it is related to a health concern or impacting a resident's health.

A facility policy titled, Dining Service Standard-Food and Nutrition Services, review date of 7/21/23 was provided. It indicated that residents will be provided meals that are nourishing, attractive, and palatable and are served at a safe and appetizing temperature.

SUGGESTED METHOD OF CORRECTION:
The director of nutrition services, or designee, could review applicable policies and procedures to ensure timely serving of prepared food items to ensure palatability; then educate staff and audit to ensure ongoing compliance.

Minnesota Department of Health

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2 960	Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 960		

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
February 14, 2024

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

RE: CCN: 245317
Cycle Start Date: December 28, 2023

Dear Administrator:

On February 8, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 14, 2024

Administrator
Good Samaritan Society - Comforcare
1201 17th Street NE
Austin, MN 55912

Re: Reinspection Results
Event ID: 2KDF12

Dear Administrator:

On February 8, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 28, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us