DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Certified Mail # 7013 3020 0001 8869 3399

July 20, 2018

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Subject: Good Samaritan Society - Ambassador - IDR
CMS Certification Number (CCN) 245149
Project # S5149028

Dear Ms. Barta:

This is in response to your letter of April 6, 2018, in regard to your request of an independent informal dispute resolution (I IDR) for the federal deficiency at tag F576 issued pursuant to the survey event 45LK11, completed on March 15, 2018. A letter was received from your facility dated 7/17/18, requesting the IIDR be changed to an IDR after a preparatory meeting between the administrative law judge, the state agency and facility.

The information presented with your letter, the CMS 2567 dated March 15, 2018, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

F576 - 42 CFR
§483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, *including TTY and TDD services, and a place in the facility* where calls can be made without being overheard. *This includes the right to retain and use a cellular phone at the resident's own expense.*
§483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:

(i) A telephone, *including TTY and TDD services;*
(ii) *The internet, to the extent available to the facility; and*
(iii) Stationery, postage, writing implements *and the ability to send mail.*

§483.10(g)(8) The resident has the right to send and receive mail, *and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:*

(i) Privacy of such communications consistent with this section; and
(ii) Access to stationery, postage, and writing implements at the resident's own expense.

§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.

(i) If the access is available to the facility
(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.
(iii) Such use must comply with State and Federal law.

Summary of the facility's reason for IDR of this tag.
The facility did not staff the main reception desk on Saturdays until 11:00 a.m., and they did not have anyone to secure the mail once delivered. Residents had been seen going through the mail to see if they had received any. The facility felt the postal service was unable to secure the mail on Saturdays and so had worked with the postal service over 1 year ago to stop the Saturday mail deliveries. The facility believed that they met the F576 regulation, because they had stopped Saturday mail delivery to the facility.

Summary of findings:
The facility is responsible to ensure residents receive their mail promptly which would include Saturdays that are normal delivery days.

This is a valid deficiency at this tag. The scope and severity will be reduced from a D to a C level (a deficiency that has the potential for causing no more than minimal harm and has the potential to affect all residents).

The revised Statement of Deficiencies is attached.

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

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

Sincerely,

Pam Kerssen, Assistant Program Manager
Licensing and Certification Program
Health Regulation Division
705 5th Street NW, Suite A
Bemidji, MN 56601
Telephone: (218) 308-2129 Fax: (218) 308-2122

cc: Office of Ombudsman for Long-Term Care
Licensing and Certification File
Kathleen Lucas, St. Cloud Team B Unit Supervisor
Becky Wong, Nurse Evaluator II

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on March 12 through March 15, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 12 through March 15, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 576 SS=C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.	F 576		4/23/18

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

Electronically Signed | 04/06/2018

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

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F 576	Continued From page 1 §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect 16 of 74 residents who received personal mail at the facility Findings include:	F 576	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	

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F 576	Continued From page 2 On 3/14/18, at 10:27 a.m. a group of four residents met to discuss the resident council. When asked whether residents received their mail Monday through Saturday, residents stated they did not receive their mail on Saturdays and did not know why. During an interview on 3/14/18, at 1:45 p.m. the activity director (AD) and the music therapist (MT) stated residents did not receive mail on Saturdays because the postal service treated the facility as a "business" so they did not receive Saturday deliveries. When interviewed on 3/15/18, at 1:42 p.m. the administrator stated, "We have Monday through Friday mail delivery, and we do not have delivery on Saturdays." The administrator stated they had a problem with the postal service leaving the mail on the unattended reception desk on Saturdays and residents were going through other residents' mail, so arrangements were made with the post office at least a year ago to hold the Saturday mail, and to only deliver it during the week. The administrator stated, "It's not secure because the postman can't secure it. They can't guarantee that it's secure." The administrator stated, "It's not technically violating the regulation if they don't deliver on Saturdays." Review of the facility's policy, Resident Mail, dated 2/17, included,"The resident has the right to privacy in oral, written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the location for the resident."	F 576	solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. Postal office will deliver mail on Saturdays effective 4/14/18. Resident mail received will be delivered. Random audits to ensure mail is received on Saturdays and delivered to residents will be completed by the HIM staff weekly for one month, monthly for 3 months and quarterly thereafter. Results will be reviewed by the HIM Director with changes implemented as needed. Findings will be reported to the QAPI Committee for further evaluation and recommendation.	

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F 692	Continued From page 3	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement dietary recommendations from the registered dietician of a consistent carbohydrate diet (CCHO) for 1 of 4 residents (R35) reviewed for nutrition and dietary status. Findings Include: R35's admission Minimum Data Set Assessment (MDS) included diagnoses of diabetes mellitus, coronary artery disease and peripheral vascular disease.	F 692	Chart review completed for R35 by Dietitian on 3/15/18. Wrote reccomendation to change diet to CCHO. Orders received for CCHO diet. Care plan and tray card updated to reflect therapeutic diet. All resident diets were reviewed on 3/16/18. Residents with diagnoses requiring therapeutic diets had appropriate diets ordered. Dietitian received re-education on policy,	4/23/18

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F 692	Continued From page 4 R35's admission Care Area Assessment (CAA) indicated R35 was hyperglycemic, receiving Lantus sliding scale Humalog (insulin) added. Pt (patient) admitted to TCU (transitional care unit) for PT (physical therapy), OT (occupational therapy) and ST (speech therapy). R35's Face Sheet indicated R35 was on a regular diet. The Interagency Assessment and Transfer Form from the hospital, dated 1/16/18, indicated R35 had a diagnosis of type 2 diabetes mellitus (DM), with long term current use of insulin. In addition, the form indicated the diet was ADA(American dietetic association) Diabetic-Carb (carbohydrate) Control. The Interagency Transfer Orders, from the hospital, dated 1/16/18, indicated diet as tolerated. R35's Food and Nutrition Data Collection, electronically signed by the registered dietician (RD), and dated 1/19/18, indicated that R35 "received a diabetic diet in hospital and at home. 1/19 recommend switching to CCHO diet" R35's Order Summary Report, dated 5/15/18, indicated Blood glucose monitoring 4 times per day, Humalog Kwikpen solution pen-injector, 100 units/ML(milliliter) (insulin lispro)-Inject per sliding scale, start date of 1/31/18 for DM, Januvia-tablet 50 MG (milligrams) daily, start date of 3/6/18 for DM, Toujeo Solostar solution pen-injector 300 units/ML (insulin glargine) inject 16 units in the morning for DM, start date of 3/6/18. During interview on 3/15/18, at 9:04 a.m. the	F 692	procedure and system process for diet orders and nutrition. Random audits to ensure reccomended and ordered diets are in place will be done by the Dietician weekly for a month, monthly for 3 months and quarterly thereafter. Results of audits will be reviewed by Dietitian and DNS with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations	

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F 692	Continued From page 5 assistant director of nursing (ADON) stated the process for initiating special diets, is that their dietician assesses the resident, provides dietary recommendation and gives this recommendation to the nurse who sends the diet recommendation to the physician to sign. Once signed, the nurse then provides this order to the kitchen to implement. Review of the Medication Administration Records (MAR) for February and March of 2018, indicated R35's blood glucose levels ranged from low 50's to 297, with one reading on 2/13/18, at 478. The MAR for February indicated no special diet, The MAR for March, with a print date of 3/15/18, indicated a diet including CCHO diet regular texture, regular fluid consistency, for DM. During interview on 3/15/18 at 9:11 a.m., the RD provided the Tray Card (the card that is used by kitchen staff to follow dietary recommendations). R35's Tray Card indicated diet as regular with thin liquids. The RD reviewed the Food and Data Collection, dated 1-19-18, and stated she had made a recommendation for a CCHO diet and stated the main difference between a CCHO diet and the regular diet is that the resident is offered sugar free desserts if they are on a CCHO diet. The RD stated the process was to assess the new resident, complete a recommendation form and provide to the nurses who would send to the physician for a signature. The RD stated this recommendation and order should be stored in their electronic record. Upon review of the electronic record, the RD was unable to locate and was unsure what happened to the recommendation. During interview on 3/15/18, at 10:27 a.m.	F 692		

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F 692	Continued From page 6	F 692		

registered nurse (RN)-A, stated the diet for the residents are listed on the tray card. She went on to state that this is how the nurse or nursing assistant that assist with serving, know what the resident diet is. RN-A pulled out the tray card from the drawer in the dining room serving area. The diet was now listed as CCHO and had a print date of 3/15/18.

During interview on 3/15/18, at 1:06 p.m. the DON stated the process they use when a new resident comes from the hospital is to follow the Interagency Transfer Orders form. The DON reviewed the form and stated R35's diet was listed as diet "as tolerated." The DON went on to state that typically when a new resident comes, the dietician assesses the resident within 24 hours, makes a recommendation, this recommendation goes to nursing to give to the nurse practitioner, who comes 2-3 times per week.. The DON reviewed the RD recommendation, dated 1/19/18 and indicated the RD recommended a CCHO diet. In addition, the DON reviewed current orders and indicated current orders for R35 stated, regular diet. The DON remarked that she would look into what happened.

In a subsequent interview on 3/15/18, at 2:07 p.m. the DON stated they understood where the breakdown occurred. She stated the dietician never wrote the recommendation. She went on to state we know this because we spoke with the nurse practitioner who never received the order. She further stated, "we be working on this process."

The Facilities policy on Diet Orders, with a revision date of 12/17, indicate a therapeutic diet

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F 692	Continued From page 7 is a diet intervention ordered by a healthcare practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status; to eliminate, decrease or increase certain substances in the diet.	F 692		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and serving utensils were served and handled in a sanitary manner. This had the potential to affect 74 out of 74 residents currently residing in the facility who received their food from the kitchen. Findings include:	F 812	Plates, cups and surfaces were washed and sanitized on 3/14/18. DCA was re-educated on infection control and sanitation on 3/14/18. DAA was re-educated on cellphone usage and hand washing on 3/14/18. Food and Nutrition staff will be re-educated on hand washing, glove use	4/23/18

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F 812	Continued From page 8 On 3/14/18, at 11:32 a.m. dietary cook (DC)-A was observed to be walking through the kitchen while coughing and not covering her cough. DC-A's cough was dry and non-productive as she continued to cough three times over the counter tops, ovens and food preparation table before covering her mouth with her bare right hand while coughing another time. She then proceeded to put on gloves without washing her hands. DC-A then immediately started to temp the noon meal food that was in metal containers covered with foil. While DC-A was temping the food she continued to cough into her antecubital area of right arm three times. During observation on 3/14/18, at 11:40 a.m. dietary aid (DA)-A was observed to be talking on her cell phone in the kitchen in front of dish washing room. (DA)-B walked up to DA-A and handed her a stack of clean plates. DA-A put her phone in her pocket and without washing her hands took the plates and set them on a brown cart and she wheeled cart into the dining room. On 3/14/18, at 11:00 a.m. DA-A was observed in Breezy Meadows kitchenette with a cart that had stacks of clean cups, tongs, and several other utensils. DA-A pushed the cart out of the area when approximately 10 clear plastic cups fell on the kitchenette floor. DA-A then picked the cups up off the dining room floor and placed them onto the second shelf of the cart. DA-A the was observed to push the cart to the Fire Side Crossing kitchenette and proceeded to put the clean dishes away with out washing her hands. During interview on 3/14/18, at 11:05 a.m. DA-A stated she typically puts dirty dishes on the second level of the cart. DA-A stated she	F 812	and safe food handling by 4/13/18. Random audits will be completed by the Food and Nutrition Director daily for one month, weekly for three months and quarterly thereafter. Results of audits will be reviewed and analyzed by Food and Nutrition Director any changes will be implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendation	

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F 812	Continued From page 9	F 812		

typically washes her hands before putting clean dishes away and stated "darn it I forgot to wash my hands". DA-A stated the floor was just washed 15 minutes ago so it wasn't completely contaminated like it would have been after the night shift. DA-A then stated she should have washed her hands.

During interview on 3/14/18, at 11:55 a.m. dietary manager (DM)-A stated that DA-A is new to the day/morning shift, she is pretty good, organized and meticulous. DM-A stated DA-A may needs some reminders and education. DM-A stated all dietary staff are trained on hand washing and safe food handling during orientation and every six months.

During interview on 3/15/18, at 9:00 a.m. facility registered dietitian (RD)-A stated she believes cell phones should not be in the kitchen at all and anyone with a cough should leave the kitchen until done coughing, and always was hands. RD-A stated dishes that have touched the floor and picked up by staff should always wash their hands.

Review of the staff training records indicated the following:
DA-A received Safe Food Handling on 11/29/17 and Hand Washing and Hygiene on 1/24/18.
DC-A received training on Safe Food Handling on 8/6/17 and Hand Washing and Hygiene on 11/7/17.

Review of the facilities' 12/17, revised policy titled Hand Washing and Glove Use indicated washing hands after touching any contaminated object (face, hair, body or clothing, garbage or dirty utensils, dirty dishes, phones, linen or money)

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F 812	Continued From page 10 and after sneezing, coughing or blowing nose.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		4/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 880	Continued From page 11 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that staff properly changed gloves and performed hand hygiene during personal cares to maintain good infection control practices for 1 of 4 residents (R42) observed during personal cares. Findings include:	F 880	RN-B was re-educated on 3-12-18 policy and procedures for Hand hygiene, Hand washing and proper glove use. NA-A was reeducated on policy and procedures for Hand hygiene, Hand washing and proper glove use on 3-14-18. All residents in facility were reviewed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 880	Continued From page 12 R42's admission record, dated 12/27/17, included diagnoses of dementia with Lewy bodies (clumps of protein that can form in the brain, causing progressive decline in intellectual functioning), history of urinary tract infection, and history of Escherichia coli (bacterial infection). R42's significant change Minimum Data Set (MDS), dated 1/29/18, identified R42 had severe cognitive impairment, required extensive assistance for all activities of daily living, and was frequently incontinent of bowel and bladder. During an observation of personal cares on 3/12/18, at 6:34 p.m. R42's call light was on, and registered nurse (RN)-B entered the room. R42 stated she needed to be changed. RN-B donned gloves and retrieved a brief. RN-B unfastened R42's brief, tossed the brief into the garbage, and proceeded to use a washcloth to clean R42's peri area. RN-B dried R42's bottom with a towel and placed a new brief under her. Without removing the soiled gloves, RN-B pulled up R42's pajama pants, pulled up her blankets, placed R42's call light across her abdomen, and used the bed controls to lower the bed. Still, without removing the soiled gloves, RN-B tied the garbage bag and carried it to the bathroom, where she used the gloved right hand to open the bathroom door. Once inside the bathroom, RN-B removed the soiled gloves, washed her hands, and left the room carrying the garbage bag. When interviewed on 3/12/18, at 6:40 p.m. RN-B indicated she should have taken off the soiled gloves at the bedside, after completing peri cares, instead of touching R42's bed controls, call light, and the bathroom door handle.	F 880	facility acquired infections on 3/29/2018. No facility acquired infections were identified at time of review. Nursing staff will be re-educated by 4/13/18 on Infection control Policy and Procedures for hand Hygiene, Hand washing and proper glove use. Random Infection control audits will be completed by nursing staff weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Infection Preventionist Nurse and DNS. Results of audits will be reviewed and analyzed by Infection Preventionist and DNS with changes implemented as needed. Infection Preventionist Nurse will report findings to the QAPI committee for further evaluation and recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 880	Continued From page 13 During an observation on 3/14/18, at 7:49 a.m. nursing assistant (NA)-A was performing personal cares for R42 with gloved hands. NA-A gave R42 a washcloth to wash her face. NA-A washed R42's torso and armpits, and unfastened her brief. NA-A used the washcloth to clean R42's peri area of incontinent stool, dried the area with a towel, and applied barrier cream to R42's bottom. NA-A removed the soiled right glove, exposing another glove underneath. NA-A did not remove the soiled glove on the left hand. NA-A continued to dress R42, pulling open dresser drawers, putting on clothing, and assisted R42 to sit on the edge of the bed. NA-A placed the sit to stand lift sling around R42 and proceeded to use the lift to transfer R42 into the wheelchair. Once in the wheelchair, NA-A placed a pillow behind R42, offered to assist with brushing her teeth, tied the plastic bag containing the soiled brief, and went into the bathroom. NA-A removed the remaining glove on the right hand, exposing her bare hand, and a removed a glove from the left hand, exposing another glove underneath. Without performing hand hygiene, NA-A picked up the plastic bag with her gloved left hand, and opened R42's room door leading into the hallway with her right hand. NA-A pushed R42 through the hallway, stopped at the soiled utility room door, opened it, threw the plastic bag into a large bin, and removed the glove on her left hand and threw it away. NA-A came back out of the soiled utility room, touching the door handle, and walked to a nearby sink and washed her hands. NA-A then pushed R42 to a dining room table. When interviewed, NA-A stated, "I usually put two [gloves] on each hand so when I put cream on, it keeps it moving." NA-A verified R42 had a bowel movement, and stated, "I removed the dirty one	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 880	Continued From page 14	F 880		

after I cleaned her, so it's clean." NA-A indicated she had been a nursing assistant for 30 years and "double gloving" was "maybe just a bad habit." NA-A stated, "It's [double gloving] probably not okay but that's how I do it. It keeps me moving, then I don't have to stop to switch them out."

During an interview on 3/14/18, at 12:22 p.m. the director of nursing (DON) stated staff were educated upon hire, regarding glove use and hand hygiene, and had annual competency testing on handwashing and donning and doffing of personal protective equipment, with demonstration and return demonstration. DON stated staff are reminded that gloves should be removed after peri care, and hands should be washed before touching other belongings of the resident. DON stated wearing more than one pair of gloves was not a practice that was taught at the facility because, "You can't be 100% sure that the glove underneath would be clean." DON further stated, "The expectation is that staff would change their gloves in between cares and wash after taking gloves off."

Review of the facility's policy, Putting On and Taking Off Personal Protective Equipment (PPE), dated 2/18, directed staff to, "Change gloves during resident, patient and child care if the hands will move from a contaminated body site (e.g., perineal area) to a clean body site (e.g., face). Always wash hands between gloving."

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 45LK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00898

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245149**
2.STATE VENDOR OR MEDICAID NO.
(L2) **564214100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - AMBASSADOR**
(L4) **8100 MEDICINE LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55427**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **05/08/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **77** (L18)
13.Total Certified Beds **77** (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
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Carlene Lange, HFE NE- II — 05/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Joanne Simon, Enforcement Specialist — 05/22/2018 (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
02/26/1968
(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
05/02/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245149

May 22, 2018

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Dear Ms. Barta:

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

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

Effective May 8, 2018 the above facility is recommended for:

77 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 77 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 22, 2018

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

RE: Project Number S5149028

Dear Ms. Barta:

On March 29, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 15, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 8, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 15, 2018, effective May 8, 2018 and therefore remedies outlined in our letter to you dated March 29, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 22, 2018

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Re: Reinspection Results - Project Number S5149028

Dear Ms. Barta:

On May 8, 2018 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 March 15, 2018, with orders received by you on March 29, 2018. At this time these correction orders were found corrected.

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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 45LK

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00898

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245149**

2.STATE VENDOR OR MEDICAID NO.
(L2) **564214100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - AMBASSADOR**
(L4) **8100 MEDICINE LAKE ROAD**
(L5) **NEW HOPE, MN** (L6) **55427**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/15/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **77** (L18)

13.Total Certified Beds **77** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	77			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lou Anne Degagne, HFE NE II 04/10/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 04/26/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/26/1968
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 29, 2018

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

RE: Project Number S5149028

Dear Ms. Barta:

On March 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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>Electronic 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 an "F" tag) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be directed to:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
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 April 24, 2018, 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 April 24, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 15, 2018 (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 September 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on March 12 through March 15, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On March 12 through March 15, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 576 SS=E	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.	F 576		4/23/18

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

Electronically Signed | 04/06/2018

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F 576	Continued From page 1 §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect 16 of 74 residents who received personal mail at the facility Findings include:	F 576	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	

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F 576	Continued From page 2 On 3/14/18, at 10:27 a.m. a group of four residents met to discuss the resident council. When asked whether residents received their mail Monday through Saturday, residents stated they did not receive their mail on Saturdays and did not know why. During an interview on 3/14/18, at 1:45 p.m. the activity director (AD) and the music therapist (MT) stated residents did not receive mail on Saturdays because the postal service treated the facility as a "business" so they did not receive Saturday deliveries. When interviewed on 3/15/18, at 1:42 p.m. the administrator stated, "We have Monday through Friday mail delivery, and we do not have delivery on Saturdays." The administrator stated they had a problem with the postal service leaving the mail on the unattended reception desk on Saturdays and residents were going through other residents' mail, so arrangements were made with the post office at least a year ago to hold the Saturday mail, and to only deliver it during the week. The administrator stated, "It's not secure because the postman can't secure it. They can't guarantee that it's secure." The administrator stated, "It's not technically violating the regulation if they don't deliver on Saturdays." Review of the facility's policy, Resident Mail, dated 2/17, included,"The resident has the right to privacy in oral, written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the location for the resident."	F 576	solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. Postal office will deliver mail on Saturdays effective 4/14/18. Resident mail received will be delivered. Random audits to ensure mail is received on Saturdays and delivered to residents will be completed by the HIM staff weekly for one month, monthly for 3 months and quarterly thereafter. Results will be reviewed by the HIM Director with changes implemented as needed. Findings will be reported to the QAPI Committee for further evaluation and recommendation.	

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F 692	Continued From page 3	F 692		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to implement dietary recommendations from the registered dietician of a consistent carbohydrate diet (CCHO) for 1 of 4 residents (R35) reviewed for nutrition and dietary status. Findings Include: R35's admission Minimum Data Set Assessment (MDS) included diagnoses of diabetes mellitus, coronary artery disease and peripheral vascular disease.	F 692	Chart review completed for R35 by Dietitian on 3/15/18. Wrote reccomendation to change diet to CCHO. Orders received for CCHO diet. Care plan and tray card updated to reflect therapeutic diet. All resident diets were reviewed on 3/16/18. Residents with diagnoses requiring therapeutic diets had appropriate diets ordered. Dietitian received re-education on policy,	4/23/18

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F 692	Continued From page 4 R35's admission Care Area Assessment (CAA) indicated R35 was hyperglycemic, receiving Lantus sliding scale Humalog (insulin) added. Pt (patient) admitted to TCU (transitional care unit) for PT (physical therapy), OT (occupational therapy) and ST (speech therapy). R35's Face Sheet indicated R35 was on a regular diet. The Interagency Assessment and Transfer Form from the hospital, dated 1/16/18, indicated R35 had a diagnosis of type 2 diabetes mellitus (DM), with long term current use of insulin. In addition, the form indicated the diet was ADA(American dietetic association) Diabetic-Carb (carbohydrate) Control. The Interagency Transfer Orders, from the hospital, dated 1/16/18, indicated diet as tolerated. R35's Food and Nutrition Data Collection, electronically signed by the registered dietician (RD), and dated 1/19/18, indicated that R35 "received a diabetic diet in hospital and at home. 1/19 recommend switching to CCHO diet" R35's Order Summary Report, dated 5/15/18, indicated Blood glucose monitoring 4 times per day, Humalog Kwikpen solution pen-injector, 100 units/ML(milliliter) (insulin lispro)-Inject per sliding scale, start date of 1/31/18 for DM, Januvia-tablet 50 MG (milligrams) daily, start date of 3/6/18 for DM, Toujeo Solostar solution pen-injector 300 units/ML (insulin glargine) inject 16 units in the morning for DM, start date of 3/6/18. During interview on 3/15/18, at 9:04 a.m. the	F 692	procedure and system process for diet orders and nutrition. Random audits to ensure reccomended and ordered diets are in place will be done by the Dietician weekly for a month, monthly for 3 months and quarterly thereafter. Results of audits will be reviewed by Dietitian and DNS with changes implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendations	

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F 692	Continued From page 5	F 692		

assistant director of nursing (ADON) stated the process for initiating special diets, is that their dietician assesses the resident, provides dietary recommendation and gives this recommendation to the nurse who sends the diet recommendation to the physician to sign. Once signed, the nurse then provides this order to the kitchen to implement.

Review of the Medication Administration Records (MAR) for February and March of 2018, indicated R35's blood glucose levels ranged from low 50's to 297, with one reading on 2/13/18, at 478. The MAR for February indicated no special diet, The MAR for March, with a print date of 3/15/18, indicated a diet including CCHO diet regular texture, regular fluid consistency, for DM.

During interview on 3/15/18 at 9:11 a.m., the RD provided the Tray Card (the card that is used by kitchen staff to follow dietary recommendations). R35's Tray Card indicated diet as regular with thin liquids. The RD reviewed the Food and Data Collection, dated 1-19-18, and stated she had made a recommendation for a CCHO diet and stated the main difference between a CCHO diet and the regular diet is that the resident is offered sugar free desserts if they are on a CCHO diet. The RD stated the process was to assess the new resident, complete a recommendation form and provide to the nurses who would send to the physician for a signature. The RD stated this recommendation and order should be stored in their electronic record. Upon review of the electronic record, the RD was unable to locate and was unsure what happened to the recommendation.

During interview on 3/15/18, at 10:27 a.m.

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F 692	Continued From page 6	F 692		

registered nurse (RN)-A, stated the diet for the residents are listed on the tray card. She went on to state that this is how the nurse or nursing assistant that assist with serving, know what the resident diet is. RN-A pulled out the tray card from the drawer in the dining room serving area. The diet was now listed as CCHO and had a print date of 3/15/18.

During interview on 3/15/18, at 1:06 p.m. the DON stated the process they use when a new resident comes from the hospital is to follow the Interagency Transfer Orders form. The DON reviewed the form and stated R35's diet was listed as diet "as tolerated." The DON went on to state that typically when a new resident comes, the dietician assesses the resident within 24 hours, makes a recommendation, this recommendation goes to nursing to give to the nurse practitioner, who comes 2-3 times per week.. The DON reviewed the RD recommendation, dated 1/19/18 and indicated the RD recommended a CCHO diet. In addition, the DON reviewed current orders and indicated current orders for R35 stated, regular diet. The DON remarked that she would look into what happened.

In a subsequent interview on 3/15/18, at 2:07 p.m. the DON stated they understood where the breakdown occurred. She stated the dietician never wrote the recommendation. She went on to state we know this because we spoke with the nurse practitioner who never received the order. She further stated, "we be working on this process."

The Facilities policy on Diet Orders, with a revision date of 12/17, indicate a therapeutic diet

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F 692	Continued From page 7 is a diet intervention ordered by a healthcare practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status; to eliminate, decrease or increase certain substances in the diet.	F 692		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and serving utensils were served and handled in a sanitary manner. This had the potential to affect 74 out of 74 residents currently residing in the facility who received their food from the kitchen. Findings include:	F 812	Plates, cups and surfaces were washed and sanitized on 3/14/18. DCA was re-educated on infection control and sanitation on 3/14/18. DAA was re-educated on cellphone usage and hand washing on 3/14/18. Food and Nutrition staff will be re-educated on hand washing, glove use	4/23/18

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F 812	Continued From page 8 On 3/14/18, at 11:32 a.m. dietary cook (DC)-A was observed to be walking through the kitchen while coughing and not covering her cough. DC-A's cough was dry and non-productive as she continued to cough three times over the counter tops, ovens and food preparation table before covering her mouth with her bare right hand while coughing another time. She then proceeded to put on gloves without washing her hands. DC-A then immediately started to temp the noon meal food that was in metal containers covered with foil. While DC-A was temping the food she continued to cough into her antecubital area of right arm three times. During observation on 3/14/18, at 11:40 a.m. dietary aid (DA)-A was observed to be talking on her cell phone in the kitchen in front of dish washing room. (DA)-B walked up to DA-A and handed her a stack of clean plates. DA-A put her phone in her pocket and without washing her hands took the plates and set them on a brown cart and she wheeled cart into the dining room. On 3/14/18, at 11:00 a.m. DA-A was observed in Breezy Meadows kitchenette with a cart that had stacks of clean cups, tongs, and several other utensils. DA-A pushed the cart out of the area when approximately 10 clear plastic cups fell on the kitchenette floor. DA-A then picked the cups up off the dining room floor and placed them onto the second shelf of the cart. DA-A the was observed to push the cart to the Fire Side Crossing kitchenette and proceeded to put the clean dishes away with out washing her hands. During interview on 3/14/18, at 11:05 a.m. DA-A stated she typically puts dirty dishes on the second level of the cart. DA-A stated she	F 812	and safe food handling by 4/13/18. Random audits will be completed by the Food and Nutrition Director daily for one month, weekly for three months and quarterly thereafter. Results of audits will be reviewed and analyzed by Food and Nutrition Director any changes will be implemented as needed. Findings will be reported to the QAPI committee for further evaluation and recommendation	

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F 812	Continued From page 9	F 812		

typically washes her hands before putting clean dishes away and stated "darn it I forgot to wash my hands". DA-A stated the floor was just washed 15 minutes ago so it wasn't completely contaminated like it would have been after the night shift. DA-A then stated she should have washed her hands.

During interview on 3/14/18, at 11:55 a.m. dietary manager (DM)-A stated that DA-A is new to the day/morning shift, she is pretty good, organized and meticulous. DM-A stated DA-A may needs some reminders and education. DM-A stated all dietary staff are trained on hand washing and safe food handling during orientation and every six months.

During interview on 3/15/18, at 9:00 a.m. facility registered dietitian (RD)-A stated she believes cell phones should not be in the kitchen at all and anyone with a cough should leave the kitchen until done coughing, and always was hands. RD-A stated dishes that have touched the floor and picked up by staff should always wash their hands.

Review of the staff training records indicated the following:
DA-A received Safe Food Handling on 11/29/17 and Hand Washing and Hygiene on 1/24/18.
DC-A received training on Safe Food Handling on 8/6/17 and Hand Washing and Hygiene on 11/7/17.

Review of the facilities' 12/17, revised policy titled Hand Washing and Glove Use indicated washing hands after touching any contaminated object (face, hair, body or clothing, garbage or dirty utensils, dirty dishes, phones, linen or money)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 812	Continued From page 10 and after sneezing, coughing or blowing nose.	F 812		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		4/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(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 880	Continued From page 11 to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that staff properly changed gloves and performed hand hygiene during personal cares to maintain good infection control practices for 1 of 4 residents (R42) observed during personal cares. Findings include:	F 880	RN-B was re-educated on 3-12-18 policy and procedures for Hand hygiene, Hand washing and proper glove use. NA-A was reeducated on policy and procedures for Hand hygiene, Hand washing and proper glove use on 3-14-18. All residents in facility were reviewed for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 12 R42's admission record, dated 12/27/17, included diagnoses of dementia with Lewy bodies (clumps of protein that can form in the brain, causing progressive decline in intellectual functioning), history of urinary tract infection, and history of Escherichia coli (bacterial infection). R42's significant change Minimum Data Set (MDS), dated 1/29/18, identified R42 had severe cognitive impairment, required extensive assistance for all activities of daily living, and was frequently incontinent of bowel and bladder. During an observation of personal cares on 3/12/18, at 6:34 p.m. R42's call light was on, and registered nurse (RN)-B entered the room. R42 stated she needed to be changed. RN-B donned gloves and retrieved a brief. RN-B unfastened R42's brief, tossed the brief into the garbage, and proceeded to use a washcloth to clean R42's peri area. RN-B dried R42's bottom with a towel and placed a new brief under her. Without removing the soiled gloves, RN-B pulled up R42's pajama pants, pulled up her blankets, placed R42's call light across her abdomen, and used the bed controls to lower the bed. Still, without removing the soiled gloves, RN-B tied the garbage bag and carried it to the bathroom, where she used the gloved right hand to open the bathroom door. Once inside the bathroom, RN-B removed the soiled gloves, washed her hands, and left the room carrying the garbage bag. When interviewed on 3/12/18, at 6:40 p.m. RN-B indicated she should have taken off the soiled gloves at the bedside, after completing peri cares, instead of touching R42's bed controls, call light, and the bathroom door handle.	F 880	facility acquired infections on 3/29/2018. No facility acquired infections were identified at time of review. Nursing staff will be re-educated by 4/13/18 on Infection control Policy and Procedures for hand Hygiene, Hand washing and proper glove use. Random Infection control audits will be completed by nursing staff weekly for 1 month, monthly for 3 months and quarterly thereafter as coordinated by the Infection Preventionist Nurse and DNS. Results of audits will be reviewed and analyzed by Infection Preventionist and DNS with changes implemented as needed. Infection Preventionist Nurse will report findings to the QAPI committee for further evaluation and recommendations.	

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	245149	A. BUILDING _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 880	Continued From page 13	F 880		

During an observation on 3/14/18, at 7:49 a.m. nursing assistant (NA)-A was performing personal cares for R42 with gloved hands. NA-A gave R42 a washcloth to wash her face. NA-A washed R42's torso and armpits, and unfastened her brief. NA-A used the washcloth to clean R42's peri area of incontinent stool, dried the area with a towel, and applied barrier cream to R42's bottom. NA-A removed the soiled right glove, exposing another glove underneath. NA-A did not remove the soiled glove on the left hand. NA-A continued to dress R42, pulling open dresser drawers, putting on clothing, and assisted R42 to sit on the edge of the bed. NA-A placed the sit to stand lift sling around R42 and proceeded to use the lift to transfer R42 into the wheelchair. Once in the wheelchair, NA-A placed a pillow behind R42, offered to assist with brushing her teeth, tied the plastic bag containing the soiled brief, and went into the bathroom. NA-A removed the remaining glove on the right hand, exposing her bare hand, and a removed a glove from the left hand, exposing another glove underneath. Without performing hand hygiene, NA-A picked up the plastic bag with her gloved left hand, and opened R42's room door leading into the hallway with her right hand. NA-A pushed R42 through the hallway, stopped at the soiled utility room door, opened it, threw the plastic bag into a large bin, and removed the glove on her left hand and threw it away. NA-A came back out of the soiled utility room, touching the door handle, and walked to a nearby sink and washed her hands. NA-A then pushed R42 to a dining room table.

When interviewed, NA-A stated, "I usually put two [gloves] on each hand so when I put cream on, it keeps it moving." NA-A verified R42 had a bowel movement, and stated, "I removed the dirty one

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	245149	A. BUILDING _____ B. WING _____	03/15/2018

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F 880	Continued From page 14	F 880		

after I cleaned her, so it's clean." NA-A indicated she had been a nursing assistant for 30 years and "double gloving" was "maybe just a bad habit." NA-A stated, "It's [double gloving] probably not okay but that's how I do it. It keeps me moving, then I don't have to stop to switch them out."

During an interview on 3/14/18, at 12:22 p.m. the director of nursing (DON) stated staff were educated upon hire, regarding glove use and hand hygiene, and had annual competency testing on handwashing and donning and doffing of personal protective equipment, with demonstration and return demonstration. DON stated staff are reminded that gloves should be removed after peri care, and hands should be washed before touching other belongings of the resident. DON stated wearing more than one pair of gloves was not a practice that was taught at the facility because, "You can't be 100% sure that the glove underneath would be clean." DON further stated, "The expectation is that staff would change their gloves in between cares and wash after taking gloves off."

Review of the facility's policy, Putting On and Taking Off Personal Protective Equipment (PPE), dated 2/18, directed staff to, "Change gloves during resident, patient and child care if the hands will move from a contaminated body site (e.g., perineal area) to a clean body site (e.g., face). Always wash hands between gloving."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 14, 2018. At the time of this survey, Good Samaritan Society Ambassador was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Good Samaritan Society Ambassador Building 1 is a 1-story building with a partial basement. The building was constructed at 2 different times. The original building was constructed in 1963 and was determined to be of Type II(000) construction. In 1996, an addition was constructed and was determined to be of Type II(000) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The facility is protected throughout by an automatic fire sprinkler system and 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 77 beds and had a census of 73 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING **02 - NEW ADDITION** B. WING _____	**03/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	**8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 14, 2018. At the time of this survey, Good Samaritan Society Ambassador was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Good Samaritan Society Ambassador Building 2 is a 1-story building without a basement. The building was built in 2010 and was determined to be of Type V (111) construction. There is a 2-hour fire wall between the 2010 addition and the rest of the building. Therefore, the facility is surveyed as two buildings with two CMS-2786R forms used. The facility is protected throughout by an automatic fire sprinkler system and 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 77 beds and had a census of 73 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.

Electronically delivered
March 29, 2018

Ms. Marie Barta, Administrator
Good Samaritan Society - Ambassador
8100 Medicine Lake Road
New Hope, MN 55427

Re: State Nursing Home Licensing Orders - Project Number S5149028

Dear Ms. Barta:

The above facility was surveyed on March 12, 2018 through March 15, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathleen Lucas, Unit Supervisor, at (320) 223-7343 or kathleen.lucas@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00898	A. BUILDING: _____ B. WING _____	03/15/2018

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/12/18 through 3/15/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 965	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 interview and record review, the facility failed to implement dietary recommendations from the registered dietician of a consistent carbohydrate diet (CCHO) for 1 of 4 residents (R35) reviewed for nutrition and dietary status. Findings Include: R35's admission Minimum Data Set Assessment (MDS) included diagnoses of diabetes mellitus, coronary artery disease and peripheral vascular disease. R35's admission Care Area Assessment (CAA) indicated R35 was hyperglycemic, receiving Lantus sliding scale Humalog (insulin) added. Pt (patient) admitted to TCU (transitional care unit) for PT (physical therapy), OT (occupational	2 965	corrected	4/23/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

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2 965	Continued From page 3 therapy) and ST (speech therapy). R35's Face Sheet indicated R35 was on a regular diet. The Interagency Assessment and Transfer Form from the hospital, dated 1/16/18, indicated R35 had a diagnosis of type 2 diabetes mellitus (DM), with long term current use of insulin. In addition, the form indicated the diet was ADA(American dietetic association) Diabetic-Carb (carbohydrate) Control. The Interagency Transfer Orders, from the hospital, dated 1/16/18, indicated diet as tolerated. R35's Food and Nutrition Data Collection, electronically signed by the registered dietician (RD), and dated 1/19/18, indicated that R35 "received a diabetic diet in hospital and at home. 1/19 recommend switching to CCHO diet" R35's Order Summary Report, dated 5/15/18, indicated Blood glucose monitoring 4 times per day, Humalog Kwikpen solution pen-injector, 100 units/ML(milliliter) (insulin lispro)-Inject per sliding scale, start date of 1/31/18 for DM, Januvia-tablet 50 MG (milligrams) daily, start date of 3/6/18 for DM, Toujeo Solostar solution pen-injector 300 units/ML (insulin glargine) inject 16 units in the morning for DM, start date of 3/6/18. During interview on 3/15/18, at 9:04 a.m. the assistant director of nursing (ADON) stated the process for initiating special diets, is that their dietician assesses the resident, provides dietary recommendation and gives this recommendation to the nurse who sends the diet recommendation to the physician to sign. Once signed, the nurse	2 965		

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2 965	Continued From page 4 then provides this order to the kitchen to implement. Review of the Medication Administration Records (MAR) for February and March of 2018, indicated R35's blood glucose levels ranged from low 50's to 297, with one reading on 2/13/18, at 478. The MAR for February indicated no special diet, The MAR for March, with a print date of 3/15/18, indicated a diet including CCHO diet regular texture, regular fluid consistency, for DM. During interview on 3/15/18 at 9:11 a.m., the RD provided the Tray Card (the card that is used by kitchen staff to follow dietary recommendations). R35's Tray Card indicated diet as regular with thin liquids. The RD reviewed the Food and Data Collection, dated 1-19-18, and stated she had made a recommendation for a CCHO diet and stated the main difference between a CCHO diet and the regular diet is that the resident is offered sugar free desserts if they are on a CCHO diet. The RD stated the process was to assess the new resident, complete a recommendation form and provide to the nurses who would send to the physician for a signature. The RD stated this recommendation and order should be stored in their electronic record. Upon review of the electronic record, the RD was unable to locate and was unsure what happened to the recommendation. During interview on 3/15/18, at 10:27 a.m. registered nurse (RN)-A, stated the diet for the residents are listed on the tray card. She went on to state that this is how the nurse or nursing assistant that assist with serving, know what the resident diet is. RN-A pulled out the tray card from the drawer in the dining room serving area. The diet was now listed as CCHO and had a print	2 965		

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2 965	Continued From page 5 date of 3/15/18. During interview on 3/15/18, at 1:06 p.m. the DON stated the process they use when a new resident comes from the hospital is to follow the Interagency Transfer Orders form. The DON reviewed the form and stated R35's diet was listed as diet "as tolerated." The DON went on to state that typically when a new resident comes, the dietician assesses the resident within 24 hours, makes a recommendation, this recommendation goes to nursing to give to the nurse practitioner, who comes 2-3 times per week.. The DON reviewed the RD recommendation, dated 1/19/18 and indicated the RD recommended a CCHO diet. In addition, the DON reviewed current orders and indicated current orders for R35 stated, regular diet. The DON remarked that she would look into what happened. In a subsequent interview on 3/15/18, at 2:07 p.m. the DON stated they understood where the breakdown occurred. She stated the dietician never wrote the recommendation. She went on to state we know this because we spoke with the nurse practitioner who never received the order. She further stated, "we be working on this process." The Facilities policy on Diet Orders, with a revision date of 12/17, indicate a therapeutic diet is a diet intervention ordered by a healthcare practitioner as part of the treatment for a disease or clinical condition manifesting an altered nutritional status; to eliminate, decrease or increase certain substances in the diet.	2 965		

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2 965	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing could review and revise policies and procedures to ensure residents are receiving the recommended diet. Director of nursing could educate staff and monitor compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 965		
21000	MN Rule 4658.0610 Subp. 4 Dietary Staff Requirements-Hygiene. Subp. 4. Hygiene. Dietary staff must thoroughly wash their hands and the exposed portions of their arms with soap and warm water in a hand washing facility before starting work, during work as often as is necessary to keep them clean, and after smoking, eating, drinking, using the toilet, or handling soiled equipment or utensils. Dietary staff must keep their fingernails clean and trimmed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure food and serving utensils were served and handled in a sanitary manner. This had the potential to affect 74 out of 74 residents currently residing in the facility who received their food from the kitchen. Findings include: On 3/14/18, at 11:32 a.m. dietary cook (DC)-A was observed to be walking through the kitchen while coughing and not covering her cough. DC-A's cough was dry and non-productive as she	21000	corrected	4/23/18

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continued to cough three times over the counter tops, ovens and food preparation table before covering her mouth with her bare right hand while coughing another time. She then proceeded to put on gloves without washing her hands. DC-A then immediately started to temp the noon meal food that was in metal containers covered with foil. While DC-A was temping the food she continued to cough into her antecubital area of right arm three times.

During observation on 3/14/18, at 11:40 a.m. dietary aid (DA)-A was observed to be talking on her cell phone in the kitchen in front of dish washing room. (DA)-B walked up to DA-A and handed her a stack of clean plates. DA-A put her phone in her pocket and without washing her hands took the plates and set them on a brown cart and she wheeled cart into the dining room.

On 3/14/18, at 11:00 a.m. DA-A was observed in Breezy Meadows kitchenette with a cart that had stacks of clean cups, tongs, and several other utensils. DA-A pushed the cart out of the area when approximately 10 clear plastic cups fell on the kitchenette floor. DA-A then picked the cups up off the dining room floor and placed them onto the second shelf of the cart. DA-A the was observed to push the cart to the Fire Side Crossing kitchenette and proceeded to put the clean dishes away with out washing her hands.

During interview on 3/14/18, at 11:05 a.m. DA-A stated she typically puts dirty dishes on the second level of the cart. DA-A stated she typically washes her hands before putting clean dishes away and stated "darn it I forgot to wash my hands". DA-A stated the floor was just washed 15 minutes ago so it wasn't completely contaminated like it would have been after the

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21000	Continued From page 8 night shift. DA-A then stated she should have washed her hands. During interview on 3/14/18, at 11:55 a.m. dietary manager (DM)-A stated that DA-A is new to the day/morning shift, she is pretty good, organized and meticulous. DM-A stated DA-A may needs some reminders and education. DM-A stated all dietary staff are trained on hand washing and safe food handling during orientation and every six months. During interview on 3/15/18, at 9:00 a.m. facility registered dietitian (RD)-A stated she believes cell phones should not be in the kitchen at all and anyone with a cough should leave the kitchen until done coughing, and always was hands. RD-A stated dishes that have touched the floor and picked up by staff should always wash their hands. Review of the staff training records indicated the following: DA-A received Safe Food Handling on 11/29/17 and Hand Washing and Hygiene on 1/24/18. DC-A received training on Safe Food Handling on 8/6/17 and Hand Washing and Hygiene on 11/7/17. Review of the facilities' 12/17, revised policy titled Hand Washing and Glove Use indicated washing hands after touching any contaminated object (face, hair, body or clothing, garbage or dirty utensils, dirty dishes, phones, linen or money) and after sneezing, coughing or blowing nose. SUGGESTED METHOD OF CORRECTION:	21000		

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21000	Continued From page 9 The director of nursing (DON) and/or designee could develop, review or revise policies, provide education for staff regarding regarding appropriate food preparation and sanitation in the kitchen. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21000		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure that staff properly changed gloves and performed hand hygiene during personal cares to maintain good infection control practices for 1 of 4 residents (R42) observed during personal cares. Findings include: R42's admission record, dated 12/27/17, included diagnoses of dementia with Lewy bodies (clumps of protein that can form in the brain, causing progressive decline in intellectual functioning), history of urinary tract infection, and history of Escherichia coli (bacterial infection). R42's significant change Minimum Data Set (MDS),	21375	corrected	4/23/18

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dated 1/29/18, identified R42 had severe cognitive impairment, required extensive assistance for all activities of daily living, and was frequently incontinent of bowel and bladder.

During an observation of personal cares on 3/12/18, at 6:34 p.m. R42's call light was on, and registered nurse (RN)-B entered the room. R42 stated she needed to be changed. RN-B donned gloves and retrieved a brief. RN-B unfastened R42's brief, tossed the brief into the garbage, and proceeded to use a washcloth to clean R42's peri area. RN-B dried R42's bottom with a towel and placed a new brief under her. Without removing the soiled gloves, RN-B pulled up R42's pajama pants, pulled up her blankets, placed R42's call light across her abdomen, and used the bed controls to lower the bed. Still, without removing the soiled gloves, RN-B tied the garbage bag and carried it to the bathroom, where she used the gloved right hand to open the bathroom door. Once inside the bathroom, RN-B removed the soiled gloves, washed her hands, and left the room carrying the garbage bag.

When interviewed on 3/12/18, at 6:40 p.m. RN-B indicated she should have taken off the soiled gloves at the bedside, after completing peri cares, instead of touching R42's bed controls, call light, and the bathroom door handle.

During an observation on 3/14/18, at 7:49 a.m. nursing assistant (NA)-A was performing personal cares for R42 with gloved hands. NA-A gave R42 a washcloth to wash her face. NA-A washed R42's torso and armpits, and unfastened her brief. NA-A used the washcloth to clean R42's peri area of incontinent stool, dried the area with a towel, and applied barrier cream to R42's bottom. NA-A removed the soiled right glove,

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exposing another glove underneath. NA-A did not remove the soiled glove on the left hand. NA-A continued to dress R42, pulling open dresser drawers, putting on clothing, and assisted R42 to sit on the edge of the bed. NA-A placed the sit to stand lift sling around R42 and proceeded to use the lift to transfer R42 into the wheelchair. Once in the wheelchair, NA-A placed a pillow behind R42, offered to assist with brushing her teeth, tied the plastic bag containing the soiled brief, and went into the bathroom. NA-A removed the remaining glove on the right hand, exposing her bare hand, and a removed a glove from the left hand, exposing another glove underneath. Without performing hand hygiene, NA-A picked up the plastic bag with her gloved left hand, and opened R42's room door leading into the hallway with her right hand. NA-A pushed R42 through the hallway, stopped at the soiled utility room door, opened it, threw the plastic bag into a large bin, and removed the glove on her left hand and threw it away. NA-A came back out of the soiled utility room, touching the door handle, and walked to a nearby sink and washed her hands. NA-A then pushed R42 to a dining room table.

When interviewed, NA-A stated, "I usually put two [gloves] on each hand so when I put cream on, it keeps it moving." NA-A verified R42 had a bowel movement, and stated, "I removed the dirty one after I cleaned her, so it's clean." NA-A indicated she had been a nursing assistant for 30 years and "double gloving" was "maybe just a bad habit." NA-A stated, "It's [double gloving] probably not okay but that's how I do it. It keeps me moving, then I don't have to stop to switch them out."

During an interview on 3/14/18, at 12:22 p.m. the director of nursing (DON) stated staff were

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21375	Continued From page 12 educated upon hire, regarding glove use and hand hygiene, and had annual competency testing on handwashing and donning and doffing of personal protective equipment, with demonstration and return demonstration. DON stated staff are reminded that gloves should be removed after peri care, and hands should be washed before touching other belongings of the resident. DON stated wearing more than one pair of gloves was not a practice that was taught at the facility because, "You can't be 100% sure that the glove underneath would be clean." DON further stated, "The expectation is that staff would change their gloves in between cares and wash after taking gloves off." Review of the facility's policy, Putting On and Taking Off Personal Protective Equipment (PPE), dated 2/18, directed staff to, "Change gloves during resident, patient and child care if the hands will move from a contaminated body site (e.g., perineal area) to a clean body site (e.g., face). Always wash hands between gloving." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review policies and procedures to ensure proper infection control techniques are followed. Facility staff could be reeducated and an auditing system developed to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21375		
21885	MN St. Statute 144.651 Subd. 21 Patients & Residents Of HC Fac.Bill of Rights	21885		4/23/18

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21885	Continued From page 13 Subd. 21. Communication privacy. Patients and residents may associate and communicate privately with persons of their choice and enter and, except as provided by the Minnesota Commitment Act, leave the facility as they choose. Personal mail shall be sent without interference and received unopened unless medically or programmatically contraindicated and documented by the physician in the medical record. (Only portions indicated of this subdivision are subject to assessment.) This MN Requirement is not met as evidenced by: Based on interview and record review the facility failed to ensure mail was delivered to residents on Saturdays. This had the potential to affect 16 of 74 residents who received personal mail at the facility Findings include: On 3/14/18, at 10:27 a.m. a group of four residents met to discuss the resident council. When asked whether residents received their mail Monday through Saturday, residents stated they did not receive their mail on Saturdays and did not know why. During an interview on 3/14/18, at 1:45 p.m. the activity director (AD) and the music therapist (MT) stated residents did not receive mail on Saturdays because the postal service treated the facility as a "business" so they did not receive Saturday deliveries. When interviewed on 3/15/18, at 1:42 p.m. the administrator stated, "We have Monday through	21885	corrected	

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21885	Continued From page 14 Friday mail delivery, and we do not have delivery on Saturdays." The administrator stated they had a problem with the postal service leaving the mail on the unattended reception desk on Saturdays and residents were going through other residents' mail, so arrangements were made with the post office at least a year ago to hold the Saturday mail, and to only deliver it during the week. The administrator stated, "It's not secure because the postman can't secure it. They can't guarantee that it's secure." The administrator stated, "It's not technically violating the regulation if they don't deliver on Saturdays." Review of the facility's policy, Resident Mail, dated 2/17, included,"The resident has the right to privacy in oral, written and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the location for the resident." SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure residents have a means to send and receive mail on Saturdays. The facility could work with the postal service to ensure a secure method of mail delivery. The administrator or designee could revise policies and procedures, educate staff on these changes, and audit periodically to ensure resident are receiving mail on Saturdays. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21885		