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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2SXE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/27/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Rebecca Wong, HFE NE II — 12/27/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Enforcement Specialist — 3/7/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/26/2013
(L33)

DETERMINATION APPROVAL

Page 2
Provider Number: CCN# 24-5278 Item 16
Continuation for CMS-1539

Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective December 6, 2013, the facility is certified for 35 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245278

March 7, 2014

Ms. Laura Rindfleisch, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, Minnesota 55349

Dear Ms. Rindfleisch:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective December 6, 2013, the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

January 29, 2014

Ms. Laura Rindfleisch, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Re: Enclosed Reinspection Results - Project Number S5278021

Dear Ms. Rindfleisch:

On December 27, 2013 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 1, 2013. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Kate Johnston

Kate Johnston, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure (s)
cc: Licensing and Certification File

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00019	A. Building B. Wing	12/19/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **12/06/2013**	ID Prefix **20565** Reg. # **MN Rule 4658.0405 Subp. 3** LSC	Correction Completed **12/06/2013**	ID Prefix **20885** Reg. # **MN Rule 4658.0525 Subp. 1** LSC	Correction Completed **12/06/2013**
ID Prefix **20895** Reg. # **MN Rule 4658.0525 Subp. 2.B** LSC	Correction Completed **12/06/2013**	ID Prefix **20900** Reg. # **MN Rule 4658.0525 Subp. 3** LSC	Correction Completed **12/06/2013**	ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp. 5 A.I** LSC	Correction Completed **12/06/2013**
ID Prefix **20965** Reg. # **MN Rule 4658.0600 Subp. 2** LSC	Correction Completed **12/06/2013**	ID Prefix **21325** Reg. # **MN Rule 4658.0725 Subp. 1** LSC	Correction Completed **12/06/2013**	ID Prefix **21475** Reg. # **MN Rule 4658.1005 Subp. 1** LSC	Correction Completed **12/06/2013**
ID Prefix **21942** Reg. # **MN St. Statute 144A.10 Subd. 8** LSC	Correction Completed **12/06/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	BF/KJ	1/14/2014	30951	12/19/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 11/1/2013

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245278	A. Building B. Wing	12/19/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **12/06/2013**	ID Prefix **F0250** Reg. # **483.15(g)(1)** LSC	Correction Completed **12/06/2013**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **12/06/2013**
ID Prefix **F0310** Reg. # **483.25(a)(1)** LSC	Correction Completed **12/06/2013**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **12/06/2013**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **12/06/2013**
ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **12/06/2013**	ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **12/06/2013**	ID Prefix **F0411** Reg. # **483.55(a)** LSC	Correction Completed **12/06/2013**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	BF/KJ	1/14/2014	30951	12/19/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
11/1/2013			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 2SXE

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**
2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/01/2013** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **38** (L18)

13. Total Certified Beds 38 (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	38			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. Please refer to the CMS 2567 for health along with the facliity's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE Date :
Jessica Sellner - HFE NE II 12/09/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen Leach - Program Specialist 12/18/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7791

November 20, 2013

Ms. Laura Rindfleisch, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, Minnesota 55349

RE: Project Number S5278021

Dear Ms. Rindfleisch:

On November 1, 2013, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301

Telephone: (320) 223-7338
Fax: (320) 223-7348

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 11, 2013, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 11, 2013 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 1, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2014 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205
Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

RECEIVED DEC 0 2 2013

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

MN Dept of Health St.Cloud

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	— General Disclaimer 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 allegations that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility's allegation of compliance in accordance with section 7305 of the State Operations Manual.	—
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in	F 157	12/9/13 157	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Laura Salonek — TITLE: Administrator — (X6) DATE: 11/29/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 157	Continued From page 1 resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician for 1 of 1 resident (R21) reviewed, who had a change in condition when he developed a pressure ulcer. Findings include: R21's medical record identified diagnosis fracture of left femur. The admission Minimum Data Set (MDS) dated 9/24/13, identified R21 had moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and was at high risk for developing pressure ulcers. R21's Daily Skilled Notes included the following: 10/25/13- "Noted on right big toe on right foot what appears to be a blood blister; nickel size... placed in treatment book to monitor every shift until resolved." 10/26/13- "What appears to be a blood blister remains on right big toe, noted no change in size."	F 157	**F 157 Physician Notifications** 1. Resident's primary physician was notified of blood blister on right great toe. Resident was discharged to home 11/15/13. 2. All residents currently at risk for pressure ulcers were reviewed to verify skin integrity. Physician notification has been completed for all residents who currently have pressure ulcers, in order to ensure implementation of adequate treatment to promote healing. 3. All newly admitted residents and residents with significant change in condition related to the development of a pressure ulcer will have prompt physician notification by the first licensed nurse to recognize the pressure ulcer. Educational in-service was provided to all nursing staff on 11/27/13 regarding the risk factors, identification of, and the importance of prompt notification to the physician related to ensuring adequate treatment of pressure ulcers.	

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F 157	Continued From page 2 10/27/13- "Blood blister remains intact on right great toe; no change in size." 10/28/13- "Blood blister intact on right great toe; no change noted in size." 10/29/13- "Blood blister on right great toe intact." 10/30/13- Blood blister on right great toe intact." When interviewed on 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A stated the nurses are monitoring the blood blister. LPN-A stated she could not find any where in R21's medical record that the physician had been notified of this area. When interviewed on 10/30/13, at 9:30 a.m. the occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half ago. She was not aware R21 currently had a "blood blister" on his right toe, and had not notified the physician. When interviewed on 10/31/13, at 9:45 a.m. RN-A stated she had been monitoring R21's "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring. RN-A was unsure where the blister on his toe came from but stated she did not think it was pressure related because R21, "Doesn't wear shoes." RN-A verified the physician had not been notified and the nurse discovering the blood blister should have notified the physician. When interviewed on 10/31/13, at 10:35 a.m. director of nursing (DON) stated she was just	F 157	4. DNS / Designee will do random audits of the 24 hr communication report to ensure that all reported pressure ulcer development has been reported timely to the physician and communication of all resident-related information. These audits will be done weekly x 8 with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 157	Continued From page 3 made aware of the blood blister two days ago but had not had time to look at the area. The DON verified the nurses should have done an assessment to determine the cause, should be documenting size, and should have notified the physician. DON stated none of the above had been done. She also verified the timing of R21 beginning to wear his shoes and the development of the blood blister was probably related to the pressure of his shoes. The facility provided a policy entitled Skilled Nursing Coverage and Documentation dated 2/2012. The policy instructed, "Nursing documentation to help support a skilled nursing service should include assessments, nursing concerns, physician contacts and documentation of abnormal or unstable conditions..." Although R21 had developed a "blood blister" on a pressure area, the facility failed contact the residents physician to ensure adequate treatment was in place to promote healing. The National Pressure Ulcer Advisory Panel defines pressure ulcer's, "Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and or shear," as "Suspected deep tissue injury."	F 157		
F 250 SS=D	483.15(g)(1) PROVISION OF MEDICALLY RELATED SOCIAL SERVICE The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial	F 250		

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F 250	Continued From page 4 well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the social service department failed to coordinate discharge services with an outside agency for 1 of 1 residents (R3) reviewed who desired to discharge to the community. Findings include: R3's medical record indicated a diagnoses of quadriplegia (paralysis resulting in partial or total loss of upper and lower limb use) and had history of pressure ulcers for 10 years. The annual Minimum Data Set (MDS) dated 9/25/13, identified R3 was cognitively intact, needed extensive assistance with all activities of daily living (ADL's) except eating, had pressure ulcers, and had an active discharge plan in place to return to the community. R3's care plan dated 10/16/12, included, "Will consider placement in the community when open areas have healed," and "social worker/ interdisciplinary team to assist resident/ family with discharge planning." However, added to this was, "Discharge plan: Currently long term care related to level of care needs in ADL's." During interview on 10/28/13, at 3:40 p.m. R3 stated he had been living in the facility for a little over a year. He had lived at a group home for	F 250	**F 250 Social Services** 1. ADON reviewed discharge plans with R3 again on 11/27/13. R3 states "Same as I tell you every time; I want a group home in Howard Lake or Cokato because this is where my family lives, and since nothing like that currently even exists, I am staying here until it does." R3 also states that he has been in contact with his county (Wright) social worker, Konnie Laudenback. Documentation from Konnie Laudenback on the date of 5/15/13 does indicate a face-to-face visit and screening for alternative placement. Message was once again left for Konnie Laudenback on 11/27/13 reiterating the request that facility DON or ADON be kept informed of progress related to discharge planning. DON / designee will continue to search for alternative placement that meet resident preferences quarterly, as well as on an as-needed or per-request basis.	

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F 250	Continued From page 5 about 10 years, but moved to the facility to be closer to family. R3 stated he does not do much at the facility as he does not have much in common with the "older people," but he was unable to find another place to live close to his family. He stated last he had spoke with the county social worker about discharge was several months ago and the county case worker was trying to find more appropriate placement for him in a facility with people more his age. During observation on 10/28/13, at 5:45 p.m. R3 was in his room eating supper. On 10/29/13, at 12:25 p.m. R3 was observed eating lunch in his room. On 10/29/13, at 12:55 p.m. R3 was observed in his electric wheelchair going outside of the facility and going to the end of the driveway and smoking a cigarette. R3 was not seen interacting with other residents. R3's progress notes revealed the following: 4/17/13- "Care team met with resident present. Social service reports resident is stable... resident will be meeting with his social worker in May. She will be presenting [R3] with a list of housing options." No further social work notes were found in R3's medical record. 7/10/13- "Quarterly care conference. Nursing reports chronic wounds are maintained by treatment order...Resident declined attendance at care conference and has no concerns except locating alternate placement. Has been working with his social worker on this."	F 250	2. All current residents have been reviewed and evaluated for the appropriateness of discharge. If it is deemed that discharge is appropriate, facility will coordinate with an outside agency in order to facilitate the discharge process. 3. All discharge planning and coordination duties are now designated to DON / ADON, and will be reviewed routinely in all quarterly care conferences. Education is provided to all new admissions, and was provided to all nursing staff on 11/27/13 regarding resident's rights to choose where he/she lives as well as the importance of notifying discharge coordinator of desire to relocate so assistance can be provided. 4. DNS/designee will do random audits of quarterly care conferences weekly x 4 weeks, then monthly x 3 months to ensure discharge planning is being reviewed during care conferences and coordinated with outside agencies if indicated. Results will be forwarded to QA for further recommendations. 5. Completion Date: December 6th, 2013	

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F 250	Continued From page 6 When interviewed on 10/30/13, at 11:14 a.m. county social worker (CSW)-J stated the last meeting she had with R3 was in May 2013, approximately 5-6 months ago. CSW-J stated R3 wanted to find more appropriate placement with others, "closer to his age," but wanted to stay in the area so he could be close to his family. CSW-J stated she had looked at several different living facility's in May for R3 but either R3 rejected them or they had a "long waiting list." However, CSW-J was unable to provide information regarding what facilities were considered and which facilities R3 rejected going to. CSW-J verified R3 had no active plans for discharge, nor was the resident placed on any waiting lists. She also stated she had not spoken with anyone from the facility regarding R3 discharging and she does not give the facility information regarding the facility's R3 had been spoken to about. CSW-J further went on to say that she thought she "heard" R3 was not going to be discharged until his wounds heal. She was not aware the wounds had been present for 10 years prior to his admission to the facility. When interviewed on 10/30/13, at 12:33 p.m. The director of nursing (DON) stated the facility social worker had retired several months ago. The DON stated there was no further information regarding R3 discharging and stated, "I never addressed discharge" with R3 as she thought the county social worker was working on discharge. Furthermore, she had not spoken to the county social worker to verify if any discharge plan was in place. DON verified there was no plan regarding R3 discharging from the facility, and the	F 250		

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F 250	Continued From page 7 facility had not coordinated with the resident county social worker to ensure R3 was discharged to more appropriate placement. A policy was requested, but not provided by the facility.	F 250		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the care plan was followed for 3 of 4 residents (R19 and R36 and R2) reviewed who were assessed as needing restorative nursing services. Findings include: R19 did not receive restorative nursing services as directed by the care plan. R19's quarterly Minimum Data Set (MDS) dated 9/12/13, included a diagnosis of schizophrenia and rheumatoid arthritis. The MDS indicated he was cognitively intact, did not reject cares, had functional limitations in range of motion of upper	F 282	**F 282 Qualified Persons** 1. Care plans for R2, R19, and R36 were reviewed by Restorative RN, and they have been referred to therapy for evaluation of current level of functional abilities to ensure appropriateness of current restorative programs. Restorative RN is working with therapies to develop comprehensive plans of care based on identified need and care plans will be followed. 2. All residents with restorative programs were reviewed to ensure resident-appropriateness and programs are being done according to the care plan and documented and if refused, communicated to the Restorative RN.	

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F 282	Continued From page 8 extremities, but did not receive a restorative nursing program. R19's care plan dated 9/18/13, included a restorative nursing program twice a week, and directed staff to assist R19 with use of a Restorator (an exercise machine) for five minutes, dowel exercises moving side to side and pushing out, circles forward and backwards and push up, two sets of ten. R19's Physical Therapy discharge summary dated 8/9/13, included, "Patient and therapist developed a new restorative program that patient feels he can tolerate, despite having to rest frequently which he says he had to do in the past. Patient will use arm bike for five minutes, lower extremity Restorator x 10 and dowel in all planes." R19's Care Plan Approaches report from 7/30/13 through 10/30/13, revealed he had received his restorative nursing program only twice in these 13 weeks, on 8/26/13 and 10/23/13. The report did not include why R19 had not received the restorative program twice a week as directed by the care plan. When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she is assigned to assist residents with their restorative nursing programs. She is only given four hours a day in the afternoon to do this. In the morning she is assigned dining services. The facility use to have	F 282	3. Education was provided to all nursing staff on 11/27/13 regarding the importance of following the restorative programs as listed in each individual care plan, crucial documentation of refusals and/or completion, as well as what to do in the event that residents restorative program is not getting completed, regardless of the reason. More specific, individualized education will be provided to all primary restorative nursing assistants on 12/4/13, when a meeting will be held with the Administrator, DON, ADON/Restorative RN, and all primary restorative aides for the purpose of restructure and restoration of the overall program. During this meeting we will also review the necessity of CP compliance, consistent and accurate documentation, and how to document / communicate referrals, with results to QA for further recommendation.	

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F 282	Continued From page 9 a full day restorative nursing assistant, but this was cut back to just four hours a day in April 2013. NA-B stated she is unable to assist everyone with their restorative programs because of this, there is not enough time. R19 "is a morning person," and will only do the restorative program in the mornings, when she is assigned dining duties. NA-B had not reported her inability to provide R19 with the restorative program to anyone. When interviewed on 10/30/13, at 1:03 p.m. R19 stated he always use to go for his restorative nursing program in the morning with the restorative aide. About six months ago the staff quit asking him to go to the program. If they would offer his program in the mornings, he would go. When interviewed on 10/30/13, at 11:22 a.m. the assistant director of nursing (ADON) stated even though she is responsible for reviewing the restorative programs for each resident monthly, she was not aware R19 was not attending as directed by his care plan. No one had reported this to her. R36 did not receive the restorative nursing program as directed by the care plan. R36's quarterly MDS dated 9/4/13, included diagnoses of diabetes and depression. The MDS indicated he was cognitively intact and participated in a restorative nursing program for	F 282	4. Audits of all CNA documentation of care plan approaches, including daily intakes, ADLs, and all FMP/restorative program attempts) will be completed by the DNS and Designee (s) at the end of each shift x 7 days, and random weekly audits x 5 weeks thereafter. These random weekly audits regarding completion and documentation of pertinent care plan approaches will occur x 3 months to ensure compliance and that all refusals are being communicated to the appropriate designated person. 5. Completion Date: December 6th, 2013	

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F 282	Continued From page 10 active range of motion (ROM) two times during the assessment week. R36's care plan dated 9/4/13, indicated he was to attend a restorative nursing program twice a week. This would include, Restorator for ten minutes and/or up and down the stairs twice, and/or leg exercises with three pounds for 15 repetitions. R36's Care Plan Approaches report from 7/30/13 to 10/30/13, indicated he received his restorative program 14 times during these 13 weeks. There was no documentation to indicated why R36 had not received the program twice a week as ordered. When interviewed on 10/31/13, at 10:22 a.m. NA-B stated R36 does not refuse to come to his restorative nursing program, but she does not always have time to assist him with it. She had not reported this to anyone. When interviewed on 10/31/13, at 12:30 p.m. the ADON stated she had reviewed R36's restorative program monthly, but was not aware it was not being offered as directed by the care plan. No one had reported this to her. R2 did not receive the restorative nursing program as directed by the care plan.	F 282		

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F 282	Continued From page 11 R2's diagnosis included adult failure to thrive. The quarterly MDS dated 10/21/13, included moderate cognitive impairment, required extensive assistance with ambulation, and received a restorative nursing program to include ambulation one time in the assessment week. R2's care plan dated 11/28/12, directed staff to assist with a restorative nursing program to include ambulation with one assist and rolling walker to and from all meals as tolerated. In addition, the care plan directed staff to assist with the use of the Restorator as tolerated and/or standing alternate marches 20 repetitions total with upper extremity use on walker. Step up onto wooden box of six inches, and/or 3 pound seated exercises 20 repetitions bilateral. Pulleys for 5 minutes and red pegs and putty. This exercise program was to occur daily seven days a week. R2's Physical Therapist Progress & Discharge Summary dated 5/10/13, included physical therapy (PT) had worked with R2 4/15/13 through 5/10/13, due to a decline in ability to transfer in and out of bed. The summary directed nursing staff to continue her ambulation program. The "Current Level of Function," concluded R2 was able to ambulate 60 to 100 feet with a front wheeled walker, with minimum assistance to hold onto R2 and pull the wheel chair behind. R2's Care Plan Approaches Report from 5/1/13 through 10/31/13, showed R2 had the opportunity to ambulate to and from meals as directed by the care plan 655 times. The documentation showed R2 only actually ambulated to and from meals	F 282		

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F 282	Continued From page 12 103 times. R2 had refused 113 times. There was no evidence R2 had been offered assistance to ambulate to and from meals 439 times during this time frame. R2's Care Plan Approaches Report from 7/1/13 through 10/31/13 showed R2 had not participated in the other restorative nursing program with the Restorator, standing marches, pulleys or pegs exercises at all. This was should have occurred 123 times in this time frame. When interviewed on 10/31/13, at 1:31 p.m. R2 stated she use to walk to and from all the meals. She had to get help from staff to do this. R2 stated staff just stopped asking her to walk, and just automatically take her in her wheel chair to meals. R2 had never been offered any other exercise program. When interviewed on 10/31/13, at 1:42 p.m. NA-A stated she started working in the facility in June 2013, she had never seen R2 ambulate to and from meals. NA-A was unaware R2's care plan directed staff to assist her to ambulate to and from meals. NA-A was not aware of any other exercise program R2 was to participate in either. When interviewed on 11/1/13, at 10:05 a.m. the ADON was unaware R2 was not participating with the restorative nursing program as directed by the care plan, even though she reviews each residents restorative nursing program monthly.	F 282		

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	245278	A. BUILDING _____ B. WING _____	11/01/2013

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F 282	Continued From page 13 The ADON did state R2 would refuse to ambulate at times. No one had reported to her the ambulation and exercise program were not being completed as directed by the care plan. During interview on 11/1/13, at 10:33 a.m., the Director of Nursing (DON) stated they had a restorative aid who quit in January 2013, they had hired staff to complete the restorative programs and was not aware they weren't receiving them as ordered. A policy was requested, but not provided by the facility.	F 282		
F 310 SS=G	483.25(a)(1) ADLS DO NOT DECLINE UNLESS UNAVOIDABLE Based on the comprehensive assessment of a resident, the facility must ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to bathe, dress, and groom; transfer and ambulate; toilet; eat; and use speech, language, or other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident was provided with ambulation services when recommended, and assessed when ambulation ability declined for 1 of 3 residents (R2) reviewed for ambulation services. This practice resulted in actual harm for R2, when she experienced an	F 310		

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F 310	Continued From page 14 avoidable decline in ability to ambulate. Findings include: R2's diagnoses included osteoarthritis. The quarterly Minimum Data Set (MDS) dated 10/21/13, included moderate cognitive impairment, required extensive assistance for transfers and ambulation, and received a restorative nursing program which included ambulation one day during the assessment week. R2's care plan dated 11/28/12, directed staff to assist with a restorative nursing program to include ambulation, with one assist and rolling walker, to and from all meals as tolerated. In addition, the care plan directed staff to assist with a daily exercise program to include: the use of a Restorator [an exercise machine] as tolerated and/or standing alternate marches 20 repetitions total with upper extremity use on walker. Step up onto wooden box of six inches, and/or 3 pound seated exercises 20 repetitions bilateral. Pulleys for 5 minutes and red pegs and putty. R2's Physical Therapist Progress & Discharge Summary dated 5/10/13, included physical therapy (PT) had worked with R2 4/15/13 through 5/10/13, due to a decline in ability to transfer in and out of bed. The summary directed nursing staff to continue her ambulation program. The "Current Level of Function," concluded R2 was able to ambulate 60 to 100 feet, with a front wheedled walker, with minimum assistance to hold onto R2 and pull the wheel chair behind. R2's Care Plan Approaches Report from May 1, 2013 through October 31, 2013, showed R2 had the opportunity to ambulate to and from meals as	F 310	**F310 Activities of Daily Living** 1. R2 was referred to physical therapy (PT) for evaluation of ambulation and functional ability of lower extremities and treatment, if warranted per PT on 11/1/13. Per PT, R2 was "evaluation only", completed on 11/14/13, related to "patient concerns about ambulating on a consistent basis, but still wanting to have it offered", and a revised ambulation FMP was initiated at that time. The revised FMP indicates that staff should continue to offer ambulation daily after lunch, as well as an alternative offer of standing at rail if R2 refuses to ambulate. On 11/26/13, R2 was referred again to PT and OT for review of current PT/OT FMPs as well, in order to ensure that these programs remain appropriate for this resident. 2. All ambulation programs have been reviewed for appropriateness, and are now being followed according to care plan. Additionally, staff is offering and, when needed, documenting refusals of ambulation programs on a consistent basis. These refusals will be communicated to the Restorative RN for further evaluation.	

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F 310	Continued From page 15 directed by the care plan 655 times. The documentation showed R2 only actually ambulated to and from meals 103 times. R2 had refused 113 times. There was no evidence R2 had been offered assistance to ambulate to and from meals the other 439 times during this time frame. There was no documentation to indicate why R2 had not ambulated these 439 times. R2's Care Plan Approaches Report from July 1, 2013 through October 31, 2013 showed R2 had not participated in the exercise program with the Restorator, standing marches, pulleys or pegs exercises at all. R2 should have been offered this program daily for the 123 days in this time period. There was no documentation to indicate why it was missed for all 123 days. On 10/28/13, at 5:02 p.m. R2 was sitting in the dining room in her wheel chair. At 6:10 p.m. she was propelled out of the dining room in her wheel chair by an unknown staff person. At 6:50 p.m. R2 was observed in her room sitting in her wheelchair watching television. When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she works as a dining aide in the mornings and does the restorative programs in the afternoons. NA-B said the facility use to have a full day restorative nurse aide, but that had changed in April 2013, to just half a day. NA-B stated there is not enough time to do everyone's restorative program, but verified she had not reported this to anyone. NA-B had never assisted R2 to do her exercise program that was care planned to occur every day. She had not been instructed to do so. When interviewed on 10/31/13, at 1:31 p.m. R2	F 310	3. Education was provided to all nursing staff on 11/27/13 regarding the importance of following the restorative programs as listed in each individual care plan, crucial documentation of refusals and/or completion, as well as what to do in the event that residents restorative program is not getting completed, regardless of the reason. More specific, individualized education will be provided to all primary restorative nursing assistants on 12/4/13, when a meeting will be held with the Administrator, DON, ADON/Restorative RN, and all primary restorative aides for the purpose of restructure and restoration of the overall program. During this meeting we will also review the necessity of CP compliance, consistent and accurate documentation, and how to document / communicate referrals to the appropriate person.	

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F 310	Continued From page 16 stated she use to walk to and from all the meals and that she requires assistance from staff to do this. R2 stated that about six months ago, staff just stopped asking her to walk and now they just automatically take her to meals in her wheel chair. R2 did not know about doing any exercises, and said she had not been offered any. On 10/31/13, at 1:42 p.m. R2 was sitting in her wheelchair in her room. R2 requested to lie in bed. Nursing assistant (NA)-A and trained medication aide (TMA)-A assisted R2 into bed, with two person assist. NA-A stated R2 had not ambulated to and from lunch today. NA-A stated that since she had started working in the facility in June 2013, she had never seen R2 ambulate to and from meals. NA-A was unaware R2's care plan directed staff to assist her to ambulate to and from meals. NA-A was not aware of any other exercise program R2 was supposed to participate in either. On 11/1/13, at 9:19 a.m. R2 was in the hallway next to the dining room sitting in her wheelchair, using the hallway grab bars to pull herself down the hall. R2 was asked by the physical therapist (PT)-A if she could watch her walk. R2 replied, "I can't walk anymore." R2 agreed to attempt to ambulate. NA-A and NA-D assisted R2 to stand with a transfer belt and front wheeled walker. R2 was able to ambulate 20 feet with weight bearing assistance of two nursing assistants who were also pulling the wheel chair behind her. PT-A stated in May 2013, R2 was able to ambulate 60 to 100 feet with only one assist, for balance. PT-A stated R2 had declined in her ability to ambulate. PT-A stated staff needed to encourage R2 to ambulate more.	F 310	4. Audits of all CNA documentation of care plan approaches, including daily intakes, ADLs, and all FMP/restorative program attempts) will be completed by the DNS and Designee (s) at the end of each shift x 7 days, and random weekly audits x 5 weeks thereafter. These random weekly audits regarding completion and documentation of pertinent care plan approaches will occur x 3 months to ensure compliance and that all refusals are being communicated to the appropriate designated person, with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 310	Continued From page 17 When interviewed on 11/1/13, at 9:43 a.m. NA-C stated R2 use to ambulate to meals, but could not anymore, "it is too hard for her to move her feet." NA-C stated this change occurred over the past six months, but NA-C confirmed she had not reported this change to anyone. NA-C further stated the nursing assistant assigned to do the restorative programs often gets pulled from doing that duty to work on the floor indicating this happens when staff call in sick, or when they are "just short." R2's Interdisciplinary Assessments and Summary Quarterly review dated 8/7/13, included "Resident has goals of participation in AMB [ambulation] and OT/PT [occupational therapy and physical therapy]...Resident continues to AMB [ambulate] [with] assist of [two] to get up then [one] assist to AMB [ambulate]. Often refuses with no other reason than "I'm 101 years old." Will continue goals..." R2's Quarterly review dated 10/21/13, included, "... Goal of ambulating to all meals not met r/t [related to] refusals. Simply states, "I'm a hundred, I shouldn't have to..." When interviewed on 11/1/13, at 10:05 a.m. the assistant director of nursing (ADON) stated she does the reviews on each resident's restorative nursing program every month, but was unaware R2 had not been participating with the restorative nursing programs including exercise and ambulation as directed by the care plan. The ADON said if R2 was refusing, it should be documented and reported to her. The ADON stated she should review the Care Plan Approaches Reports and speak with nursing	F 310		

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F 310	Continued From page 18 assistants when she reviews the restorative programs, but had not. The ADON did not know why her Interdisciplinary Assessment and Summary reviews did not address the exercise program R2 had been care planned to do. R2's Therapy Screen Form dated 11/1/13, included R2 had a change in condition and this change required modification of the functional maintenance program. When interviewed on 11/1/13, at 10:33 a.m., the Director of Nursing (DON) stated they had a restorative aid who quit in January 2013, and they had hired staff to complete the restorative programs, but was not aware the programs were not being implemented. The DON stated R2 has refused to ambulate at times, she was not aware it wasn't being offered. The DON stated she did not know R2 had never received the exercise program which could have helped with R2's strength and endurance. The facility's Restorative Nursing Program/ Restorative Nursing Documentation policy, last revised 1/2013, indicated the purpose is to document restorative nursing appropriately. "... for re-screens, document if a functional change has occurred; upon comparison with last screen, do follow-up and make referral to therapists as necessary... lack of progress and reason as well as any increase/ decrease in goals."	F 310		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident	F 314		

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F 314	Continued From page 19 who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R21) reviewed for pressure ulcers, had the pressure area assessed, monitored, and had interventions in place to promote healing. Findings include: R21 diagnosis included a fracture of the left femur. The admission Minimum Data Set (MDS) dated 9/24/13, identified R21 had moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and was at high risk for developing pressure ulcers. R21's Daily Skilled Notes included the following: 10/25/13- "Noted on right big toe on right foot what appears to be a blood blister; nickel size... placed in treatment book to monitor every shift until resolved." 10/26/13- "What appears to be a blood blister remains on right big toe, noted no change in size."	F 314	**F314 Pressure Sores** 1. On 10/31/13, R21's pressure area was assessed, monitoring was set up and interventions to promote healing were implemented. Upon review for the week of R21's planned discharge on 11/11/13, progress toward healing was evidenced by over a 60% decrease in size of "blister" as compared to initial assessment, and was described as "loose scab" in one of the RN's final daily skilled notes. 2. All residents currently at risk for pressure ulcers were reviewed to ensure that their comprehensive skin assessments including Braden and positioning data collection tools are complete. All care plans and treatment records were reviewed and reflect current, effective interventions for prevention of pressure ulcer formation. Physician notification has been completed for all residents who currently have pressure ulcers in order to ensure implementation of adequate treatment to promote healing.	

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F 314	Continued From page 20 10/27/13- "Blood blister remains intact on right great toe; no change in size." 10/28/13- "Blood blister intact on right great toe; no change noted in size." 10/29/13- "Blood blister on right great toe intact." 10/30/13- Blood blister on right great toe intact." R21 was observed on 10/30/13, at 12:30 a.m. in a wheelchair propelling himself with his feet back towards his room from the dining room. R21 was wearing black socks and black slip on shoes. On 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A observed R21's blister on his right toe. LPN-A stated the nurses are monitoring the area, but not measuring or doing any treatment to it. LPN-A verified there was no assessment regarding the cause of the pressure ulcer, measurements to ensure healing, or notification to the physician to ensure adequate treatment is being done to ensure healing. LPN-A stated the nurse who initially discovers the pressure area is responsible for ensuring the assessment and interventions are appropriate, and notify's the physician. During interview on 10/31/13, at 9:30 a.m. occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half. She was not aware R21 currently had a "blood blister" on his right toe. The blood blister could have been caused by the shoe. During interview on 10/31/13, at 9:45 a.m. RN- A stated she had been "monitoring" R21's "blood	F 314	3. All newly admitted residents and residents with significant change related to the development of pressure ulcer will have prompt physician notification by the first licensed nurse to recognize the pressure ulcer, in addition to implementing individualized interventions based on a comprehensive skin assessment. Educational in-service was provided to all nursing staff on 11/27/13 regarding the risk factors, identification of, and the importance of notifying the physician related to ensuring adequate intervention and effective treatment of pressure ulcers. 4. DNS / Designee will do random audits of all residents with pressure ulcers to ensure ongoing compliance regarding the assessment, monitoring, and implementation of interventions to promote healing. These audits will be done weekly x4, and monthly x3 thereafter, with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 314	Continued From page 21	F 314		

blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring. RN-A was unsure where the blister on his toe came from but stated she did not think it was pressure related because R21 "doesn't wear shoes." RN-A verified there was no assessment, interventions, or notification to the physician and stated the nurse discovering the area should have done the assessment attempted to determine what caused the area.

During interview on 10/31/13, at 10:35 a.m. director of nursing (DON) stated she was just made aware of the blood blister 2 days ago but had not had time to look at the area. DON verified the nurses should have done an assessment to determine the cause, should be documenting size, and should have notified the physician. DON stated none of the above had been done. She also verified the timing of R21 beginning to wear his shoes and the development of the blood blister was probably related to the pressure of his shoes. DON stated she was not aware if any staff had determined if R21's shoes fit properly to ensure healing of the pressure ulcer on his right toe.

Although R21 had developed a "blood blister" on a pressure area, the facility failed to ensure an assessment was completed to ensure monitoring and interventions were put into place to ensure healing.

The facility provided a policy entitled Skilled Nursing Coverage and Documentation, dated 2/2012, instructed, "Nursing documentation to help support a skilled nursing service should

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F 314	Continued From page 22 include assessments, nursing concerns, physician contacts and documentation of abnormal or unstable conditions..." The National Pressure Ulcer Advisory Panel defines pressure ulcer's which appear as, "Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and or shear," as "Suspected deep tissue injury."	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the continued need for the use of an indwelling urinary catheter for 1 of 2 residents (R20) reviewed who had an indwelling urinary catheter. Findings include:	F 315	**F315 Urinary Incontinence** 1. See enclosed dictation from Dr. M. Schulenberg, dated 11/7/13 regarding the use of indwelling catheter for this R20. Nursing staff will continue to review the risks vs. benefits associated with long term use of an indwelling catheter with R20. On 11/29/13, trial was initiated with resident's permission and physician order to "clamp" catheter tubing for a maximum of 4 hours in order to assess whether or not R20 has any sensations of pressure or urge to void that might indicate the possibility of regaining at least some bladder control. Further trials and/or discontinuation will be dependent on these results and according to physician determination.	

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F 315	Continued From page 23 R20's diagnoses included multiple sclerosis (MS) and cerebrovascular accident (CVA). The admission Minimum Data Set (MDS) dated 09/26/13, indicated R20 was cognitively intact and needed extensive assistance with toileting. The MDS also indicated she had an indwelling catheter. R20's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 09/27/13, included, "Resident had Foley [name brand of catheter] placed during hospitalization and prefers to keep in at this point for ease in voiding. Is aware of infection risks. Needs assist with cath [catheter] management and cares." R20's care plan dated 09/18/12, included, "... inability to toilet self and indwelling Foley cath. Will have no urinary tract infections. Will progress towards discontinuation of catheter. Cath cares Q [every] shift. No leg bag in use when in bed." R20's physician orders dated 09/18/13, included, "Urinary drain: you have a urinary drain the reason for the drain is inability to get to the toilet...Urinary drain voiding trial: Pt [patient] has declined Foley removal. Prefers to keep in for ease, understands infection risk. Please keep addressing with her when she would agree to Foley removal." During observation on 10/28/13, at 6:15 p.m., R20 was observed to be sitting in her Broda [name brand] chair eating her supper meal in her room with her catheter bag attached to her chair on the right side.	F 315	HOWARD LAKE GOOD SAMARITAN NAME: Barbara Winter DATE OF BIRTH: 10/22/1944 DATE OF SERVICE: 11/07/2013 PROVIDER: Michael Schulenberg, MD HISTORY: This 69-year-old female is in the nursing home for CVA, complicating already pretty advanced spastic paresis of the lower extremities related to multiple sclerosis, longstanding and progressive. The patient was discharged from the hospital to Howard Lake Good Samaritan with Foley catheter in place for preservation of skin integrity on the perineum and for patient dignity and at her request so she would not suffer episodes of incontinence. The State Surveyors were here recently and had expressed a concern regarding this catheter and that there was no medical indication for it. I have had previous discussions with Ms. Winter but not clearly documented in the chart that she desires to have this catheter remain in place. From a medical perspective, it seems reasonable to keep this catheter in place until discharge to home for prevention of skin ulceration in the perineal and ischial area. The patient desires the catheter in at this time for preservation of her dignity and self control. Therefore, I believe it is reasonable to continue with this. I have had this discussion with the patient previously and the purpose of this note is for documentation. MICHAEL SCHULENBERG, MD 13-11-12 15:18 To- Howard Lake Good Sam FROM- EXCELSIOR CLINIC 2. All residents in the building are free of indwelling catheters unless deemed necessary per orders from primary physician.	

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F 315	Continued From page 24 When interviewed on 10/29/13, at 1:00 p.m. R20 stated she has MS and has not been able to walk for the last 10 years while living at home. R20 also stated she would like to get back her bladder control, as she did prior to her CVA. R20 verified that since admission to the facility on 09/18/13, staff or her physician have not mentioned to her any attempts to remove her urinary catheter. During observation on 10/29/13 at 2:01 p.m., R20 was observed to be lying watching TV with her catheter bag hanging on the right side of the bed. When interviewed on 10/29/13, at 2:11 p.m., nursing assistant (NA)-C stated R20 has a catheter because she has difficulty with mobility due to her recent stroke. When interviewed on 10/30/13, at 11:05 a.m., the director of nursing (DON) stated R20 was admitted to the facility with the indwelling catheter, and she thinks the doctor orders read "to discharge catheter when patient wants it removed." The DON had not addressed removal of the catheter with R20. R20's Physician Progress note, dated 10/24/13, included, "she [R20] continues to have Foley catheter in place and has not had any issues related to this. Anticipate we will discontinue it before discharging her home." R20's Nursing Progress notes dated 09/18/13 through 10/28/13, only indicated R20 has a Foley	F 315	3. All residents admitted with an indwelling catheter will be assessed for medical necessity and catheter will be removed if placement lacks medical reason/ justification. No current resident has or will have a catheter inserted and left in bladder if medically unnecessary. On 11/29/13, all nursing staff received education regarding the importance of avoiding indwelling catheters for the purposes of resident and/or staff convenience, and the necessity of appropriate medical justification for long-term placement of catheter. 4. DNS or designee will do random audits to ensure that a comprehensive assessment has been done and that there is evidence of medical justification for all residents with indwelling catheters weekly x 3 weeks, then monthly x 2 months, and with all new admissions for the next 3 months with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 315	Continued From page 25 catheter and a description of the fluid observed in the catheter bag. The notes did not include any discussion with R20 regarding the removal of the indwelling catheter. A facility policy entitled Catheterization (Indwelling/Retention) Insertion and Removal, revised 11/09, included "clinical conditions that may require catheterization include: relieve bladder distention due to: urinary obstruction due to a tumor or enlarged prostate, urine retention, Multiple Sclerosis... The medical record must have documentation of attempts to remove indwelling catheters and the results of these attempts... It is recommended that removal be attempted at least two or three times during his/her stay before it can be determined that it is unsuccessful." Although R20 had the indwelling catheter placed prior to admission due to a recent CVA, R20 wanted to regain bladder control, and the physician ordered to attempt removal, the facility did not make any attempt to discontinue the catheter during her stay at the facility.	F 315		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		

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F 318	Continued From page 26 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the recommended restorative nursing services, to prevent a change in range of motion, for 2 of 3 residents (R19 & R36) reviewed who had restorative nursing services ordered. Findings include: R19 did not receive restorative nursing services as directed. R19's quarterly Minimum Data Set (MDS) dated 9/12/13, included a diagnoses of schizophrenia and rheumatoid arthritis. The MDS indicated he was cognitively intact, did not reject cares, had functional limitations in range of motion of upper extremities, but did not receive a restorative nursing program. R19's care plan dated 9/18/13, included a restorative nursing program twice a week, and directed staff to assist R19 with use of a Restorator (an exercise machine) for five minutes, dowel exercises moving side to side and pushing out, circles forward and backwards and push up, two sets of ten. R19's Physical Therapy discharge summary dated 8/9/13, included, "Patient and therapist developed a new restorative program that patient	F 318	**F 318 Range of Motion** 1. R19 and R36 restorative ROM programs were reviewed by Restorative RN, and have been referred to therapy for evaluation of current level of functional abilities and for review of current restorative ROM and FMP programs. They are being assisted with Restorative RN to develop comprehensive plans of care, including an appropriate ROM program based on identified need. 2. All residents with restorative/ROM programs were reviewed and are being completed according to the care plan to ensure that they are receiving the appropriate services / treatment to increase ROM and/or prevent further decrease in ROM.	

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F 318	Continued From page 27 feels he can tolerate, despite having to rest frequently which he says he had to do in the past. Patient will use arm bike for five minutes, lower extremity Restorator x 10 and dowel in all planes." R19's Care Plan Approaches report from 7/30/13 through 10/30/13, revealed he had received his restorative nursing program only twice in these 13 weeks, on 8/26/13 and 10/23/13. The report did not include why R19 had not received the restorative program twice a week as directed by the care plan. When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she works as a dining aide in the mornings, and does the restorative programs in the afternoons. NA-B stated she had not been able to offer R19 his restorative program since she does not have time, and also stated R19 is a morning person and she is unable to offer the restorative nursing programs in the morning. R19 does not like to do it in the afternoon. NA-B further stated the facility used to have restorative aide that worked all day but that was stopped in January 2013. When interviewed on 10/30/13, at 1:03 p.m. R19 stated he used to always go to his restorative program in the morning with the rehab aide. The rehab aide had retired about six months ago, and the staff no longer asked him to go to the exercise program. R20 also stated if the staff would offer his program to him in the morning he would attend.	F 318	3. Education was provided to all nursing staff on 11/27/13 regarding the importance of following the restorative programs as listed in each individual care plan, crucial documentation of refusals and/or completion, as well as what to do in the event that residents restorative program is not getting completed, regardless of the reason. More specific, individualized education will be provided to all primary restorative nursing assistants on 12/4/13, when a meeting will be held with the Administrator, DON, ADON/Restorative RN, and all primary restorative aides for the purpose of restructure and restoration of the overall program. During this meeting we will also review the necessity of CP compliance, consistent and accurate documentation, and how to document / communicate referrals. Staff was instructed that any change in range of motion is to be reported to the charge nurse on duty as well as any refusals of program.	

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F 318	Continued From page 28 When interviewed on 10/30/13, at 11:22 a.m. the assistant director of nursing (ADON) stated she reviews the restorative programs monthly, but she was not aware R19 was not attending his program. She stated she just assumed he was attending and shouldn't have. The ADON stated the staff should inform her if someone is refusing there program. During observation 10/31/13, at 1:03 p.m. R19 was observed to be in the therapy room completing his restorative program with NA-B with no difficulties. During interview on 10/31/13 at 1:10 p.m., NA-B stated R19 had agreed to complete his program at after breakfast. R36 did not receive his restorative nursing program as ordered. R36's quarterly MDS dated 9/4/13, included diagnoses of diabetes and depression. The MDS indicated he was cognitively intact, required extensive assistance with dressing, and participated in a restorative nursing program for active ROM two times during the assessment week. R36's care plan dated 9/4/13, included a restorative program twice a week. The care plan	F 318	4. Audits of all CNA documentation of care plan approaches, including daily intakes, ADLs, and all FMP/restorative program attempts) will be completed by the DNS and Designee (s) at the end of each shift x 7 days, and random weekly audits x 5 weeks thereafter. These random weekly audits regarding completion and documentation of pertinent care plan approaches will occur x 3 months to ensure compliance and that all refusals are being communicated to the appropriate designated person, with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 318	Continued From page 29 directed staff to assist R36 with the Restorator for ten minutes, and/or up and down the stairs twice, and/or leg exercises with three pound weights for 15 repetitions. R36's Care Plan Approaches report from 7/30/13 to 10/30/13, indicated R36 had only received his restorative program 14 times out of 24 opportunities. The documentation did not indicate why R36 had not received it the other 10 times as directed by the care plan. When interviewed on 10/31/13, at 10:22 a.m. NA-B stated R36 does not refuse his restorative nursing program, but she doesn't always have enough time to assist him with it. She had not reported this to anyone. When interviewed on 10/31/13, at 12:30 p.m. the ADON stated R36 doesn't not refuse his restorative program, she had thought he was attending the program as ordered. The ADON also stated the staff had not informed her he wasn't receiving his restorative nursing. During observation on 10/31/13 at 1:15 p.m., R36 was observed in the therapy room receiving his restorative program. When interviewed on 10/31/13, at 1:30 p.m. NA-B stated R19 & R36 had not declined in their functional range of motion (ROM).	F 318		

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F 318	Continued From page 30 When interviewed on 11/1/13, at 9:43 a.m. NA-C stated R19 & R36 had not had any declines in there ROM. NA-C also stated the facility used to have a restorative aide who worked all day and the restorative programs were completed then, but there is just not enough time to complete them now as they are only allowed half a day. She had not reported this to anyone. When interviewed on 11/1/13, at 10:33 a.m. the director of nursing (DON) stated they had a restorative aid who quit in January 2013, they had hired staff to complete the restorative programs and had not been informed they were not being completed as ordered. A policy was requested, but not provided by the facility.	F 318		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by:	F 325		

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F 325	Continued From page 31 Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R21) reviewed who had a significant weight loss, was comprehensivly assessed to determine weight loss, and implement a nutritional program to prevent further weight loss. Findings include: R21's diagnosis included dysphasia (difficulty speaking). The admission Minimum Data Set (MDS) dated 9/24/13, identified moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and had no natural teeth. The MDS did not identify that R21 had any broken or loose fitting dentures. Review of R21's weights were documented as follows: 9/17/13 (admission)- 127.5 lbs. (pounds). 9/24/13- 122 lbs. 10/1/13- 119 lbs. 10/9/13- 115.5 lbs. 10/20/13- 115 lbs. 10/23/13- 117 lbs. 10/26/13- 114.5 lbs. 10/30/13- 118 lbs. R21 was weighed again on 10/31/13, with a weight of 115 lbs. Nursing assistant (NA)-A stated R21 has been weighed on this same sale since admission. This was a 12.5 lbs weight loss in the 43 days since admission, almost a 10	F 325	**F 325 Nutritional Status** 1. A comprehensive re-assessment of resident's nutritional status and weight loss was completed on 11/8/13. Resident R21's care plan was reviewed and on 11/11/13 Resident's diet was upgraded with risks and benefits explained and understood by resident and wife, and they were agreeable to this change. 2. The comprehensive nutritional assessment and the individual care plans of all current residents were reviewed by the Dietary Manager and and/or Designee. All current residents are being offered a diet which supplies the caloric and nutritional needs as determined by their individual nutritional assessment. In addition, a process has been implemented to ensure that all full meal refusals are appropriately communicated to the Dietary Manager for review and investigation, as well as to ensure that the resident who refused is offered and served a substitute of similar nutritive value.	

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F 325	Continued From page 32 percent weight loss. When interviewed on 10/28/13, at 6:15 p.m. R21 stated his dentures didn't fit, and he was unable to wear them any more. They had not fit for "a while." R21 stated the facility required him to eat "mashed" (pureed) food related to his dentures not fitting properly, and he would like to go to the dentist to get them fixed so he can eat regular food. R21 stated he did not like the ground up food because it had no taste and stated he was losing weight because "I don't eat!" The Physical Nursing Data completed on 9/17/13, indicated R21 had no upper or lower edema (swelling), weight was 127.5 lbs., and had upper and lower dentures documented as "not with him?" R21 had been referred to speech therapy related to increased coughing noted by nursing. Review of speech therapy notes included the following: 10/7/13- "Patient has dentures but states he doesn't wear them complains of not liking ground up food. Education on why need to wear dentures to participate in trails of upgrade food." 10/10/13- Speech therapy trialed R21's dentures with Fixodent. "Bottom denture came loose but top dentures stayed fixed. Patient feels it is easier to chew without his dentures in...patient unwilling/ unable to keep dentures in due to discomfort..." On 10/10/13 Speech therapy wrote an	F 325	3. Upon admission Dietary Manager or designee will interview Resident by using the Initial Interdisciplinary Data Collection Tool / Nutrition Data. The Nutrition Data will be completed with Resident and family or Guardian to obtain pertinent information related to any issues with Nutritional status. Speech therapy will communicate all concerns, progress and interventions related to residents' nutritional status via the center's weekly Medicare meetings to the Dietary Manager, throughout the course of therapy. Education will be provided on 12/2/13 to all Therapists, Nursing and Dietary Staff to inform them of the Signs/Symptoms that may indicate a decline in nutritional status, the importance of accurate and consistent documentation of weights, and the new process that has been implemented in order to ensure that all full meal refusals have been communicated to the appropriate person and documented.	

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F 325	Continued From page 33 Interdisciplinary Rehab Round note indicating, "[R21] needs to be seen by the dentist to have his dentures refit. Even with Fixodent [a denture adherant paste] his dentures do not adhere to his gums and without dentures there is no possibility of progressing him to a regular diet." This was signed and reviewed by registered nurse (RN)-B. A Physician Note dated 10/10/13, included, "Appetite is made a little bit difficult by difficulty with his dentures fitting at this time." R21's Nutrition Data completed on 9/18/13, indicated, "No dentures worn; does not wear." Also indicated R21 was a "meat man" and preferred to "nibble all day." This assessment was completed by the director of dietary services and R21's family member. The Consultant Dietician Note written on 10/16/13, included, "[R21] discussed with nutritional risk team meeting secondary to weight loss and decreased appetite. He receives a level two [pureed] diet; planned extras of NDS [a high calorie nutritional supplement] 6 oz TID [three times a day] for weight maintenance. He sees speech to evaluate for proper diet texture. (Level 2 diet may be impacting intakes). He is consuming less then 25-75% of meals; current weight 10/15/13 116, admit weight (9/26/13) was 122. Weight loss related to fluid losses from hospital stay... Will also add to nutritional risk monitoring with monthly review..." During interview on 10/31/13, at 8:50 a.m. RN-A	F 325	4. Dietary Manager will review and audit the current weights for all residents who are at risk for weight loss weekly to identify and implement immediate interventions for any resident who has been conformed as having a weight loss of 3 or more pounds in one week. Audits of all CNA documentation of care plan approaches, including daily intakes, weights and / or weight loss, will be completed by the Dietary Manager, and/or Designee(s) at the end of each shift x 7 days, and random weekly audits x 5 weeks thereafter. These random weekly audits regarding completion and documentation of pertinent care plan approaches will occur x 3 months to ensure compliance and that all refusals are being documented and communicated to the appropriate designated person, with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 325	Continued From page 34 stated she was not aware R21 needed to be seen by the dentist. RN-A stated usually when residents come in to the facility for short term, the facility usually "does not do dental appointments." During interview on 10/31/13, at 10:35 a.m. director of nursing (DON) stated the medical records person said she called R21's family but the family told her they did not want a dental appointment made. The DON stated she had also brought up the dentures during the initial care conference and R21's wife stated the resident could eat anything without dentures and didn't need to wear them. However, there was no documentation regarding any conversation with R21 or his wife regarding being offered a dental appointment or the need to have dentures fit in order to be upgraded to a regular diet per speech therapy recommendations. During interview on 10/31/13, at 1:25 p.m. R21's family member (FM)-F stated she thought R21 had been getting regular food (not pureed) starting last week. FM-F stated R21 ate regular food before at home without wearing his dentures, and she did not realize his dentures needed to be fixed in order for the facility to allow him to eat "regular" food. FM-F stated R21 told her he didn't like the ground up food and it had no taste and he does not want to eat it anymore. FM-F stated she had spoken to the facility regarding R21's dentures not fitting, however, she does not recall being offered a dental appointment or being informed R21 could not eat regular food until his dentures were fixed.	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(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 325	Continued From page 35 During interview on 10/31/13, at 12:20 p.m. dietary manager (DM) stated she had completed the initial nutritional assessment on R21 and was told the resident had a poor appetite. DM stated she was not aware R21 was not eating because he didn't like the ground food. DM was unaware if R21 had dentures or not but she had been told the resident did not want to go to the dentist and dietary could not upgrade to regular food without the resident wearing dentures. R21 was not able to recall who had told her he did not want to go to the dentist. During interview on 11/1/13, at 9:35 a.m. speech therapist (ST)-A stated she made recommendations to the facility regarding R21 needing to be seen by the dentist to get his dentures to fit. ST-A stated she had never spoke directly to the resident or family about making a dental appointment. She had referred that to the facility and thought they were "taking care of it." During interview on 11/1/13, at 11:15 a.m. registered dietician (RD)-A stated she had not spoken to R21 and had only spoken to the facility at the nutrition risk meeting regarding the residents weight loss. She stated the resident was on nutritional supplements and was seeing speech, but she was not aware of the recommendations regarding the resident needing to see the dentist. RD-A stated if R21 is losing weight related to not liking the pureed food, the facility should be working with the family regarding upgrading the diet to ensure the resident receives the adequate nutrition. The facility policy entitled Dental/ Oral Health	F 325		

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F 325	Continued From page 36 Services and Assessments dated 1/2009 instructed, "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures...Referral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances."	F 325		
F 411 SS=D	483.55(a) ROUTINE/EMERGENCY DENTAL SERVICES IN SNFS The facility must assist residents in obtaining routine and 24-hour emergency dental care. A facility must provide or obtain from an outside resource, in accordance with §483.75(h) of this part, routine and emergency dental services to meet the needs of each resident; may charge a Medicare resident an additional amount for routine and emergency dental services; must if necessary, assist the resident in making appointments; and by arranging for transportation to and from the dentist's office; and promptly refer residents with lost or damaged dentures to a dentist. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide necessary dental services for 1 of 1 resident (R21) who was reviewed regarding dentures which did not fit.	F 411	**F 411 Dental Services** 1. On 11/6/13, R21 had an appointment scheduled to see a dentist on 11/15/13, his date of discharge. 2. All current residents were reviewed to ensure proper fitting dentures, and/or adequate dentition. Residents with poor dentition and/or poorly fitting dentures have already seen, or have an appointment made to see a dentist. All residents and family members were re-educated about the availability and assistance with arranging dental services if needed.	

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GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 411	Continued From page 37 Findings include: R21's medical record identifed diagnosis of dysphasia (difficulty speaking). The admission Minimum Data Set (MDS) dated 9/2/13, identified R21 had moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and had no natural teeth. The MDS did not identify that R21 had any broken or loose fitting dentures. During observation on 10/28/13, at 6:30 p.m. R21 was laying in bed watching television and there was a set of dentures sitting on the night stand in a denture cup. On 10/31/13, R21 was observed at 9:05 a.m. in the dining room eating cheerios with milk. The resident was not wearing top or bottom dentures. During interview on 10/28/13, at 6:30 p.m. R21 stated his dentures do not fit him and he is unable to wear them anymore. He stated they had not fit for "a while." R21 stated the facility required him to eat "mashed" (pureed) food related to his dentures not fitting properly, and he would like to go to the dentist to get them fixed. R21 was not able to recall the last time he had been to the dentist and he had not recalled anyone at the facility offering to assist him in obtaining a dental appointment. R21 stated he would probably have to wait until he was discharged from the facility to see a dentist. R21's Initial Interdisciplinary Data Collection Tool	F 411	3. All residents receive a comprehensive oral/dental assessment by a licensed nurse within 24 hours of admission, as needed, as well as on a quarterly basis. Good Samaritan Society - Howard Lake currently has a contract with Distinctive Dental Services of Howard Lake, MN in order to provide on-site routine dental exams and cleanings annually, and referrals to see an orthodontist or oral surgeon, if needed, are made at that time, as well as on an "as-needed", or emergency basis by the nursing staff throughout the year. On 11/27/13, all nursing staff received education regarding the importance of thorough oral cares, assessments, and the necessity of making an immediate referral if/when needed. 4. DNS / Designee will do random audits of all residents with dentures to ensure ongoing compliance regarding proper fitting and related nutritional risks. These audits will be done weekly x4 with results to QA for further recommendation. 5. Completion Date: December 6th, 2013	

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F 411	Continued From page 38 dated 9/17/13, indicated R21 had no natural teeth, had upper and lower dentures and included, "Not with him?" The Nutrition Data form dated 9/20/13, indicated R21, "Had no dentures worn, does not wear." The information on this form was obtained from R21's daughter as the resident was documented as "sleeping." A Physician Note dated 10/10/13, included, "Appetite is made a little bit difficult by difficulty with his dentures fitting at this time." R21 was being evaluated by speech therapy related to pureed diet and for a diagnoses of dysphasia. On 10/10/13, Speech therapy wrote a Interdisciplinary Rehab Round note indicating, "[R21] needs to be seen by the dentist to have his dentures refit. Even with Fixodent [a denture adherent paste] his dentures do not adhere to his gums and without dentures there is no possibility of progressing him to a regular diet." This was signed off by Registered nurse (RN)-B. During interview on 10/31/13 at 8:50 a.m. RN-A stated she was not aware R21 needed to be seen by the dentist. RN-A stated usually when residents come in to the facility for short term the facility usually, "Does not do dental appointments." During interview on 10/31/13, at 10:35 a.m. the director of nursing (DON) stated the medical	F 411		

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	245278	A. BUILDING _____ B. WING _____	11/01/2013

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F 411	Continued From page 39 records person said she had called R21's family but the family told her they did not want a dental appointment made. The DON stated she had also brought up the dentures during the initial care conference and R21's wife stated the resident could eat anything without dentures and didn't need to wear them. However, there was no documentation regarding any conversation with R21 or his wife regarding being offered a dental appointment or the need to have dentures which fit to be upgraded to a regular diet per speech therapy recommendations. During interview on 10/31/13, at 1:25 p.m. R21's family member (FM)-F stated she thought R21 had been getting regular food (not pureed) starting last week. FM-F stated R21 ate regular food at home without wearing his dentures, and she did not realize his dentures needed to be fixed in order for the facility to allow him to eat "regular" food. FM-F stated R21 told her he didn't like the ground up food and it had no taste and he does not want to eat it anymore. FM-F stated she had spoken to the facility regarding R21's dentures not fitting, however, she does not recall being offered a dental appointment or being informed R21 could not eat regular food until his dentures were fixed. A facility policy entitled Dental/ Oral Health Services and Assessments dated 1/2009, instructed, "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and	F 411		

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F 411	Continued From page 40 referral to a dentist in case of lost or damaged dentures...Referral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances."	F 411		

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	245278	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/07/2013**

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GOOD SAMARITAN SOCIETY - HOWARD LAK	**413 13TH AVENUE HOWARD LAKE, MN 55349**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society-Howard Lake was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society-Howard Lake is a 1-story building with no basement. The building was constructed at 3 different times. The original building was constructed in 1971 and was determined to be of Type II(111) construction. In 1981, an addition was constructed to the east wing and was determined to be of Type II(111) construction. Another addition was added in 1995 to the north wing and was determined to be Type II (111). Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 38 beds and had a census of 31 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

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

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MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 7791

November 20, 2013

Ms. Laura Rindfleisch, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, Minnesota 55349

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5278021

Dear Ms. Rindfleisch:

The above facility was surveyed on October 28, 2013 through November 1, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

and the Time Period For Correction.

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

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

When all orders are corrected, the order form should be signed and returned to:

Brenda Fischer, Unit Supervisor
Minnesota Department of Health
3333 West Division, #212
St. Cloud, Minnesota 56301
Telephone: (320) 223-7338
Fax: (320) 223-7348

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 me.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure(s)
cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00019	A. BUILDING: _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On October 28, 29, 30, 31 and November 1, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of	2 000	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.	

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2 000	Continued From page 1 Compliance Monitoring, Licensing and Certification Program; 3333 West Division Street Suite 212, St. Cloud, MN 56301-4557.	2 000	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 which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an	2 265		

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2 265	Continued From page 2 attending physician must be involved in the development of these policies. The policies must have criteria which address at least the appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician for 1 of 1 resident (R21) reviewed, who had a change in condition when he developed a pressure ulcer. Findings include: R21's medical record identified diagnosis fracture of left femur. The admission Minimum Data Set (MDS) dated 9/24/13, identified R21 had	2 265		

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2 265	Continued From page 3 moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and was at high risk for developing pressure ulcers. R21's Daily Skilled Notes included the following: 10/25/13- "Noted on right big toe on right foot what appears to be a blood blister; nickel size... placed in treatment book to monitor every shift until resolved." 10/26/13- "What appears to be a blood blister remains on right big toe, noted no change in size." 10/27/13- "Blood blister remains intact on right great toe; no change in size." 10/28/13- "Blood blister intact on right great toe; no change noted in size." 10/29/13- "Blood blister on right great toe intact." 10/30/13- Blood blister on right great toe intact." When interviewed on 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A stated the nurses are monitoring the blood blister. LPN-A stated she could not find any where in R21's medical record that the physician had been notified of this area. When interviewed on 10/30/13, at 9:30 a.m. the occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half ago. She was not aware R21 currently had a "blood blister" on his right toe, and had not notified the physician. When interviewed on 10/31/13, at 9:45 a.m. RN-	2 265		

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2 265	Continued From page 4 A stated she had been monitoring R21's "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring. RN-A was unsure where the blister on his toe came from but stated she did not think it was pressure related because R21, "Doesn't wear shoes." RN-A verified the physician had not been notified and the nurse discovering the blood blister should have notified the physician. When interviewed on 10/31/13, at 10:35 a.m. director of nursing (DON) stated she was just made aware of the blood blister two days ago but had not had time to look at the area. The DON verified the nurses should have done an assessment to determine the cause, should be documenting size, and should have notified the physician. DON stated none of the above had been done. She also verified the timing of R21 beginning to wear his shoes and the development of the blood blister was probably related to the pressure of his shoes. The facility provided a policy entitled Skilled Nursing Coverage and Documentation dated 2/2012. The policy instructed, "Nursing documentation to help support a skilled nursing service should include assessments, nursing concerns, physician contacts and documentation of abnormal or unstable conditions..." Although R21 had developed a "blood blister" on a pressure area, the facility failed contact the residents physician to ensure adequate treatment was in place to promote healing.	2 265		

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2 265	Continued From page 5 The National Pressure Ulcer Advisory Panel defines pressure ulcer's, "Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and or shear," as "Suspected deep tissue injury." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding notification of the physician. All staff involved with notifying the physician of resident changes could be educated regarding the procedure. The quality assurance committee could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 265		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the care plan was followed for 3 of 4 residents (R19 and R36 and R2) reviewed who were assessed as needing	2 565		

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2 565	Continued From page 6 restorative nursing services. Findings include: R19 did not receive restorative nursing services as directed by the care plan. R19's quarterly Minimum Data Set (MDS) dated 9/12/13, included a diagnosis of schizophrenia and rheumatoid arthritis. The MDS indicated he was cognitively intact, did not reject cares, had functional limitations in range of motion of upper extremities, but did not receive a restorative nursing program. R19's care plan dated 9/18/13, included a restorative nursing program twice a week, and directed staff to assist R19 with use of a Restorator (an exercise machine) for five minutes, dowel exercises moving side to side and pushing out, circles forward and backwards and push up, two sets of ten. R19's Physical Therapy discharge summary dated 8/9/13, included, "Patient and therapist developed a new restorative program that patient feels he can tolerate, despite having to rest frequently which he says he had to do in the past. Patient will use arm bike for five minutes, lower extremity Restorator x 10 and dowel in all planes." R19's Care Plan Approaches report from 7/30/13	2 565		

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2 565	Continued From page 7 through 10/30/13, revealed he had received his restorative nursing program only twice in these 13 weeks, on 8/26/13 and 10/23/13. The report did not include why R19 had not received the restorative program twice a week as directed by the care plan. When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she is assigned to assist residents with their restorative nursing programs. She is only given four hours a day in the afternoon to do this. In the morning she is assigned dining services. The facility use to have a full day restorative nursing assistant, but this was cut back to just four hours a day in April 2013. NA-B stated she is unable to assist everyone with their restorative programs because of this, there is not enough time. R19 "is a morning person," and will only do the restorative program in the mornings, when she is assigned dining duties. NA-B had not reported her inability to provide R19 with the restorative program to anyone. When interviewed on 10/30/13, at 1:03 p.m. R19 stated he always use to go for his restorative nursing program in the morning with the restorative aide. About six months ago the staff quit asking him to go to the program. If they would offer his program in the mornings, he would go. When interviewed on 10/30/13, at 11:22 a.m. the assistant director of nursing (ADON) stated even though she is responsible for reviewing the restorative programs for each resident monthly, she was not aware R19 was not attending as	2 565		

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2 565	Continued From page 8 directed by his care plan. No one had reported this to her. R36 did not receive the restorative nursing program as directed by the care plan. R36's quarterly MDS dated 9/4/13, included diagnoses of diabetes and depression. The MDS indicated he was cognitively intact and participated in a restorative nursing program for active range of motion (ROM) two times during the assessment week. R36's care plan dated 9/4/13, indicated he was to attend a restorative nursing program twice a week. This would include, Restorator for ten minutes and/or up and down the stairs twice, and/or leg exercises with three pounds for 15 repetitions. R36's Care Plan Approaches report from 7/30/13 to 10/30/13, indicated he received his restorative program 14 times during these 13 weeks. There was no documentation to indicated why R36 had not received the program twice a week as ordered. When interviewed on 10/31/13, at 10:22 a.m. NA-B stated R36 does not refuse to come to his restorative nursing program, but she does not always have time to assist him with it. She had not reported this to anyone.	2 565		

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2 565	Continued From page 9 When interviewed on 10/31/13, at 12:30 p.m. the ADON stated she had reviewed R36's restorative program monthly, but was not aware it was not being offered as directed by the care plan. No one had reported this to her. R2 did not receive the restorative nursing program as directed by the care plan. R2's diagnosis included adult failure to thrive. The quarterly MDS dated 10/21/13, included moderate cognitive impairment, required extensive assistance with ambulation, and received a restorative nursing program to include ambulation one time in the assessment week. R2's care plan dated 11/28/12, directed staff to assist with a restorative nursing program to include ambulation with one assist and rolling walker to and from all meals as tolerated. In addition, the care plan directed staff to assist with the use of the Restorator as tolerated and/or standing alternate marches 20 repetitions total with upper extremity use on walker. Step up onto wooden box of six inches, and/or 3 pound seated exercises 20 repetitions bilateral. Pulleys for 5 minutes and red pegs and putty. This exercise program was to occur daily seven days a week. R2's Physical Therapist Progress & Discharge Summary dated 5/10/13, included physical therapy (PT) had worked with R2 4/15/13 through 5/10/13, due to a decline in ability to transfer in and out of bed. The summary directed nursing staff to continue her ambulation program. The "Current Level of Function," concluded R2 was able to ambulate 60 to 100 feet with a front	2 565		

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2 565	Continued From page 10 wheeled walker, with minimum assistance to hold onto R2 and pull the wheel chair behind. R2's Care Plan Approaches Report from 5/1/13 through 10/31/13, showed R2 had the opportunity to ambulate to and from meals as directed by the care plan 655 times. The documentation showed R2 only actually ambulated to and from meals 103 times. R2 had refused 113 times. There was no evidence R2 had been offered assistance to ambulate to and from meals 439 times during this time frame. R2's Care Plan Approaches Report from 7/1/13 through 10/31/13 showed R2 had not participated in the other restorative nursing program with the Restorator, standing marches, pulleys or pegs exercises at all. This was should have occurred 123 times in this time frame. When interviewed on 10/31/13, at 1:31 p.m. R2 stated she use to walk to and from all the meals. She had to get help from staff to do this. R2 stated staff just stopped asking her to walk, and just automatically take her in her wheel chair to meals. R2 had never been offered any other exercise program. When interviewed on 10/31/13, at 1:42 p.m. NA-A stated she started working in the facility in June 2013, she had never seen R2 ambulate to and from meals. NA-A was unaware R2's care plan directed staff to assist her to ambulate to and from meals. NA-A was not aware of any other	2 565		

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2 565	Continued From page 11 exercise program R2 was to participate in either. When interviewed on 11/1/13, at 10:05 a.m. the ADON was unaware R2 was not participating with the restorative nursing program as directed by the care plan, even though she reviews each residents restorative nursing program monthly. The ADON did state R2 would refuse to ambulate at times. No one had reported to her the ambulation and exercise program were not being completed as directed by the care plan. During interview on 11/1/13, at 10:33 a.m., the Director of Nursing (DON) stated they had a restorative aid who quit in January 2013, they had hired staff to complete the restorative programs and was not aware they weren't receiving them as ordered. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 885	MN Rule 4658.0525 Subp. 1 Rehabilitation Nursing Care; Program required	2 885		

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2 885	Continued From page 12 Subpart 1. Program required. A nursing home must have an active program of rehabilitation nursing care directed toward assisting each resident to achieve and maintain the highest practicable physical, mental, and psychosocial well-being according to the comprehensive resident assessment and plan of care described in parts 4658.0400 and 4658.0405. Continuous efforts must be made to encourage ambulation and purposeful activities. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure each resident was provided with ambulation services when recommended, and assessed when ambulation ability declined for 1 of 3 residents (R2) reviewed for ambulation services. This practice resulted in actual harm for R2, when she experienced an avoidable decline in ability to ambulate. Findings include: R2's diagnoses included osteoarthritis. The quarterly Minimum Data Set (MDS) dated 10/21/13, included moderate cognitive impairment, required extensive assistance for transfers and ambulation, and received a restorative nursing program which included ambulation one day during the assessment week. R2's care plan dated 11/28/12, directed staff to assist with a restorative nursing program to include ambulation, with one assist and rolling walker, to and from all meals as tolerated. In addition, the care plan directed staff to assist with a daily exercise program to include: the use of a Restorator [an exercise machine] as tolerated	2 885		

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2 885	Continued From page 13	2 885		

and/or standing alternate marches 20 repetitions total with upper extremity use on walker. Step up onto wooden box of six inches, and/or 3 pound seated exercises 20 repetitions bilateral. Pulleys for 5 minutes and red pegs and putty.

R2's Physical Therapist Progress & Discharge Summary dated 5/10/13, included physical therapy (PT) had worked with R2 4/15/13 through 5/10/13, due to a decline in ability to transfer in and out of bed. The summary directed nursing staff to continue her ambulation program. The "Current Level of Function," concluded R2 was able to ambulate 60 to 100 feet, with a front wheedled walker, with minimum assistance to hold onto R2 and pull the wheel chair behind.

R2's Care Plan Approaches Report from May 1, 2013 through October 31, 2013, showed R2 had the opportunity to ambulate to and from meals as directed by the care plan 655 times. The documentation showed R2 only actually ambulated to and from meals 103 times. R2 had refused 113 times. There was no evidence R2 had been offered assistance to ambulate to and from meals the other 439 times during this time frame. There was no documentation to indicate why R2 had not ambulated these 439 times.

R2's Care Plan Approaches Report from July 1, 2013 through October 31, 2013 showed R2 had not participated in the exercise program with the Restorator, standing marches, pulleys or pegs exercises at all. R2 should have been offered this program daily for the 123 days in this time period. There was no documentation to indicate why it was missed for all 123 days.

On 10/28/13, at 5:02 p.m. R2 was sitting in the dining room in her wheel chair. At 6:10 p.m. she

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2 885	Continued From page 14	2 885		

was propelled out of the dining room in her wheel chair by an unknown staff person. At 6:50 p.m. R2 was observed in her room sitting in her wheelchair watching television.

When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she works as a dining aide in the mornings and does the restorative programs in the afternoons. NA-B said the facility use to have a full day restorative nurse aide, but that had changed in April 2013, to just half a day. NA-B stated there is not enough time to do everyone's restorative program, but verified she had not reported this to anyone. NA-B had never assisted R2 to do her exercise program that was care planned to occur every day. She had not been instructed to do so.

When interviewed on 10/31/13, at 1:31 p.m. R2 stated she use to walk to and from all the meals and that she requires assistance from staff to do this. R2 stated that about six months ago, staff just stopped asking her to walk and now they just automatically take her to meals in her wheel chair. R2 did not know about doing any exercises, and said she had not been offered any.

On 10/31/13, at 1:42 p.m. R2 was sitting in her wheelchair in her room. R2 requested to lie in bed. Nursing assistant (NA)-A and trained medication aide (TMA)-A assisted R2 into bed, with two person assist. NA-A stated R2 had not ambulated to and from lunch today. NA-A stated that since she had started working in the facility in June 2013, she had never seen R2 ambulate to and from meals. NA-A was unaware R2's care plan directed staff to assist her to ambulate to and from meals. NA-A was not aware of any other exercise program R2 was supposed to participate

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2 885	Continued From page 15 in either. On 11/1/13, at 9:19 a.m. R2 was in the hallway next to the dining room sitting in her wheelchair, using the hallway grab bars to pull herself down the hall. R2 was asked by the physical therapist (PT)-A if she could watch her walk. R2 replied, "I can't walk anymore." R2 agreed to attempt to ambulate. NA-A and NA-D assisted R2 to stand with a transfer belt and front wheeled walker. R2 was able to ambulate 20 feet with weight bearing assistance of two nursing assistants who were also pulling the wheel chair behind her. PT-A stated in May 2013, R2 was able to ambulate 60 to 100 feet with only one assist, for balance. PT-A stated R2 had declined in her ability to ambulate. PT-A stated staff needed to encourage R2 to ambulate more. When interviewed on 11/1/13, at 9:43 a.m. NA-C stated R2 use to ambulate to meals, but could not anymore, "it is too hard for her to move her feet." NA-C stated this change occurred over the past six months, but NA-C confirmed she had not reported this change to anyone. NA-C further stated the nursing assistant assigned to do the restorative programs often gets pulled from doing that duty to work on the floor indicating this happens when staff call in sick, or when they are "just short." R2's Interdisciplinary Assessments and Summary Quarterly review dated 8/7/13, included "Resident has goals of participation in AMB [ambulation] and OT/PT [occupational therapy and physical therapy]...Resident continues to AMB [ambulate] [with] assist of [two] to get up then [one] assist to AMB [ambulate]. Often refuses with no other reason than "I'm 101 years old." Will continue goals..."	2 885		

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2 885	Continued From page 16 R2's Quarterly review dated 10/21/13, included, "... Goal of ambulating to all meals not met r/t [related to] refusals. Simply states, "I'm a hundred, I shouldn't have to..." When interviewed on 11/1/13, at 10:05 a.m. the assistant director of nursing (ADON) stated she does the reviews on each resident's restorative nursing program every month, but was unaware R2 had not been participating with the restorative nursing programs including exercise and ambulation as directed by the care plan. The ADON said if R2 was refusing, it should be documented and reported to her. The ADON stated she should review the Care Plan Approaches Reports and speak with nursing assistants when she reviews the restorative programs, but had not. The ADON did not know why her Interdisciplinary Assessment and Summary reviews did not address the exercise program R2 had been care planned to do. R2's Therapy Screen Form dated 11/1/13, included R2 had a change in condition and this change required modification of the functional maintenance program. When interviewed on 11/1/13, at 10:33 a.m., the Director of Nursing (DON) stated they had a restorative aid who quit in January 2013, and they had hired staff to complete the restorative programs, but was not aware the programs were not being implemented. The DON stated R2 has refused to ambulate at times, she was not aware it wasn't being offered. The DON stated she did not know R2 had never received the exercise program which could have helped with R2's strength and endurance.	2 885		

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2 885	Continued From page 17 The facility's Restorative Nursing Program/ Restorative Nursing Documentation policy, last revised 1/2013, indicated the purpose is to document restorative nursing appropriately. "... for re-screens, document if a functional change has occurred; upon comparison with last screen, do follow-up and make referral to therapists as necessary... lack of progress and reason as well as any increase/ decrease in goals." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the policy and procedures related to continued resident assessment for range of motion programs and ambulation needs and the prevention of contractures. Administer or designee could provide ongoing education to all staff to ensure residents do not experience a loss in range of motion or ambulation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 885		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	2 895		

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2 895	Continued From page 18 increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide the recommended restorative nursing services, to prevent a decline in range of motion, for 2 of 3 residents (R19 & R36) reviewed who had restorative nursing services ordered. Findings include: R19 did not receive restorative nursing services as directed. R19's quarterly Minimum Data Set (MDS) dated 9/12/13, included a diagnoses of schizophrenia and rheumatoid arthritis. The MDS indicated he was cognitively intact, did not reject cares, had functional limitations in range of motion of upper extremities, but did not receive a restorative nursing program. R19's care plan dated 9/18/13, included a restorative nursing program twice a week, and directed staff to assist R19 with use of a Restorator (an exercise machine) for five minutes, dowel exercises moving side to side and pushing out, circles forward and backwards and push up, two sets of ten. R19's Physical Therapy discharge summary	2 895		

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2 895	Continued From page 19 dated 8/9/13, included, "Patient and therapist developed a new restorative program that patient feels he can tolerate, despite having to rest frequently which he says he had to do in the past. Patient will use arm bike for five minutes, lower extremity Restorator x 10 and dowel in all planes." R19's Care Plan Approaches report from 7/30/13 through 10/30/13, revealed he had received his restorative nursing program only twice in these 13 weeks, on 8/26/13 and 10/23/13. The report did not include why R19 had not received the restorative program twice a week as directed by the care plan. When interviewed on 10/30/13, at 11:30 a.m. nursing assistant (NA)-B stated she works as a dining aide in the mornings, and does the restorative programs in the afternoons. NA-B stated she had not been able to offer R19 his restorative program since she does not have time, and also stated R19 is a morning person and she is unable to offer the restorative nursing programs in the morning. R19 does not like to do it in the afternoon. NA-B further stated the facility used to have restorative aide that worked all day but that was stopped in January 2013. When interviewed on 10/30/13, at 1:03 p.m. R19 stated he used to always go to his restorative program in the morning with the rehab aide. The rehab aide had retired about six months ago, and the staff no longer asked him to go to the exercise program. R20 also stated if the staff would offer his program to him in the morning he	2 895		

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2 895	Continued From page 20 would attend. When interviewed on 10/30/13, at 11:22 a.m. the assistant director of nursing (ADON) stated she reviews the restorative programs monthly, but she was not aware R19 was not attending his program. She stated she just assumed he was attending and shouldn't have. The ADON stated the staff should inform her if someone is refusing there program. During observation 10/31/13, at 1:03 p.m. R19 was observed to be in the therapy room completing his restorative program with NA-B with no difficulties. During interview on 10/31/13 at 1:10 p.m., NA-B stated R19 had agreed to complete his program at after breakfast. R36 did not receive his restorative nursing program as ordered. R36's quarterly MDS dated 9/4/13, included diagnoses of diabetes and depression. The MDS indicated he was cognitively intact, required extensive assistance with dressing, and participated in a restorative nursing program for active ROM two times during the assessment week. R36's care plan dated 9/4/13, included a restorative program twice a week. The care plan	2 895		

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2 895	Continued From page 21 directed staff to assist R36 with the Restorator for ten minutes, and/or up and down the stairs twice, and/or leg exercises with three pound weights for 15 repetitions. R36's Care Plan Approaches report from 7/30/13 to 10/30/13, indicated R36 had only received his restorative program 14 times out of 24 opportunities. The documentation did not indicate why R36 had not received it the other 10 times as directed by the care plan. When interviewed on 10/31/13, at 10:22 a.m. NA-B stated R36 does not refuse his restorative nursing program, but she doesn't always have enough time to assist him with it. She had not reported this to anyone. When interviewed on 10/31/13, at 12:30 p.m. the ADON stated R36 doesn't not refuse his restorative program, she had thought he was attending the program as ordered. The ADON also stated the staff had not informed her he wasn't receiving his restorative nursing. During observation on 10/31/13 at 1:15 p.m., R36 was observed in the therapy room receiving his restorative program. When interviewed on 10/31/13, at 1:30 p.m. NA-B stated R19 & R36 had not declined in their functional range of motion (ROM). When interviewed on 11/1/13, at 9:43 a.m. NA-C	2 895		

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2 895	Continued From page 22 stated R19 & R36 had not had any declines in there ROM. NA-C also stated the facility used to have a restorative aide who worked all day and the restorative programs were completed then, but there is just not enough time to complete them now as they are only allowed half a day. She had not reported this to anyone. When interviewed on 11/1/13, at 10:33 a.m. the director of nursing (DON) stated they had a restorative aid who quit in January 2013, they had hired staff to complete the restorative programs and had not been informed they were not being completed as ordered. A policy was requested, but not provided by the facility. SUGGESTED METHOD OF CORRECTION: The Director of Nursing could review and revise the policies and procedures for the range of motion programs, educate the appropriate personnel in any changes and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 900		

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2 900	Continued From page 23 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based observation, interview, and record review, the facility failed to ensure 1 of 3 residents (R21) reviewed for pressure ulcers, had the pressure area assessed, monitored, and had interventions in place to promote healing. Findings include: R21 diagnosis included a fracture of the left femur. The admission Minimum Data Set (MDS) dated 9/24/13, identified R21 had moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and was at high risk for developing pressure ulcers. R21's Daily Skilled Notes included the following: 10/25/13- "Noted on right big toe on right foot what appears to be a blood blister; nickel size... placed in treatment book to monitor every shift until resolved."	2 900		

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2 900	Continued From page 24 10/26/13- "What appears to be a blood blister remains on right big toe, noted no change in size." 10/27/13- "Blood blister remains intact on right great toe; no change in size." 10/28/13- "Blood blister intact on right great toe; no change noted in size." 10/29/13- "Blood blister on right great toe intact." 10/30/13- Blood blister on right great toe intact." R21 was observed on 10/30/13, at 12:30 a.m. in a wheelchair propelling himself with his feet back towards his room from the dining room. R21 was wearing black socks and black slip on shoes. On 10/30/13, at 12:40 p.m. licensed practical nurse (LPN)-A observed R21's blister on his right toe. LPN-A stated the nurses are monitoring the area, but not measuring or doing any treatment to it. LPN-A verified there was no assessment regarding the cause of the pressure ulcer, measurements to ensure healing, or notification to the physician to ensure adequate treatment is being done to ensure healing. LPN-A stated the nurse who initially discovers the pressure area is responsible for ensuring the assessment and interventions are appropriate, and notify's the physician. During interview on 10/31/13, at 9:30 a.m. occupational therapist (OT)-G stated R21 had just started wearing shoes in the last week to week and a half. She was not aware R21 currently had a "blood blister" on his right toe. The blood blister could have been caused by the shoe.	2 900		

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2 900	Continued From page 25 During interview on 10/31/13, at 9:45 a.m. RN- A stated she had been "monitoring" R21's "blood blister" on his right toe. She stated the nurses have not been measuring it and verified it would be difficult to know if it was healing related to the lack of monitoring. RN-A was unsure where the blister on his toe came from but stated she did not think it was pressure related because R21 "doesn't wear shoes." RN-A verified there was no assessment, interventions, or notification to the physician and stated the nurse discovering the area should have done the assessment attempted to determine what caused the area. During interview on 10/31/13, at 10:35 a.m. director of nursing (DON) stated she was just made aware of the blood blister 2 days ago but had not had time to look at the area. DON verified the nurses should have done an assessment to determine the cause, should be documenting size, and should have notified the physician. DON stated none of the above had been done. She also verified the timing of R21 beginning to wear his shoes and the development of the blood blister was probably related to the pressure of his shoes. DON stated she was not aware if any staff had determined if R21's shoes fit properly to ensure healing of the pressure ulcer on his right toe. Although R21 had developed a "blood blister" on a pressure area, the facility failed to ensure an assessment was completed to ensure monitoring and interventions were put into place to ensure healing. The facility provided a policy entitled Skilled Nursing Coverage and Documentation, dated 2/2012, instructed, "Nursing documentation to	2 900		

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2 900	Continued From page 26 help support a skilled nursing service should include assessments, nursing concerns, physician contacts and documentation of abnormal or unstable conditions..." The National Pressure Ulcer Advisory Panel defines pressure ulcer's which appear as, "Purple or maroon localized area of discolored intact skin or blood-filled blister due to damage of underlying soft tissue from pressure and or shear," as "Suspected deep tissue injury." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review policies and procedures regarding care for residents at risk for or with pressure ulcers, educate staff on pressure ulcers protocols and develop a monitoring system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder	2 910		

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2 910	Continued From page 27 receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the continued need for the use of an indwelling urinary catheter for 1 of 2 residents (R20) reviewed who had an indwelling urinary catheter. Findings include: R20's diagnoses included multiple sclerosis (MS) and cerebrovascular accident (CVA). The admission Minimum Data Set (MDS) dated 09/26/13, indicated R20 was cognitively intact and needed extensive assistance with toileting. The MDS also indicated she had an indwelling catheter. R20's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 09/27/13, included, "Resident had Foley [name brand of catheter] placed during hospitalization and prefers to keep in at this point for ease in voiding. Is aware of infection risks. Needs assist with cath [catheter] management and cares." R20's care plan dated 09/18/12, included, "... inability to toilet self and indwelling Foley cath. Will have no urinary tract infections. Will progress towards discontinuation of catheter. Cath cares Q	2 910		

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2 910	Continued From page 28 [every] shift. No leg bag in use when in bed." R20's physician orders dated 09/18/13, included, "Urinary drain: you have a urinary drain the reason for the drain is inability to get to the toilet...Urinary drain voiding trial: Pt [patient] has declined Foley removal. Prefers to keep in for ease, understands infection risk. Please keep addressing with her when she would agree to Foley removal." During observation on 10/28/13, at 6:15 p.m., R20 was observed to be sitting in her Broda [name brand] chair eating her supper meal in her room with her catheter bag attached to her chair on the right side. When interviewed on 10/29/13, at 1:00 p.m. R20 stated she has MS and has not been able to walk for the last 10 years while living at home. R20 also stated she would like to get back her bladder control, as she did prior to her CVA. R20 verified that since admission to the facility on 09/18/13, staff or her physician have not mentioned to her any attempts to remove her urinary catheter. During observation on 10/29/13 at 2:01 p.m., R20 was observed to be lying watching TV with her catheter bag hanging on the right side of the bed. When interviewed on 10/29/13, at 2:11 p.m., nursing assistant (NA)-C stated R20 has a catheter because she has difficulty with mobility due to her recent stroke.	2 910		

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2 910	Continued From page 29 When interviewed on 10/30/13, at 11:05 a.m., the director of nursing (DON) stated R20 was admitted to the facility with the indwelling catheter, and she thinks the doctor orders read "to discharge catheter when patient wants it removed." The DON had not addressed removal of the catheter with R20. R20's Physician Progress note, dated 10/24/13, included, "she [R20] continues to have Foley catheter in place and has not had any issues related to this. Anticipate we will discontinue it before discharging her home." R20's Nursing Progress notes dated 09/18/13 through 10/28/13, only indicated R20 has a Foley catheter and a description of the fluid observed in the catheter bag. The notes did not include any discussion with R20 regarding the removal of the indwelling catheter. A facility policy entitled Catheterization (Indwelling/Retention) Insertion and Removal, revised 11/09, included "clinical conditions that may require catheterization include: relieve bladder distention due to: urinary obstruction due to a tumor or enlarged prostate, urine retention, Multiple Sclerosis... The medical record must have documentation of attempts to remove indwelling catheters and the results of these attempts... It is recommended that removal be attempted at least two or three times during his/her stay before it can be determined that it is unsuccessful." Although R20 had the indwelling catheter placed	2 910		

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2 910	Continued From page 30 prior to admission due to a recent CVA, R20 wanted to regain bladder control, and the physician ordered to attempt removal, the facility did not make any attempt to discontinue the catheter during her stay at the facility. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could develop policies and procedures to ensure residents are comprehensively assessed for urinary catheter justification. The director of nursing or designee could educate all appropriate staff members and develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days f315	2 910		

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2 965	Continued From page 31	2 965		
2 965	MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident (R21) reviewed who had a significant weight loss, was comprehensivly assessed to determine weight loss, and implement a nutritional program to prevent further weight loss. Findings include: R21's diagnosis included dysphasia (difficulty speaking). The admission Minimum Data Set (MDS) dated 9/24/13, identified moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and had no natural teeth. The MDS did not identify that R21 had any broken or loose fitting dentures. Review of R21's weights were documented as follows:	2 965		

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2 965	Continued From page 32 9/17/13 (admission)- 127.5 lbs. (pounds). 9/24/13- 122 lbs. 10/1/13- 119 lbs. 10/9/13- 115.5 lbs. 10/20/13- 115 lbs. 10/23/13- 117 lbs. 10/26/13- 114.5 lbs. 10/30/13- 118 lbs. R21 was weighed again on 10/31/13, with a weight of 115 lbs. Nursing assistant (NA)-A stated R21 has been weighed on this same sale since admission. This was a 12.5 lbs weight loss in the 43 days since admission, almost a 10 percent weight loss. When interviewed on 10/28/13, at 6:15 p.m. R21 stated his dentures didn't fit, and he was unable to wear them any more. They had not fit for "a while." R21 stated the facility required him to eat "mashed" (pureed) food related to his dentures not fitting properly, and he would like to go to the dentist to get them fixed so he can eat regular food. R21 stated he did not like the ground up food because it had no taste and stated he was losing weight because "I don't eat!" The Physical Nursing Data completed on 9/17/13, indicated R21 had no upper or lower edema (swelling), weight was 127.5 lbs., and had upper and lower dentures documented as "not with him?" R21 had been referred to speech therapy related to increased coughing noted by nursing. Review of speech therapy notes included the following:	2 965		

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2 965	Continued From page 33 10/7/13- "Patient has dentures but states he doesn't wear them complains of not liking ground up food. Education on why need to wear dentures to participate in trails of upgrade food." 10/10/13- Speech therapy trialed R21's dentures with Fixodent. "Bottom denture came loose but top dentures stayed fixed. Patient feels it is easier to chew without his dentures in...patient unwilling/ unable to keep dentures in due to discomfort..." On 10/10/13 Speech therapy wrote an Interdisciplinary Rehab Round note indicating, "[R21] needs to be seen by the dentist to have his dentures refit. Even with Fixodent [a denture adherant paste] his dentures do not adhere to his gums and without dentures there is no possibility of progressing him to a regular diet." This was signed and reviewed by registered nurse (RN)-B. A Physician Note dated 10/10/13, included, "Appetite is made a little bit difficult by difficulty with his dentures fitting at this time." R21's Nutrition Data completed on 9/18/13, indicated, "No dentures worn; does not wear." Also indicated R21 was a "meat man" and preferred to "nibble all day." This assessment was completed by the director of dietary services and R21's family member. The Consultant Dietician Note written on 10/16/13, included, "[R21] discussed with nutritional risk team meeting secondary to weight loss and decreased appetite. He receives a level	2 965		

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2 965	Continued From page 34 two [pureed] diet; planned extras of NDS [a high calorie nutritional supplement] 6 oz TID [three times a day] for weight maintenance. He sees speech to evaluate for proper diet texture. (Level 2 diet may be impacting intakes). He is consuming less then 25-75% of meals; current weight 10/15/13 116, admit weight (9/26/13) was 122. Weight loss related to fluid losses from hospital stay... Will also add to nutritional risk monitoring with monthly review..." During interview on 10/31/13, at 8:50 a.m. RN-A stated she was not aware R21 needed to be seen by the dentist. RN-A stated usually when residents come in to the facility for short term, the facility usually "does not do dental appointments." During interview on 10/31/13, at 10:35 a.m. director of nursing (DON) stated the medical records person said she called R21's family but the family told her they did not want a dental appointment made. The DON stated she had also brought up the dentures during the initial care conference and R21's wife stated the resident could eat anything without dentures and didn't need to wear them. However, there was no documentation regarding any conversation with R21 or his wife regarding being offered a dental appointment or the need to have dentures fit in order to be upgraded to a regular diet per speech therapy recommendations. During interview on 10/31/13, at 1:25 p.m. R21's family member (FM)-F stated she thought R21 had been getting regular food (not pureed) starting last week. FM-F stated R21 ate regular food before at home without wearing his	2 965		

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2 965	Continued From page 35 dentures, and she did not realize his dentures needed to be fixed in order for the facility to allow him to eat "regular" food. FM-F stated R21 told her he didn't like the ground up food and it had no taste and he does not want to eat it anymore. FM-F stated she had spoken to the facility regarding R21's dentures not fitting, however, she does not recall being offered a dental appointment or being informed R21 could not eat regular food until his dentures were fixed. During interview on 10/31/13, at 12:20 p.m. dietary manager (DM) stated she had completed the initial nutritional assessment on R21 and was told the resident had a poor appetite. DM stated she was not aware R21 was not eating because he didn't like the ground food. DM was unaware if R21 had dentures or not but she had been told the resident did not want to go to the dentist and dietary could not upgrade to regular food without the resident wearing dentures. R21 was not able to recall who had told her he did not want to go to the dentist. During interview on 11/1/13, at 9:35 a.m. speech therapist (ST)-A stated she made recommendations to the facility regarding R21 needing to be seen by the dentist to get his dentures to fit. ST-A stated she had never spoke directly to the resident or family about making a dental appointment. She had referred that to the facility and thought they were "taking care of it." During interview on 11/1/13, at 11:15 a.m. registered dietician (RD)-A stated she had not spoken to R21 and had only spoken to the facility at the nutrition risk meeting regarding the	2 965		

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2 965	Continued From page 36 residents weight loss. She stated the resident was on nutritional supplements and was seeing speech, but she was not aware of the recommendations regarding the resident needing to see the dentist. RD-A stated if R21 is losing weight related to not liking the pureed food, the facility should be working with the family regarding upgrading the diet to ensure the resident receives the adequate nutrition. The facility policy entitled Dental/ Oral Health Services and Assessments dated 1/2009 instructed, "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures...Referral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances." SUGGESTED METHOD FOR CORRECTION: The Director of Nursing (DON) or designee could develop and implement policies and procedures to ensure residents at nutritional risk received appropriate interventions to maintain nutrition as determined necessary by their individualized assessment to ensure healing. The DON or her designee could educate all appropriate staff on the policies and procedures. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	2 965		

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21325	MN Rule 4658.0725 Subp. 1 Providing Routine & Emergency Oral Health Ser Subpart 1. Routine dental services. A nursing home must provide, or obtain from an outside resource, routine dental services to meet the needs of each resident. Routine dental services include dental examinations and cleanings, fillings and crowns, root canals, periodontal care, oral surgery, bridges and removable dentures, orthodontic procedures, and adjunctive services that are provided for similar dental patients in the community at large, as limited by third party reimbursement policies. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide necessary dental services for 1 of 1 resident (R21) who was reviewed regarding dentures which did not fit. Findings include: R21's medical record identifed diagnosis of dysphasia (difficulty speaking). The admission Minimum Data Set (MDS) dated 9/2/13, identified R21 had moderate cognitive impairment, needed extensive assistance with with most activities of daily living (ADL's), and had no natural teeth. The MDS did not identify that R21 had any broken or loose fitting dentures. During observation on 10/28/13, at 6:30 p.m. R21 was laying in bed watching television and there was a set of dentures sitting on the night stand in a denture cup. On 10/31/13, R21 was observed	21325		

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21325	Continued From page 38	21325		

at 9:05 a.m. in the dining room eating cheerios with milk. The resident was not wearing top or bottom dentures.

During interview on 10/28/13, at 6:30 p.m. R21 stated his dentures do not fit him and he is unable to wear them anymore. He stated they had not fit for "a while." R21 stated the facility required him to eat "mashed" (pureed) food related to his dentures not fitting properly, and he would like to go to the dentist to get them fixed. R21 was not able to recall the last time he had been to the dentist and he had not recalled anyone at the facility offering to assist him in obtaining a dental appointment. R21 stated he would probably have to wait until he was discharged from the facility to see a dentist.

R21's Initial Interdisciplinary Data Collection Tool dated 9/17/13, indicated R21 had no natural teeth, had upper and lower dentures and included, "Not with him?"

The Nutrition Data form dated 9/20/13, indicated R21, "Had no dentures worn, does not wear." The information on this form was obtained from R21's daughter as the resident was documented as "sleeping."

A Physician Note dated 10/10/13, included, "Appetite is made a little bit difficult by difficulty with his dentures fitting at this time."

R21 was being evaluated by speech therapy related to pureed diet and for a diagnoses of

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21325	Continued From page 39	21325		

dysphasia. On 10/10/13, Speech therapy wrote a Interdisciplinary Rehab Round note indicating, "[R21] needs to be seen by the dentist to have his dentures refit. Even with Fixodent [a denture adherent paste] his dentures do not adhere to his gums and without dentures there is no possibility of progressing him to a regular diet." This was signed off by Registered nurse (RN)-B.

During interview on 10/31/13 at 8:50 a.m. RN-A stated she was not aware R21 needed to be seen by the dentist. RN-A stated usually when residents come in to the facility for short term the facility usually, "Does not do dental appointments."

During interview on 10/31/13, at 10:35 a.m. the director of nursing (DON) stated the medical records person said she had called R21's family but the family told her they did not want a dental appointment made. The DON stated she had also brought up the dentures during the initial care conference and R21's wife stated the resident could eat anything without dentures and didn't need to wear them. However, there was no documentation regarding any conversation with R21 or his wife regarding being offered a dental appointment or the need to have dentures which fit to be upgraded to a regular diet per speech therapy recommendations.

During interview on 10/31/13, at 1:25 p.m. R21's family member (FM)-F stated she thought R21 had been getting regular food (not pureed) starting last week. FM-F stated R21 ate regular food at home without wearing his dentures, and she did not realize his dentures needed to be

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21325	Continued From page 40 fixed in order for the facility to allow him to eat "regular" food. FM-F stated R21 told her he didn't like the ground up food and it had no taste and he does not want to eat it anymore. FM-F stated she had spoken to the facility regarding R21's dentures not fitting, however, she does not recall being offered a dental appointment or being informed R21 could not eat regular food until his dentures were fixed. A facility policy entitled Dental/ Oral Health Services and Assessments dated 1/2009, instructed, "The center will provide or obtain from an outside source routine and 24 hour emergency dental services that meet professional standards and principles. Residents will be assisted, when necessary, in making routine and annual appointments, arranging transportation and referral to a dentist in case of lost or damaged dentures...Referral will be made to appropriate specialized care as needed, as well as assistance given in obtaining appropriately fitting appliances." SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could review and revise the policies and procedures for the dental assessments and providing routine dental services, educate the appropriate personnel, and appoint a designee to monitor the procedures to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21325		

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21475	Continued From page 41	21475		
21475	MN Rule 4658.1005 Subp. 1 Social Services: General Requirements Subpart 1. General requirements. A nursing home must have an organized social services department or program to provide medically related social services to each resident. A nursing home must make referrals to or collaborate with outside resources for a resident who is in need of additional mental health, substance abuse, or financial services. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the social service department failed to coordinate discharge services with an outside agency for 1 of 1 residents (R3) reviewed who desired to discharge to the community. Findings include: R3's medical record indicated a diagnoses of quadriplegia (paralysis resulting in partial or total loss of upper and lower limb use) and had history of pressure ulcers for 10 years. The annual Minimum Data Set (MDS) dated 9/25/13, identified R3 was cognitively intact, needed extensive assistance with all activities of daily living (ADL's) except eating, had pressure ulcers, and had an active discharge plan in place to return to the community. R3's care plan dated 10/16/12, included, "Will consider placement in the community when open areas have healed," and "social worker/ interdisciplinary team to assist resident/ family with discharge planning."	21475		

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21475	Continued From page 42 However, added to this was, "Discharge plan: Currently long term care related to level of care needs in ADL's." During interview on 10/28/13, at 3:40 p.m. R3 stated he had been living in the facility for a little over a year. He had lived at a group home for about 10 years, but moved to the facility to be closer to family. R3 stated he does not do much at the facility as he does not have much in common with the "older people," but he was unable to find another place to live close to his family. He stated last he had spoke with the county social worker about discharge was several months ago and the county case worker was trying to find more appropriate placement for him in a facility with people more his age. During observation on 10/28/13, at 5:45 p.m. R3 was in his room eating supper. On 10/29/13, at 12:25 p.m. R3 was observed eating lunch in his room. On 10/29/13, at 12:55 p.m. R3 was observed in his electric wheelchair going outside of the facility and going to the end of the driveway and smoking a cigarette. R3 was not seen interacting with other residents. R3's progress notes revealed the following: 4/17/13- "Care team met with resident present. Social service reports resident is stable... resident will be meeting with his social worker in May. She will be presenting [R3] with a list of housing options." No further social work notes were found in R3's medical record. 7/10/13- "Quarterly care conference. Nursing	21475		

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21475	Continued From page 43 reports chronic wounds are maintained by treatment order...Resident declined attendance at care conference and has no concerns except locating alternate placement. Has been working with his social worker on this." When interviewed on 10/30/13, at 11:14 a.m. county social worker (CSW)-J stated the last meeting she had with R3 was in May 2013, approximately 5-6 months ago. CSW-J stated R3 wanted to find more appropriate placement with others, "closer to his age," but wanted to stay in the area so he could be close to his family. CSW-J stated she had looked at several different living facility's in May for R3 but either R3 rejected them or they had a "long waiting list." However, CSW-J was unable to provide information regarding what facilities were considered and which facilities R3 rejected going to. CSW-J verified R3 had no active plans for discharge, nor was the resident placed on any waiting lists. She also stated she had not spoken with anyone from the facility regarding R3 discharging and she does not give the facility information regarding the facility's R3 had been spoken to about. CSW-J further went on to say that she thought she "heard" R3 was not going to be discharged until his wounds heal. She was not aware the wounds had been present for 10 years prior to his admission to the facility. When interviewed on 10/30/13, at 12:33 p.m. The director of nursing (DON) stated the facility social worker had retired several months ago. The DON stated there was no further information regarding R3 discharging and stated, "I never	21475		

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GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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21475	Continued From page 44 addressed discharge" with R3 as she thought the county social worker was working on discharge. Furthermore, she had not spoken to the county social worker to verify if any discharge plan was in place. DON verified there was no plan regarding R3 discharging from the facility, and the facility had not coordinated with the resident county social worker to ensure R3 was discharged to more appropriate placement. A policy was requested, but not provided by the facility. Suggested Method of Correction: The administrator or designee could review and revise the policy and procedures as related to discharge planning. The facility could educate appropriate staff on policy and procedures. The facility could develop a monitoring system to ensure compliance. Time for Correction: Fourteen (14) days.	21475		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section	21942		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00019	A. BUILDING: _____ B. WING _____	11/01/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21942	Continued From page 45 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure a family council group was attempted at least yearly. This had the potential to effect all 32 residents families who currently resided in the facility. Findings include: During interview on 10/31/13 at 8:55 a.m. administrator stated she was unable to locate a date of when the last family council meeting was held or attempted to hold a meeting. She stated the social worker (who had retired several months ago) had a family council meeting "years ago" and she thought maybe it was in 2011. The administrator stated she was not aware the facility needed to attempt to have a family council meeting yearly. The facility was not able to provide a policy regarding family council meetings.	21942		