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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4I8I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**

2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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 **06/28/2021** (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 **45** (L18)

13.Total Certified Beds **45** (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
	45			
(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 :
Jennifer Kolsrud Brown, Unit Supervisor 07/20/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 07/20/2021 (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
06/01/1986
(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.
03401
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/24/2021
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 19, 2021

CMS Certification Number (CCN): 245317

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

Dear Administrator:

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 June 11, 2021 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
July 19, 2021

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

RE: CCN: 245317
Cycle Start Date: March 22, 2021

Dear Administrator:

On June 3, 2021, we notified you a remedy was imposed. On June 28, 2021 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of June 11, 2021.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 22, 2021, did not go into effect. (42 CFR 488.417 (b))

In our letter of April 9, 2021, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 18, 2021 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 11, 2021, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

July 19, 2021

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

Re: Reinspection Results
Event ID: 4I8I13

Dear Administrator:

On June 28, 2021 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 22, 2021. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4I8I

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5. Validation 6. Complaint
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8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 05/18/2021 (L34)

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2 AOA 3 Other

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03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING . (L35)
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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
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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1861 (e) (1) or 1861 (j) (1): (L15)

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

17. SURVEYOR SIGNATURE Date :
Jennifer Kolsrud Brown, Unit Supervisor 06/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 07/30/2021 (L20)

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____ 2. Facility is not Eligible
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22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
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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.
03401
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered

June 3, 2021

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

RE: CCN: 245317
Cycle Start Date: March 22, 2021

Dear Administrator:

On April 9, 2021, we informed you that we may impose enforcement remedies.

On May 18, 2021, the Minnesota Department of Health and Public Safety completed a revisit and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 22, 2021

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 22, 2021. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 22, 2021.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of

payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION (Delete this section if SQC and this note)

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,160; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by June 22, 2021, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Comforcare will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from June 22, 2021. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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 22, 2021 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	R-C 05/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS On 5/11/21 to 5/18/21, a revisit was conducted to follow up on deficiencies issued related to a standard recertification survey exited on 3/22/21. Your facility was NOT compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaints were reviewed for compliance, previously identified as deficient are in compliance: H5317025C (MN67456) H5317021C (MN70560) H5317022C (MN67923) H5317023C (MN64439) H5317024C (MN66283) H5317028C (MN70987, MN71016) H5317029C (MN64177)	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to assess and monitor edema in order to determine effectiveness of prescribed interventions or prevent/reduce the risk of fluid overload for 3 of 4 residents (R4, R8, R100) reviewed for edema.	{F 684}	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	6/11/21

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

Electronically Signed | 06/10/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	R-C 05/18/2021

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

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{F 684}	Continued From page 1 Findings include: R4's Face Sheet dated 5/19/21, included diagnoses of localized edema, unsteadiness on feet, and chronic kidney disease. R4's quarterly Minimum Data Set (MDS) dated 2/24/21, indicated R4 had moderate cognitive impairment and was administered diuretic medications. R4's physician orders included: -Lasix (diuretic medication) 20 milligrams (mg) one time a day for dependent edema (start date 5/15/21). -Teds (compression stockings) on in the morning off at night for edema (start date 4/21/17). R4's care plan current at the time of survey, lacked a plan of care for edema management/monitoring. R4's care plan 1/20/20, indicated R4 was at risk for skin impairments related to chronic edema in bilateral lower extremities. The care plan directed staff to observe skin daily with cares and weekly by licensed nurse on bath days. R4's record was reviewed between 5/1 to 5/17/21, record lacked edema monitoring and evaluation. R4's Skin Observation evaluation dated 5/7/21, identified R4 had chronic bilateral lower extremity edema which could potentially affect the skin. Evaluation also indicated Teds on in the morning and off at night. R4's Skin Observation evaluation dated 5/14/21,	{F 684}	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F684 Quality of Care 1. Baseline edema assessment completed for R4, R8, and R100. Physician reviewed and orders were received to discontinue weekly edema checks and to notify if weight gain of 5 lbs or more in 1 week for R4, R8, and R100. 2. All residents with edema have the potential to be affected. A review of all resident□s care plans that have edema or congestive heart failure or take diuretics was completed. Care plans updated as necessary. 3. Re-education will be provided to all nursing staff regarding GSS policies and procedures for measuring and monitoring of edema. 4. Audits will be conducted for 3 random residents with edema concerns by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure edema is being monitored, documented, and addressed as appropriate. Audit results will be brought to the monthly QA meeting for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	R-C 05/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 684}	Continued From page 2 identified R4 had chronic bilateral lower extremity edema which could potentially effect the skin. Evaluation also indicated Teds on in the morning and off at night. During an interview on 5/17/21, at 2:56 p.m. director of nursing (DON) reviewed R4's record, confirmed documentation lacked edema monitoring, and stated edema should be monitored daily. R8 R8's Face Sheet dated 5/19/21, included diagnosis of congestive heart failure. R8's quarterly Minimum Data Set (MDS) dated 3/10/21, identified R8 did not have cognitive impairment and was administered diuretic medication. R8's physician orders included: Torsemide (diuretic medication) 20 mg (milligrams) one time a day for congestive heart failure (start date 4/12/20) R8's congestive heart failure care plan dated 11/15/20, instructed staff to observe/document/report to health provider dependent edema of legs and feet and periorbital edema. R8's weight record identified fluctuations in weight: 5/14- 286.0 pounds (lbs.) 5/12- 286.6 lbs. 5/10- 288.6 lbs. 5/7-285.0 lbs. 5/5- 283.0 lbs. 4/30-283.9 lbs.	{F 684}	recommendations. 5. 6/11/21	

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{F 684}	Continued From page 3	{F 684}		

R8's record was reviewed between 4/14 to 5/14/21 lacked evidence of edema monitoring.

During an interview on 5/17/21, at 3:10 p.m. director of nursing (DON), reviewed R8's record, confirmed the lack of edema monitoring, and stated expectation that edema be monitored and documented daily.

R100
R100's Face Sheet dated 5/9/21, included diagnoses of congestive heart failure, presence of prosthetic heart valve, chronic kidney disease stage 3, reduced mobility, and abnormalities of breathing.
R100's physician orders included:
-Lasix (diuretic medication) 40 milligrams (mg) one time a day related to congestive heart failure (start date 2/13/22).
-Do not apply Teds stockings (compression stocking) to left foot/leg, apply ACE wrap instead remove at night (start date 5/1/21).

R100's quarterly Minimum Data Set (MDS) dated 2/10/21, indicated R100 did not have cognitive impairment, diagnosis of heart failure, and was administered diuretic medications.

R100's cardiovascular care plan dated 2/3/20, included, observe/document/report to health care provider as needed for any signs/symptoms of coronary artery disease which included dependent edema. The care plan also directed when R100 sat in recliner elevate right arm on pillows to get above level of heart for edema.

R1's record was reviewed between 5/1 to

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{F 684}	Continued From page 4 5/14/21, although the record identified the presence of edema, the record lacked evaluation and monitoring of the extent. R1's progress notes identified the following: 5/1/21, at 4:14 a.m. Presence of edema. Chronic bilateral lower extremities (BLE), Right upper extremity (RUE) 5/1/21, at 7:55 a.m. BLE-Chronic 5/2/21, at 2:54 a.m. chronic BLE, RUE 5/2/21, at 7:32 a.m. chronic BLE, RUE 5/3/21, at 2:39 a.m. chronic BLE, RUE 5/3/21, at 4:17 p.m. lower extremity edema 5/3/21, at 8:17 p.m. chronic BLE 5/4/21, at 8:54 p.m. chronic BLE 5/5/21, at 1:43 a.m. chronic BLE, RUE 5/5/21, at 11:33 a.m. chronic lower extremity 5/6/21, at 2:32 a.m. chronic BLE, RUE 5/7/21, at 2:16 a.m. chronic BLE, RUE 5/8/21, at 2:45 p.m. chronic BLE and upper right extremity 5/9/21/21, at 4:22 p.m. BLE, and right upper extremity. 5/10/21, at 12:25 a.m. BLE 5/11/21, at 1:01 a.m. BLE, RUE 5/12/21, at 9:04 a.m. RLE, RUE 5/13/21, at 7:01 a.m. chronic BLE 5/14/21, at 12.23 a.m. BLE During an interview on 3/17/21, at 3:00 p.m. director of nursing (DON) reviewed R100's record, confirmed the edema was not measured and should have been. DON stated the edema should be documented in a skin assessment. Facility policy Edema Checks dated 12/11/2020, included; Edema is an abnormal accumulation fluid in the intercellular body spaces. Any resident who shows signs of edema should have	{F 684}		

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{F 684}	Continued From page 5 the area measured on a routine basis. Baseline data for edema should be part of the resident's medical record. Procedure: A good rule is to measure weekly to detect swelling and daily to monitor swelling and any response to treatment.	{F 684}		
{F 690} SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must	{F 690}		6/11/21

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{F 690}	Continued From page 6 ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to complete a comprehensive assessment for an individualized toileting program for 3 of 4 (R4, R8, R100) resident reviewed for bowel and bladder. Findings include R4's Face Sheet dated 5/19/21, included diagnoses of urinary incontinence, history of urinary tract infection, glaucoma, difficulty in walking, macular degeneration, cataracts, and weakness. R4's urinary incontinence Care Area Assessment (CAA) dated 9/8/20, indicated R4 had occasional urinary incontinence with contributing risk factors of restricted mobility, urinary urgency, and diuretics. The goal was to maintain current level of functioning and minimize risks. R4's quarterly Minimum Data Set (MDS) dated 2/24/21, identified R4 had moderate cognitive impairment and required extensive assistance from one staff for toileting and personal hygiene. The MDS indicated R4 was not on a toileting program and was occasionally incontinent of urine and always continent of bowel. The MDS identified R4 was administered diuretic medication(s). R4's physician orders included,	{F 690}	F690 Bowel/Bladder Incontinence, Catheter, UTI 1. 72 hour bowel and bladder UDA was initiated for R4, R8, & R100. Comprehensive bladder assessments completed for R4, R8, & R100 on 6/9/21. Care plans updated as appropriate for toileting needs. 2. All residents with incontinence were reviewed to ensure a comprehensive bladder assessment was completed and appropriate interventions were implemented. 3. Upon admission and when a change in continence is noted, a 72 hour bowel and bladder UDA and bowel and bladder assessment will be completed and appropriate interventions will be implemented. Re-education will be provided to licensed nursing staff on GSS policy and procedure for comprehensive bladder assessments and care planning interventions. 4. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure comprehensive bladder assessments are being analyzed and toileting plans are being developed if	

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{F 690}	Continued From page 7 -Lasix (diuretic medication) 20 milligrams (mg) every day for dependent edema. R4's care plan activities of daily living care plan dated 11/5/2018, for toilet use "Independent with toileting, if tired resident requires A-1 [assist of one] with walker and gait belt. Staff will change toilet paper roll. Resident educated on need to notify staff." Incontinence care plan dated 11/5/18, identified R4 was incontinent of bladder, interventions included resident uses large incontinent brief products. The care plan did not identify what type of incontinence R4, modifiable risk factors, and did not identify a toileting schedule and/or plan for R4 related to her occasional incontinence. The record lacked evidence a bladder assessment was completed with the quarterly MDS and lacked evidence of interventions to improve and/or maintain bladder function. R4's record identified the last bladder assessment that was completed was dated 5/30/20 and indicated R4 had functional incontinence secondary other factors like physical weakness, cognitive impairment, medications, environmental impediments. The assessment did not identify which factor contributed to R4's incontinence. The section for recommendations was left blank and teaching and training was not provided. During an interview on 5/17/21, at 2:56 p.m. director of nursing (DON) reviewed R4's record, confirmed last bladder was completed last year and should have been completed with the	{F 690}	there is a clinical need. Audit results will be brought to the monthly QA meeting for further recommendations. 6. 6/11/21	

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{F 690}	Continued From page 8 quarterly MDS to identify any worsening/improvement. R8 R8's Face Sheet dated 5/19/21, included diagnoses of urinary incontinence, reduced mobility, congestive heart failure, and morbid obesity. R8's quarterly Minimum Data Set (MDS) dated 3/10/21, identified R8 did not have cognitive impairment and required extensive assistance from two or more staff for toileting and personal hygiene. The MDS identified R8 was not on a toileting program, was frequently incontinent of urine and always continent of bowel. MDS also indicated R8 was administered diuretic medications. R8's previous MDS dated 12/16/21, indicated R8 had an indwelling urinary catheter. R8's physician orders identified the indwelling urinary catheter was discontinued on 1/21/21. R8 record lacked evidence of a comprehensive bladder assessment was completed after R8's catheter was discontinued. R8's record identified the last bladder assessment that was completed was 7/30/19, that indicated R8 had functional incontinence (lacked identification of modifiable contributing factors), recommendation(s) section was left blank, and teaching was not provided. R8's activities of daily living for toilet use instructed staff R8 required assist of two using full body mechanical lift with large toileting sling. skin integrity care plan dated 8/22/20, indicated	{F 690}		

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{F 690}	Continued From page 9	{F 690}		

R8 had actual impaired skin integrity to her buttocks related to incontinence.

R8's care plan lacked a plan of care for urinary incontinence, did not identify type of incontinence, a toilet program/plan, or interventions to improve/maintain bladder function.

During an interview on 5/17/21, at 3:10 p.m. director of nursing (DON) reviewed R8's record, confirmed record lacked a bladder assessment was completed after her catheter was taken out, and stated one should have been completed. DON confirmed R8's care plan did not identify an individualized toileting program.

R100
R100's Face Sheet, included diagnoses of urinary incontinence, benign prostatic hyperplasia, diabetes type 2, congestive heart failure, and muscle weakness.

R100's quarterly Minimum Data Set dated 2/10/21 identified R100 did not have cognitive impairment and required extensive assistance from two or more staff for toileting. MDS indicated R100 was not on a toileting program, was frequently incontinent of urine, always continent of bowel, and administered diuretic medications.

R100's continence care plan dated 2/3/2020, identified R100 had bladder incontinence related to benign prostate hypertrophy and history of nocturia. Interventions directed to limit fluid in the evening/night and avoid beverages that would irritate the bladder. Activities of daily living care plan for toileting dated 11/28/19, indicated R100

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{F 690}	Continued From page 10	{F 690}		

required assistance from 1 staff utilized the grab bars in the bathroom to complete the stand. Assist of one for raising and lowering clothes. Staff assist with peri-care. Resident utilizes X-large incontinent products. Intervention dated 8/21/20, included: During the night offer toileting, 1 and last rounds (if sleep, do not wake him).

R100's care plan lacked a complete individualized toileting plan/schedule during daytime hours.

R100's record identified the last Bladder Assessment was completed on 2/23/20, the assessment indicated R100's condition at the time was unstable and affected toileting ability, had mixed incontinence, recommendation section was left blank, and no teaching or training was provided.

R100's Toileting Program Assessment completed on 2/12/21, identified the following: the type of assessment was "Quarterly" and a trial of a toileting program was not assessed, a toileting program or trial was not being used to manage R100's urinary continence. The assessment concluded "Resident is incontinent of urine most times and continent of bowel. Comparable Facility Policy Bowel and Bladder Assessment, Evaluation, and Retraining dated 12/11/2020 included; Based on the resident's comprehensive assessment the location will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. Every new resident will be observed for 72 hours for bladder and bowel incontinence and then evaluated for feasibility in

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{F 690}	Continued From page 11	{F 690}		

retraining for bladder and bowel control. The policy indicated based on the 72 hour data collection and other factors affecting incontinence. Determine the appropriate toileting program. The policy indicated the toileting program should be in the care plan along with individualized interventions. episodes documented incontinence as continence depending on the day. no consistence seen b/t [between] day of night continence. documentation supports no consistency; toileting needs vary at all times." The assessment identified the result as "Toileting program unsuccessful (de-activate schedule).

R100's Toileting Program Assessment completed on 5/12/21, identified the following: the type of assessment was "Quarterly" and a trial of a toileting program was not assessed, a toileting program or trial was not being used to manage R100's urinary continence. The assessment concluded "NO change in resident habits-resident is incontinent of urine most times and continent of bowel. Comparable episodes documented incontinence as continence depending on the day. no consistence seen b/t [between] day of night continence. documentation supports no consistency; toileting needs vary at all times." (Conclusion was verbatim except for "No change in resident habits".) The assessment identified the result as "Toileting program unsuccessful (de-activate schedule).

R100's record lacked evidence of a corresponding bladder assessment, lacked evidence of an individualized toileting program had been in place, and lacked a voiding diary in

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{F 690}	Continued From page 12 order to ascertain an individualized toileting program. Documentation of 100's continence was completed once per shift and did not identify how frequently R100 was assisted to the bathroom, and the record did not identify how the conclusion was ascertained. The facility was asked to provide the documentation to support the Toileting Program conclusion and was not provided. During an interview on 3/17/2021, at 3:00 p.m. director of nursing (DON) reviewed R100's record, confirmed the lack of bladder assessment. DON indicated an unawareness of how the assessment of the toileting program was completed as the record lacked evidence of a corresponding voiding diary. Facility Policy Bowel and Bladder Assessment, Evaluation, and Retraining dated 12/11/2020 included; Based on the resident's comprehensive assessment the location will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. Every new resident will be observed for 72 hours for bladder and bowel incontinence and then evaluated for feasibility in retraining for bladder and bowel control. The policy indicated based on the 72 hour data collection and other factors affecting incontinence. Determine the appropriate toileting program. The policy indicated the toileting program should be in the care plan along with individualized interventions.	{F 690}		
{F 757} SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6)	{F 757}		6/11/21

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{F 757}	Continued From page 13 §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview, and document review the facility failed to offer and/or provide non-pharmacological interventions prior to administration of as needed (PRN) pain medications for 1 of 3 (R12, R15, and R99) residents reviewed for unnecessary medications. Findings include R12 R12 Face Sheet dated 5/18/2021, included diagnoses osteoarthritis and congestive heart failure.	{F 757}	F757 Drug Regimen is Free from Unnecessary Drugs 1. The nurses caring for R12, R15, and R99 were provided with re-education with ensuring that non-pharmacological interventions were attempted and documented prior to PRN pain medication administration for R12, R15, and R99. 2. All residents who experience pain and have orders for PRN pain medication have the potential to be affected. A review of all residents who are prescribed PRN narcotic pain medication and a review of	

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{F 757}	Continued From page 14 R12's quarterly Minimum Data Set (MDS) dated 3/17/21, indicated R12 did not have cognitive impairment and required administration of opioid pain medication during the assessment period. R12's physician orders included: -Tramadol (narcotic pain medication) 50 mg (milligrams) give one tablet by mouth for chronic pain/non-acute pain with breakfast and give one tablet by mouth every 8 hours as needed for pain (start date 12/3/2021). -Acetaminophen 1000 mg by mouth two times a day (start date 4/28/2020) R12's pain care plan dated 7/8/2020, identified R12 had pain/discomfort related to skin impairments and osteoarthritis. The care plan indicated R12 could call for assistance with pain, ask for pain medication, report how much pain was experienced and what alleviated the pain. Interventions initiate on 1/31/2021, included Tilt/recline wheel chair when positioning/transferring resident into wheel chair. This will promote comfortable up right sitting posture with reduced scooting. Interventions initiated on 4/13/2021, included: Attempt non-pharmacological interventions rest, repositioning, ice pack (for 20 minutes), low stimuli (dim light, quiet, etc.), music & diversional activities. Review of R12's progress notes between 4/30/21 to 5/14/21, identified R12 was administered Tramadol for acute pain not chronic and/or lacked evidence of non-pharmacological interventions prior to administration. -eAdmin progress note dated 5/5/21 at 10:20	{F 757}	their care plans for non-pharmacological interventions will be completed by 6/11/21. 3. Policy Pain Management will be reviewed by the DON or designee with all nurses and trained medication aides by 6/11/21. All nurses were provided with re-education with ensuring non-pharmacological interventions were attempted and documented prior to PRN pain medication administration for R12, R15, and R99. 4. Audits will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and monthly x 2 ensure non-pharmacological interventions are being attempted before PRN narcotic pain medication administration. Audit results will be brought to the monthly QA meeting. 5. 6/11/21	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	R-C 05/18/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 757}	Continued From page 15 p.m., indicated R12 was administered Tramadol for complaints of buttock pain. Record lacked identification if the buttock pain was acute/chronic and lacked evidence of non-pharmacological interventions attempted/offered. -eAdmin progress note dated 5/13/21, at 9:54 p.m. indicated R12 was administered Tramadol for complaints of pain from catheter being changed. The care plan did not identify R12 had chronic pain related to catheter pain and lacked evidence of non-pharmacological interventions were attempted/offered. During an interview on 5/17/21, at 2:40 p.m. director of nursing (DON) stated an unawareness if R12 had chronic pain with catheter insertion, indicated that there could be other modalities/medications that could be used that may be more appropriate. DON stated an expectation non-pharmacological interventions be offered/attempted prior to administration. R15 R15's Face Sheet dated 5/19/21, included diagnoses of congestive heart failure, spinal stenosis, and localized edema, restless legs, and history of falling. R15's quarterly Minimum Data Set (MDS) dated 4/7/21, identified R15 did not have cognitive impairment, and was administered narcotic pain medication once during the assessment period. R15's care plan for pain dated 4/13/21, indicated R15 had potential for pain related to congestive heart failure and spinal stenosis. The care plan identified R15 was able to call for assistance	{F 757}		

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{F 757}	Continued From page 16 when in pain, ask for medication, communicate how much pain was experienced and what increases or alleviates the pain. Interventions included Attempt non-pharmacological interventions: rest, repositioning, ice (for 20 minutes), music, low stimuli (dim light, quiet, etc.) or massage. R15's physician orders included: -Ultram (narcotic pain medication) 50 mg (milligrams) by mouth every 6 hours as needed for moderate pain rated 4-6 out of 10 (start date 11/6/2016). -Acetaminophen 1000 mg three times a day for time (start date 1/17/21). R15's record reviewed between 5/1/21 to 5/14/21, lacked documentation of non-pharmacological interventions were attempted/offered prior to the administration. -eAdmin note dated 5/2/21, at 1:15 a.m. indicated R15 was administered Ultram 50 mg, resident requested medication for pain/discomfort on bilateral lower extremities. During an interview on 5/17/21, at 3:45 p.m. DON reviewed R15's record, confirmed the lack of non-pharmacological offered/attempted. DON indicated expectation non-pharm interventions were attempted prior to medication administration. R99 R99's face sheet dated 5/19/21, included diagnoses of infection of right hip prosthesis, artificial knee joint, artificial right hip joint, low back pain, and spinal stenosis.	{F 757}		

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{F 757}	Continued From page 17 R99's admission Minimum Data set (MDS) dated 4/2/2021, indicated R99 did not have cognitive impairment and required surgical wound care. R99's physician orders included: -Hydromorphone (narcotic pain medication) 2 mg (milligrams)- Give 1 tablet by mouth every 4 hours as needed for acute pain Exception: Take 1 tab for pain 4-6, take 2 tabs for pain 7-10. Wean off narcotic pain medication as soon as possible (start date 3/30/21) -Tramadol (narcotic pain medication) 50 mg -Give 1 tablet by mouth every 6 hours as needed for moderate pain or score 4-6 of 10 indication: acute pain Exception: take for pain 4-6. wean off narcotic medication or medication with narcotic properties such as Tramadol as soon as possible (start date 3/30/21). -Acetaminophen Tablet Give 1000 mg by mouth every 6 hours as needed for pain (start date 3/15/2021) - Attempt non-pharmacological pain intervention before administering as needed pain medication (start date 4/19/21). R99's pain care plan dated 3/17/21, indicated R99 had pain/discomfort related to right hip infection following right hip prosthesis, low back pain, left hip bursitis. The care plan indicated R99 was able to call for assistance when in pain, reposition himself, ask for medication, report how much pain is experienced, and communicate what increases or alleviates pain. Interventions included "Attempt non-pharmacological interventions: Ice, repositioning." R99's record was reviewed between 4/30/21 to 5/1/21, although the Medication administration	{F 757}		

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	245317	A. BUILDING _____ B. WING _____	R-C 05/18/2021

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{F 757}	Continued From page 18 record (MAR) indicated non-pharmacological interventions were attempted indicated by a check marked box, the record lacked documentation of the which non-pharmacological interventions was attempted and the effectiveness. In addition, the record lacked evidence of consistent documentation of the reason/location of the pain that was reported. -eAdmin progress note dated 5/1/21, at 1:40 a.m. R99 was administered for right leg pain. Record lacked documentation of which non-pharmacological interventions attempted/offered. -eAdmin progress note dated 5/1/21, at 2:23 a.m. Acetaminophen was administered. Location of pain was not documented, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin progress note dated 5/2/21, at 3:41 p.m. Acetaminophen was administered for pain in lower back. Record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin progress note dated 5/7/21, at 8:44 a.m. Tramadol was administered for right wrist pain (care plan does not identify R99 had history of wrist pain). Record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/8/21, at 2:45 a.m. Acetaminophen was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/8/21, at 12:06 p.m. Tramadol was administered for back pain, record lacked evidence of which non-pharmacological interventions attempted/offered.	{F 757}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 757}	Continued From page 19 -eAdmin note dated 5/10/21, at 11:08 a.m. Acetaminophen was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/10/21, at 11:27 p.m. Tramadol was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/11/21, at 5:27 p.m. Acetaminophen was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/11/21, at 10:02 p.m. Hydromorphone was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/12/21, at 9:11 a.m. Acetaminophen was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/13/21, at 3:10 a.m. Hydromorphone was administered after repositioning. Location of pain was not identified. -eAdmin note dated 5/13/21, at 8:02 a.m. Acetaminophen was administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions attempted/offered. -eAdmin note dated 5/14/21, at 6:51 a.m. Tramadol and Acetaminophen were administered. Location of pain was not identified, and record lacked evidence of which non-pharmacological interventions	{F 757}		

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{F 757}	Continued From page 20 attempted/offered. During an interview on 5/17/21, at 3:13 p.m., director of nursing (DON) reviewed R99's record and stated an expectation location of pain was identified and appropriate non-pharmacological interventions be attempted/offered. DON indicated if there was a new pain location, an assessment be completed and if necessary notify the physician. Facility policy Pain Management dated 11/10/2020, included in the Purpose statement: To use non-pharmacological interventions as identified by the resident to promote comfort. Non-pharmacological interventions should be attempted first; however, in the event they are not successful, they may be combined with pharmalogical regimen. Develop a care plan including pain focus, goal, and interventions, including non-pharmacological interventions that allow documentation.	{F 757}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4I8I

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**

2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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 **03/22/2021** (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 **45** (L18)
13.Total Certified Beds **45** (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
	45			
(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 :
Kyla Einertson, HFE NE II 05/04/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Melissa Poepping, Enforcement Specialist 05/21/2021 (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
06/01/1986
(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.
03401
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
April 9, 2021

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

RE: CCN: 245317
Cycle Start Date: March 22, 2021

Dear Administrator:

On March 22, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

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

If substantial compliance with the regulations is not verified by June 22, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by September 22, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 03/22/2021

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 3/16/21, 3/17/21, 3/18/21, 3/19/21, and 3/22/21 a survey for compliance with CMS Appendix Z Emergency Preparedness was conducted during a recertification survey. The facility was IN compliance with the Appendix Z Emergency Preparedness, Requirements for Long-Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS On 3/16/21, through 3/22/21, a standard recertification survey was conducted at your facility. Complaint investigations were also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be UNSUBSTANTIATED: H5317026C (MN66662) H5317027C (MN69742) The following complaints were found to be SUBSTANTIATED with deficiencies: H5317025C (MN67456) citation issued at F760 H5317021C (MN70560), citation issued at F760. H5317022C (MN67923), citation issued at F760. H5317023C (MN64439), citation issued at F760. H5317024C (MN66283), citation issued at F760. H5317028C (MN70987, MN71016), citation issued at F760. H5317029C (MN64177) citation issued at F760 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required	F 000		

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

Electronically Signed | 04/21/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 03/22/2021

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

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F 000	Continued From page 1 at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen	F 550		4/30/21

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F 550	Continued From page 2 or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed a dignified atmosphere for 1 of 1 resident (R12) observed to have an uncovered catheter bag which was visible to others. Findings include: R12's admission record indicated R1 had diagnoses of obstructive and reflux uropathy (A problem due to urine flowing backward from the bladder towards the kidneys). R12 was observed on 3/16/21, at 2:04 p.m. to be in sitting in wheelchair, the catheter bag was not covered and was in view from the hallway. R12 was observed on 3/17/21, at 8:51 a.m. in bed, the catheter bag was not covered and was in view from the hallway. R12 was observed on 3/18/21, at 8:59 a.m. to be in bed, the catheter bag was not covered and	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F550 Resident Rights/Exercise of Rights 1. A new catheter bag cover was placed on R12□s catheter bag on 3/18/21. 2. All residents with Foley catheter were checked and ensured a catheter cover is being used on 4/12/21.	

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F 550	Continued From page 3 was in view from the hallway. Registered nurse (RN)-A was interviewed and verified the catheter bag was not covered and said it should be covered and then placed a cover over the bag. R12 was observed on 3/19/21, 9:08 a.m. to be in sitting in wheelchair, the catheter bag was not covered and was in view from the hallway. During an interview on 3/18/21, at 1:24 p.m. nursing assistant (NA)-A stated staff put catheter bag in a bag, attach it to the wheelchair or bedside. During an interview on 3/19/21, at 9:44 a.m. the director of nursing (DON) stated catheter bags should be covered always unless they are being emptied. The DON stated this was a dignity issue for the resident. The DON stated she expected the catheter bags to be covered unless they are being emptied or changed. During an interview on 3/19/21, at 3:08 p.m. nursing assistant (NA)-B stated we have bags that are to be used to cover catheters. NA-B stated staff are to put the catheter bag inside the cloth bags. NA-B stated the covers are to be on all the time, staff take off to empty the catheter bag and then put the cover back on. NA-B stated the covers should be on the catheter bags for R12's privacy and stated not everybody has to know she has a catheter, and the cover was for the integrity of the resident. A policy and procedure relayed to ensuring catheter bags are covered was requested and not provided.	F 550	3. New Foley catheter kits were ordered that contain catheter bag covers. Education on GSS Policy Catheters: Types, Insertion, Irrigation, Specimen Collection, Drainage Bag Emptying and Care will be reviewed by the DON or designee with all nursing staff on 4/30/21. 4. Audits will be conducted by the Quality Assurance Coordinator or designee for (R12) and (2) other random residents with Foley catheters weekly x 4 and monthly x 2 to ensure catheter bags are being covered when not being emptied or changed. Audit results will be brought to the monthly QA meeting. 5. 4/30/21	
F 565	Resident/Family Group and Response	F 565		4/30/21

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F 565 SS=E	Continued From page 4 CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by:	F 565		

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F 565	Continued From page 5 Based on interview and document review, the facility failed to ensure resident concerns identified at resident council meetings were addressed and residents notified of a resolution or ongoing measures to ensure compliance. This affected all 7 residents (R4, R32, R30, R16, R3, R15, R13) who attended resident council. Findings include: ALWAYS AVAILABLE MENU ITEM Review of the 1/21 and 2/17/21 Resident Council meeting minutes identified residents voiced concerns that cottage cheese was not always available. There were no follow-up notes regarding any action to be taken by the facility for the 1/21 meeting or any resolution. For the 2/17/21 meeting the Follow up comments/reviewed with Concerned Party: included, "We addressed this during [R32's] care conference. Staff will be re-educated this afternoon at our department meeting that these "always available" options must be on hand at all times, and they are to deliver these when requested." During the resident council meeting held 3/18/21, at 10:00 a.m. during the survey R32 and R15 shared having cottage cheese available was an ongoing concern. R32 stated the menu says we can order cottage cheese and salad any time and we can't because they do not always have it on hand. R32 said we are told it (cottage cheese) did not come on the truck or it (cottage cheese) spoils to fast. R15 said one time they did tell me they couldn't serve it because it spoiled to fast.	F 565	F565 Resident/Family Group and Response 1. The formal grievance procedure was initiated for residents R4, R32, R30, R16, R3, R15, and R13 on 3/17/21. These suggestions/concern forms contain investigations, resolutions, and follow up. 2. A resident council meeting was held on 4/18/21 to ensure all concerns were addressed. 3. The Administrator re-educated the Activities Director on the Grievance Policy and Procedure on 3/17/21. When concerns are brought forward during resident council meetings, the formal grievance procedure will be initiated. A suggestion/concern form will be completed, given to the social worker, and brought to morning meeting for discussion by the entire interdisciplinary team.. The form will be given to the department manager of the department that the suggestion/concern form is most related to. The department manager will do the investigation and formulate a resolution. The social worker will track all suggestion and concern forms on a grievance tracking form and any trends will be reported to Quality Committee each month. 4. Audits will be conducted by the Quality Assurance Coordinator or designee of random suggestion/concern forms weekly x 4 and monthly x 2 to ensure concerns are investigated,	

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F 565	Continued From page 6 During an interview on 3/22/21, at 12:31 p.m. certified dietary manager (CDM)-A stated cottage cheese was always to be available. During an interview on 3/22/21, at 12:34 p.m. dietary staff (DS)-A stated we do have cottage cheese most of the time, but stated sometimes it does go bad before the next order was in. DS-A stated she was not aware was this was still a concern and stated she thought it was resolved. DS-A stated we bring the cottage cheese down with us for lunch and dinner daily. DS-A stated she has not tracked how often the cottage cheese goes bad has not been available to be served. HOUSEKEEPING Review of the 2/27/21 Resident Council meeting minutes identified the concern, "Don't clean like they used to. Cleaning has been worse in last months. My room has not been cleaned in weeks." The Follow up comments/reviewed with Concerned Party completed 3/18/21: included, "Director of E.S. schedule was changed to allow extra cleaning in the mornings. Director of E.S. has come in very early to get cleaning done. On 2/10 there was discussion of Talent management regarding hiring for HSK [housekeeping] internal applicants interested. During the resident council meeting held 3/18/21, at 10:27 a.m. R16 stated they are short staffed in housekeeping and then they do not have anyone to do it (clean common areas of the facility and their rooms). R32 stated nursing assistants take her garbage out. R15 stated the last three months it has been bad for	F 565	resolutions formulated, and follow ups completed. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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housekeeping/cleaning. R30 stated she did not know when the last time her floor has been mopped. All 7 residents attending the meeting agreed they had ongoing concerns with housekeeping.

During an interview on 3/18/21, at 2:01 p.m. nursing assistant (NA)-A stated the maintenance person does everything for cleaning. NA-A stated the nurse on Sunday mopped some people rooms and we need to sweep if it is a mess, but right now rooms are not getting cleaned like they should be and stated it has been this way for a least a month. NA-A stated the residents let us know if they want their rooms cleaned. NA-A stated it is hard for us to complete cares and try to clean rooms. NA-A stated R15, R16, R32, R4 and R30 have all shared concerns about housekeeping. NA-A stated R32 even had her own Swiffer.

During an interview on 03/19/21, at 9:49 a.m. the director of nursing (DON) stated I know we (the facility) have been actively trying to hire more housekeeping. The DON stated maintenance director has been working overtime. The DON stated cleaning should be a team approach and if staff notice a dirty toilet, they should clean it.

During an interview on 3/22/21, at 11:02 a.m. the administrator stated we are continuing with trying to hire housekeeping staff. The administrator stated she thought it would be a false statement to state a room had not been cleaned for two to three weeks. The administrator stated it was everybody's responsibility if they see something that was not clean to notify the appropriate personal.

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F 565	Continued From page 8 During an interview on 3/22/21, at 1:49 p.m. the activity director (AD) stated if she has gotten feedback on a concern, she tells them (the residents) about it and if it was still a concern, the concern goes back on the next month meeting minutes. The AD stated when the facility held resident council meeting prior to COVID, she did review the previous months concerns at the resident council meeting. The AD stated she has not been addressing the concerns this way since COVID as they have not been able to have group meetings. The Resident Groups-Rehab/skilled policy and procedure reviewed/revised 9/28/20 included, "The location must consider the views of the residents and act promptly upon the grievances and recommendations of the group concerning issues of resident care and life in the location." The procedure included, "7. All grievances discussed at resident council will be written in the minutes and filed on the Suggestion or Concern form. The procedure for handling the grievance will be followed. 8. Each department will respond to the resident group recommendation, concerns and grievances as requested and as appropriate, with plan of correction submitted to the administrator for final disposition.	F 565		
F 584 SS=E	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.	F 584		4/30/21

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F 584	Continued From page 9 The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and document review, the facility failed to ensure daily cleanliness of resident rooms for 3 of 3	F 584	F584 Safe/Clean/Comfortable/Homelike Environment 1. All resident rooms were cleaned on	

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F 584	Continued From page 10 residents (R6, R8, R11). During an interview and observation on 03/16/21 at 3:57 p.m., R6 stated her room has not been cleaned in weeks. R6 room had peeling/scraped paint on wall near bathroom entrance, debris, and dust on floor. R6 stated her toilet has been dirty for 3 weeks also. During an observation on 03/17/21 at 9:00 a.m., R11 floor was dirty with crumbs and paper pieces. R11 stated room has not been cleaned and she had to ask an aide to wipe down her overbed table. During an observation on 03/17/21 at 1:26 p.m., R6 floors remain dirty with debris and dust. R6 stated no one has cleaned the floors or the bathroom. During an observation on 03/18/21 at 11:46 a.m., R6 floor remained dirty with dust and debris and toilet dirty with feces. During an interview on 3/18/21 at 11:46 a.m., R8 stated no one has cleaned the floor or counters in weeks. R8 paint on wall near bedside is scraped off. During an observation on 03/18/21 at 11:59 a.m., the DON verified R6 room floor and toilet was dirty. During an interview on 03/19/21 at 09:32 a.m., R6 stated the administrator swept floor and cleaned toilet yesterday afternoon. R6 stated she did not dust or wipe down other areas or mop the floor.	F 584	4/5/21. R6□s room was painted on 4/16/21. 2. On 4/5/21, all resident rooms were audited by the Environmental Services Director and identified cleanliness issues were corrected. 3. Cleaning checklists were created on 4/13/21 for resident room cleaning assignments. All housekeepers will be educated on the cleaning checklists and cleaning schedule by the Environmental Services Supervisor or designee on 4/30/21. All nursing staff will be educated by the DON or designee on creating a homelike environment in all resident rooms on 4/30/21. 4. 2 random resident rooms on each unit will be audited for cleanliness by the Director of Maintenance or designee weekly x 4 and monthly x 2. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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F 584	Continued From page 11 During an interview on 03/19/21 at 10:55 a.m., R8 stated no one has cleaned her room or bathroom. During an observation on 03/19/21 at 11:06 a.m., R11 room floor remains dirty with crumbs and debris. R11 stated her room has not been cleaned for a few weeks. During an interview 03/19/21 at 01:37 p.m., Maintenance (MAINT) stated the housekeeper went on maternity leave 2/22/21. MAINT stated he is trying to clean 10 rooms a day but does not document what rooms have been cleaned. MAINT stated common areas and nurse stations are done daily. MAINT stated resident rooms are not cleaned daily. MAINT stated aides are expected to help pick up as needed throughout day. MAINT stated he gets called for other services and maintenance throughout the day. MAINT stated there is not a schedule for other staff to assist and it is not consistent when there is help. During an interview on 03/19/21 at 3:02 p.m., administrator stated staff are assigned high touch areas to clean daily. Administrator stated they would address any requests or concerns of housekeeping from residents and that in resident council housekeeping concerns were brought up but that they are in the process of trying to hire staff. Administrator stated there is increase crumbs and such on resident floors due to eating in their rooms. Administrator stated they implemented staff assignments to clean high touch areas and to allow maintenance time to clean rooms. Administrator stated the facility has	F 584		

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not considered contracted services. Administrator stated this was the first-time hearing residents had concerns of housekeeping. Administrator stated there is no way to prove that the rooms have not been cleaned for weeks. Administrator stated the intent was to clean resident rooms as needed. Administrator stated there is not a cleaning checklist or schedule of cleaning resident rooms.

During a follow up interview on 03/22/21 at 02:50 p.m., DON stated high touch areas are assigned to staff to be completed daily but not resident room high touch areas.

During a follow up interview on 03/22/21 at 02:51 p.m., MAINT restated that there is not a schedule for cleaning resident rooms, and he has not documented when and what resident rooms have been cleaned. MAINT stated that when there was housekeeping staff, resident rooms were cleaned daily. MAINT stated resident rooms currently have not been cleaned daily. MAINT stated there use to be two housekeeping staff that worked weekdays and alternate Saturdays.

Facility policy Housekeeping and Custodial Overview dated 1/22/21 included that housekeeping and custodial staff members are critical participants in infection control programs and without solid cleaning practices the ability to break the cycle of infection in any building becomes unobtainable. It included environmental services must become familiar with infection control policies and procedures and ensure that housekeeping and custodial staff members are trained on the portions of infection control that are relevant to the work they perform and that

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

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F 584	Continued From page 13 this information is crucial to protect staff members and to incorporate into daily practices to provide a clean and safe environment for residents and other staff members and guests. Facility policy Standard or Light Cleaning policy and procedure dated 1/22/21, indicated purpose to provide procedures for the proper, daily cleaning of resident rooms. The procedure included standard or light cleaning should occur on a daily basis in occupied rooms; if standard or light cleaning is not scheduled daily, the schedule should be adjusted for daily cleaning in rooms where residents are under transmission precautions or other conditions that may require more frequent cleaning. Facility cleaning tasks of high touched surfaces checklist included: entrance doors; learning center; main public bathroom door handles; employee lounge refrigerator handles and cabinet handles, wipe off tables; vending machines; time clock keyboard, thermometer, and Ipad; employee smoking entrance door handles; copier room door handle; and table in entryway. Facility does not have housekeeping checklist or schedule for resident rooms to provide.	F 584		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a	F 623		4/30/21

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F 623	Continued From page 14 language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section; (C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section; (D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or (E) A resident has not resided in the facility for 30 days. §483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following: (i) The reason for transfer or discharge;	F 623		

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F 623	Continued From page 15 (ii) The effective date of transfer or discharge; (iii) The location to which the resident is transferred or discharged; (iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request; (v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman; (vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure	F 623		

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F 623	Continued From page 16 In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide written hospital transfer notices to the resident(s) and/or resident's representative who had a facility-initiated transfer 1 of 2 resident (R33) reviewed for hospitalizations. Findings include R33's progress note dated 2/6/2021, at 12:03 p.m. indicated R33 had been found unresponsive with no breathing and with no pulse. R33 was administered cardiopulmonary resuscitation (CPR) and then transferred to the hospital emergency room for further evaluation. R33's progress note dated 2/6/21, at 2:51 p.m. indicated R33's family was notified and a "verbal consent given to nurse for bed hold." R33's medical record lacked evidence of a written hospital transfer notice was provided to the resident and/or resident's representative. R33's progress note dated 2/13/21, at 8:21 a.m. indicated R33 was transferred to the emergency room for reasons of "hypertensive, syncope, slurred speech, [sic] confusion." A subsequent	F 623	F623 Notice Requirements Before Transfer/Discharge 1. R33 discharged on 4/15/21. 2. Every resident newly admitted or currently residing in the facility has the potential to be affected. 3. All residents being transferred to the hospital will be provided the reason for the move in writing using the Notification of Transfer or Discharge form. In emergent situations where the reason for the move must be given verbally, a copy of the written notice will be mailed by the HIM Director to the representative for signature. The resident□s copy of the bed hold will be sent with other papers accompanying the resident to the hospital. Bed holds that are obtained verbally in emergent situations where the resident is unable to sign will be mailed by the HIM Director to the representative for signature. Facility policy Discharge and Transfer will be reviewed with all nurses by the DON or designee. 4. Audits will be conducted by the	

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F 623	Continued From page 17 note at 2:13 p.m. indicated R33 had been admitted to the hospital and "Bed hold obtained and valid" R33's medical record lacked evidence of a written hospital transfer notice was provided to the resident and/or resident's representative. During an interview on 3/19/21, at 1:00 p.m. medical records personnel (MRP) indicated an unawareness if a written reason for transfer was provided. During an interview on 3/22/2021, at 10:43 a.m. director of nurses (DON) reviewed the record, indicated a written reason for transfer was not provided. DON indicated the resident/resident representative was informed of the reason for transfer verbally at the time of the transfer. Facility policy Discharge and Transfer dated 12/29/2020, included; Before a location transfers or discharges a resident, the location must: Notify the resident and the resident's representative of the transfer or discharge and the reason for the move in writing and in a language and a manner they understand. The notification of transfer or discharge, or other state required form, will serve as the written notice to be given to the resident and/ or resident's representative.	F 623	Quality Assurance Coordinator or designee on all residents being transferred to the hospital weekly x 4 and monthly x 2 to ensure written notice and bed hold signatures are obtained. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment.	F 657		4/30/21

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F 657	Continued From page 18 (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure hospice services were integrated into the comprehensive care plan for 1 of 1 resident (R29) who received hospice services. Findings include: R29's significant change in status assessment (SCSA) Minimum Data Set (MDS) assessment dated 2/3/21, identified R29 had moderate cognitive impairment and had diagnoses which included dementia and depression. The MDS identified R29 was receiving hospice (end of life)	F 657	F657 Care Plan Timing and Revision 1. R29□s care plan was updated to ensure incorporation of the hospice care plan on 3/18/21. 2. All residents currently receiving hospice services were reviewed on 4/12/21 to ensure a hospice focus was on the care plan that incorporates the hospice care plan. 3. A hospice focus will be added to all future resident□s care plans when they admit to hospice that incorporates the	

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F 657	Continued From page 19 services. R29's SCSA Care Area Assessment (CAA) dated 2/17/21, identified R29 was receiving hospice services. R29's current care plan, revealed R29 was receiving hospice services as the nutritional care plan had been revised on 2/17/21 to include hospice. The care plan lacked any additional details regarding R29's hospice services. During an interview on 03/19/21, at 10:19 a.m. registered nurse (RN)-B stated documentation from hospice was scanned into the chart. During an interview on 03/19/21, at 2:32 p.m. registered (RN)-B stated she stated look at R29's orders for his hospice care plan. During an interview on 3/22/21, at 12:09 p.m. the director of nursing (DON) confirmed the facility care plan indicated hospice for the dietary care plan, but hospice services had not been incorporated into nursing plan of care. The DON stated the hospice care plan should be integrated into the nursing care plan. The DON stated the nursing staff should not have to look for the hospice care plan in Resident Spaces. The DON stated R29's significant change in status assessment MDS had been completed in February and stated the care plan should have already been updated and integrated to include hospice. During an interview on 3/22/21, at 12:41 registered nurse (RN)-F confirmed R29's facility care plan had not been updated to included	F 657	hospice care plan. Education was provided by the DON to the nurse manager regarding hospice care planning on 4/12/21. 4. Audits will be conducted by the Quality Assurance Coordinator or designee to identify any new residents currently receiving hospice services and a review of their care plan to ensure that a hospice focus and incorporation of the hospice care plan is added weekly x 4 and monthly x 2. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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F 657	Continued From page 20 hospice care. RN-F stated she usually put in the care plan that the resident had a terminal dx and they are on hospice. RN-F indicated R29's hospice care plan had been scanned into Resident Spaces (a secondary electronic medical record system, used by licensed staff.) The Comprehensive Care Plan and Care Conference - Rehab/Skilled policy and procedure reviewed/revised 10/27/20 included, "In addition to updates during a care plan review, care plans must be revised as the resident's needs/status changes."	F 657		
F 661 SS=D	Discharge Summary CFR(s): 483.21(c)(2)(i)-(iv) §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (i) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results. (ii) A final summary of the resident's status to include items in paragraph (b)(1) of §483.20, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or resident's representative. (iii) Reconciliation of all pre-discharge medications with the resident's post-discharge medications (both prescribed and over-the-counter). (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to	F 661		4/30/21

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F 661	Continued From page 21 adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to complete a comprehensive discharge summary for 1 of 1 resident (R33) reviewed for discharge. Findings include R10's face sheet identified an admission date to the facility on 11/30/2021, with diagnosis that included trochanter fracture (part of the femur bone), heart failure, and chronic kidney disease. R10's Discharge Summary identified that R10 was discharged from the facility on 12/18/21. The discharge summary was signed by the nurse on 12/19/2021, which was after R10 discharged from the facility on 12/18/21. The summary lacked a recapitulation of R10's stay and on the line for physician signature was left blank. During an interview on 3/22/21, at 8:56 a.m. registered nurse (RN)-C reviewed R10's discharge summary and confirmed the summary lacked recapitulation, was not signed by the physician, and was not provided to R10 and/or resident representative upon discharge. RN-C stated the form had certain areas that could not be filled out until after the residents discharged, because of this discharge summaries are not provided. RN-C stated upon discharge residents	F 661	F661 Discharge Summary 1. R46 discharged on 12/18/20. 2. All residents who discharge from the facility have the potential to be affected. 3. All residents being discharged will have discharge instructions, a final recapitulation of the resident□s stay, reconciliation of all pre-discharge medications with the post-discharge medications, a post discharge plan of care that includes where the resident plans to reside and the arrangements that have been made for follow up care and services. Education on the GSS Policy Discharge Planning will be provided to all nurses by the DON or designee by 4/30/21. 4. Audits will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and monthly x 2 to ensure residents are discharged home with the post discharge plan. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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F 661	Continued From page 22 were provided with Discharge of Therapeutic Leave Medication List form and a form that included any equipment, referrals for outpatient services, and upcoming appointments. During an interview on 3/22/2021, at 10:37 a.m. director of nursing (DON), reviewed R10's record and confirmed there was not a progress note that indicated time of discharge, where R10 discharged to, who transported, or what property was sent. DON stated the record should include that information. DON indicated the discharge summary could not be fully completed until after the resident was discharged and we can't fill it out ahead of time. DON indicated the electronic form would have to change. DON stated would expect the summary include the recapitulation, signed by the physician, and provided to the resident at the time of discharge. Facility policy Discharge and Transfer dated 12/29/2020, included; Ordination for Transfer or Discharge, A location must provide and document sufficient preparation and orientation to resident to ensure safe and orderly transfer or discharge from the location. This orientation must be provided in a form and manner the resident can understand. The policy indicated that a Discharge summary would be generated in the computer for completion; the policy did not outline discharge summary requirements and did not outline all necessary information to be given to the resident/resident representative or other facility upon discharge.	F 661		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive	F 676		4/30/21

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F 676	Continued From page 23 assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observations, interviews, and	F 676	F676 Activities of Daily Living	

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F 676	Continued From page 24 document review, the facility failed to provide recommended restorative nursing services for 1 of 1 residents (R8) reviewed. R8 diagnoses include morbid obesity, major depressive disorder, osteoarthritis, difficulty walking, reduced mobility, abnormalities of gait and mobility, muscle weakness, chronic pain and weakness. Restorative nursing program recommendations from physical therapy dated 9/23/20 indicated to resume previous lower leg restorative program for strengthening; seated exercises in recliner 20 repetitions each 3 to 5 days a week. Goal indicated to retain current strength and range of motion in lower extremities for repositioning and transfers. Restorative nursing program recommendations from physical therapy for R8 dated 1/19/21 included twice a week for 30 minutes per day, seated leg exercises of hip marching, hip abduction, knee kicks, and ankle pumps; seated forward lean in chair; arm band exercises of shoulder retraction and bicep curls; and pedaling bike ergometer if available for 10 minutes. R8 care plan reviewed at time of survey, initiated on 8/2/2018 and last revised on 11/15/2020 indicated self-care performance deficit related to cerebral infarction, congestive heart failure (CHF) as evident by decreased to perform activities of daily living (ADL) with goal to improve current level of function in bed mobility, transfers, eating, dressing, toilet use, and personal hygiene. Interventions included resident requires assist of 2 for transfers with Hoyer lift. R8 care plan	F 676	(ADLs)/Mntn Abilities 1. R8□s restorative plan was reviewed and updated to meet her needs and her preferences. 2. All residents with current restorative programs were reviewed by the Nurse Manager and Restorative Aide for accuracy and appropriateness on 4/12/21 and plans updated as necessary. 3. Residents will be provided with restorative nursing programs per their care plan. Duties of the Restorative Nursing Aide will be re-organized to ensure restorative programs are completed as care planned. Training will be provided to the CNAs and Activities Director on completing restorative programs by the DON or designee on 4/30/21. 4. Audits for R8 and 4 other random residents with current restorative programs will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and monthly x 2 to ensure that restorative programs are being completed per the care plan interventions. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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

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initiated on 10/1/2018 and revised on 11/15/2020 indicated the resident has a need for restorative interventions due to ADL self-care performance deficit and limited physical mobility when in bed related to CHF evident by weakness. Goals included resident will maintain current level of function in upper extremity strength for ADL completion through review date and resident will retain current strength and range of motion (ROM) in lower extremities for repositioning and transfers. Interventions initiated and revised on 1/20/21 included nursing rehab#1 of active range of motion of seated leg exercises, hip marching, hip abduction, knee kicks, and ankle pumps as needed; nursing rehab #2 of active range of motion seated forward as needed; nursing rehab #3 of active range of motion arm band exercises as needed; and nursing rehab #4 of active range of motion pedaling bike ergometer if available as needed.

Document review of restorative interventions completed for January 2021 indicated nursing rehab #1 active range of motion for lower extremity strengthening; seated exercises in recliner 20 reps each 3-5 times a week. This was completed on 1/4/21, 1/13/21, 1/19/21, and 1/20/21. Rehab #2 indicated active range of motion bilateral upper extremities arm bike on table for 15 minutes 3-5 times per week. This was completed on 1/4/21, 1/5/21, 1/13/21, 1/19/21, and 1/20/21.

Document review of restorative interventions completed for January 2021 indicated nursing rehab #1 active range of motion with seated leg exercises of legs, hip marching, hip abduction, knee kicks and ankle pumps as needed. This

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was completed on 1/29/20. Rehab#2 indicated active range of motion seated forward in chair as needed. This was completed 1/22/21, 1/27/21, and 1/28/21. Rehab #4 indicated active range of motion of pedaling bike ergometer if available as needed. This was completed 1/27/21.

Document review of restorative interventions completed for February 2021 indicated Nursing rehab #2 active range of motion seated forward in chair as needed. This was completed on 2/1/21, 2/10/21, 2/19/21, 2/24/21. Rehab#3 indicated active range of motion arm band exercises as needed. This was completed on 2/10/21. Nursing rehab #4 indicated active range of motion pedaling bike ergometer if available as needed. This was completed on 2/1/21, 2/10/21, 2/15/21, 2/19/21, 2/24/21.

Document review of restorative interventions completed for March 2021 indicated nursing rehab #1 active range of motion seated leg exercises of legs, hip marching, hip abduction, knee kicks, and ankle pumps as needed. This was completed on 3/4/21, 3/11/21. Nursing rehab #2 active range of motion of seated forward in chair as needed was completed on 3/4/21, 3/11/21, and 3/15/21. Nursing rehab #3 active range of motion arm band exercises as needed were completed on 3/11/21. Nursing rehab #4 active range of motion pedaling bike ergometer as needed was completed on 3/1/21, 3/11/21, and 3/15/21.

During an interview on 03/17/21 at 09:42 a.m., NA-C stated that almost all residents have a restorative program. NA-C stated she ideally works restorative aide duties daily but there has

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been staffing issues. NA-C stated there is usually 2 aides scheduled to work the floor but lately only 1 aide so has to float or work as second aide on the floor and is not able to complete work as restorative aide.

During an interview and document review on 03/17/21 at 03:26 p.m., NA-C verified restorative log book and written recommendations for R8 restorative program. Recommendations were dated 1/28/20 and indicated active range of motion (AROM) upper extremities 3-5 times per week, AROM lower extremities 3-5 times per week. NA-C stated they document when restorative is completed. NA-C stated she was not aware if the recommendations were updated or changed at all since 1/28/20.

During an interview on 03/18/21 at 08:47 a.m., R8 stated it depends on staffing whether restorative aide comes a couple times a week.

During an interview on 03/18/21 at 10:03 a.m., director of nursing (DON) said it would be expected restorative services be done as recommended by therapy.

During an interview on 03/19/21 at 01:14 p.m., R8 stated she does not want to use lift or Hoyer or use a wheelchair at home. R8 stated she wants to be able to walk again and has not walked since being here.

Facility Restorative Functional Exercise policy dated 6/5/20 indicated the purpose was to maintain muscle tone, strength, and joint function; prevent deformities caused by inactivity of a part; help maintain normal physiologic

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F 676	Continued From page 28 function of all body systems; increase strength, range of motion, coordination, activity tolerance, and postural control for fall prevention, and circulation and skin integrity.	F 676		
F 684 SS=E	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to monitor and identify dehiscence (the splitting or bursting open of a wound) of surgical incision, ensure skin tears were comprehensively assessed, monitored, and dressing changes were completed per physician orders for 2 of 2 residents (R144, R35) reviewed for non-pressure related skin injuries. Furthermore, the facility failed to assess and monitor edema in order to determine effectiveness of prescribed interventions or prevent/reduce the risk of fluid overload for 3 of 3 residents (R41, R33, R147) reviewed for edema. Findings include: R144's admission Minimum Data Set (MDS) assessment dated 3/2/21, identified R144 had severe cognitive impairment and did not have rejection of care behaviors. The MDS indicated	F 684	F684 Quality of Care 1. R144 discharged on 4/6/21. R 147 discharged on 4/13/21. R33 discharged on 4/15/21. Wound data collection and wound RN assessment was completed for R35□s right ankle on 3/17/21. Monitor edema prompt added to R41□s eTar. 2. All residents with skin tears, edema, and surgical incisions have the potential to be affected. A review of all resident□s care plans that have non-surgical dressings was completed by the nurse managers or designees and care plans updated as necessary. 3. Re-education will be provided to all nursing staff regarding GSS policies and procedures for identifying, monitoring, documenting, and treating skin issues and monitoring of edema. This will include	4/30/21

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F 684	Continued From page 29 R144 required extensive assistance from two or more staff for bed mobility, transfers, and toileting. The MDS identified R144 had skin tears however, did not identify that R144 required application of non-surgical dressings. R144's hospital discharge summary dated 2/26/21, indicated R144 was treated for a blood stream infection with antibiotics. The summary included, "if more antimicrobial is desired for the skin tears on her upper and lower extremities they recommend could have doxycycline for 5 more days, but skin tears are clinically improving". The summary indicated the plan for the skin tears was to monitor with dressing care. R144's face sheet, identified R144 was admitted to the facility on 2/26/21, with diagnoses that included, hypertensive kidney disease and anxiety disorder. R144's care plan/baseline care plan dated 2/27/21, identified the skin tears under the pain focus area; interventions focused on pain control. R144's physician orders included -Right arm skin tear: apply mepilex (adherent foam dressing) dressing change once per day (start date 2/26/2021) -Right leg skin tear: apply Mepilex dressing change daily (start date 2/26/21) R144's Nursing Admit Re-Admit dated 2/26/21, included a Skin Integrity Section that identified R144 had a skin tear on her right arm and right leg; no other description or measurement were included.	F 684	weekly skin observations and documentation including edema, weekly wound rounds, review of completing wound data collection tools and weekly wound assessments. 4. Audits will be conducted for 3 random residents with skin or edema concerns by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure completion of wound data collection and wound RN assessments and to ensure edema is being monitored. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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R144's record lacked evidence of continuous monitoring/assessment/evaluation of the skin tears to both the right arm and the right leg.

During an observation on 3/18/2021, at 7:19 a.m. R144 laid awake in her bed. Nursing assistant (NA)-E and NA-F were provided cares to R144; on R144 right upper arm there was a Mepilex dressing that was dated 3/16/21, right lower leg had a Mepilex dressing on that was not dated.

During an observation and interview on 3/18/2021, at 12:49 p.m. registered nurse (RN)-E informed R144 she was going to change the dressings on her arm and leg. RN-C observed dressing to R144's right arm, confirmed the date on the dressing was 3/16/21, and stated that meant the dressing had not been changed per physician orders. RN-E confirmed the dressing on R144's right leg did not have a date, indicating an unawareness of when the dressing was last changed. RN-E tried to remove the old Mepilex from R144's arm the dressing was sticking to the skin causing accidental debridement (the removal of damaged tissue or foreign objects from a wound) to a small area. RN-E stated R144 had very thin skin, stopped and used water to moisten the dressing to prevent further sticking to the skin. RN-E stated she was not going to put anything sticky back on the wound, would notify the physician, but until then would use non-stick dressing with roll gauze. RN-E then performed dressing change to the skin tear to the right lower extremity without complication. RN-E stated the dressing should have been changed per physician orders; stated sometimes dressings do not get changed because it was very busy and things get forgotten, or there was not enough

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F 684	Continued From page 31 staff on the unit to ensure everything got done that needed to get done. R144's Wound Data Collection dated 3/18/21, at 1:48 p.m. identified right outer shin skin tear that measured 4.1 centimeters (cm) x 0.9 cm; area is healed and has what appears to be dried blood under the skin. Small amount of pink skin. R144's Wound Data Collection dated 3/18/21, at 1:48 p.m. identified right upper arm skin tear that measured 7.0 cm x 0.5 cm. and also included "Mepilex, changed to a non telfa and gauze. Asked for order change to opsite dressing. During an interview on 3/19/21, at 9:31 a.m. RN-C reviewed R144's record and confirmed the record lacked evidence of an initial skin assessments and lacked evidence of ongoing monitoring and evaluation of the skin tears. RN-C stated a completed assessment should have been completed upon admission and a care plan should have been developed for the skin impairments. RN-C indicated impaired skin integrity should have been completed daily with dressing changes. RN-C stated weekly assessments should have been completed, and the dressing should have been changed per physician orders. R35 open incisional line R35's admission Minimum Data Set (MDS) assessment 2/11/21 identified R35 did not have cognitive impairment and required extensive assistance from one staff for dressing. The MDS also identified R35 was at risk for pressure ulcers, did not have pressure ulcers and did not have any skin concerns.	F 684		

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F 684	Continued From page 32 During an observation on 3/16/21, at 2:00 p.m. R35 sat in her room in her wheelchair with her right foot elevated without a sock on; observed on the right lower leg above her ankle was an incisional line with 3-4 steri-strips on the top area of the incision. The top portion of the incisional line was covered by a dark thick scab. The lower part of the incision did not have steri-strips (a special kind of adhesive tape); there was a small open area near the bottom of the incision. R35 stated the steri-strips at the bottom fell off during her shower the other day, and there has been some drainage. R35 picked up her sock that had been on and pointed to the small spot of light reddish drainage where the open area had drained. R35 stated the nurses had not measured the area or applied a cover dressing to the area. R35's face sheet provided on 3/22/21, included diagnosis of displaced malleolar (ankle bone) fracture of right lower leg, and subsequent encounter for closed fracture with routine healing. R35's care plan dated 2/5/2021, included "The resident has alteration in musculoskeletal status r/t [related to] right ankle fracture." R35's goal was for the wound to heal and progress without complications. An associated intervention directed staff to monitor wound for signs and symptoms of infection and/or delayed wound healing. R35's Wound Data Collection dated 2/21/21, indicated R35 had a surgical incision; the treatment was gauze and kerlix (gauze wrap).	F 684		

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F 684	Continued From page 33 The assessment did not include information pertaining to the incision (such as location, sutures/staples and measurements) R35's Wound Data Collection dated 3/9/21, identified the right outer ankle surgical incision; incision measured 9.5 centimeters (cm) x 0.2 cm and was red. The assessment indicated steri-strips were in place over the incision and treatment was gauze with kerlix. R35's Wound Data Collection dated 3/13/21, identified the right outer ankle surgical incision; no measurements were included. The assessment indicated the wound margins were pink and intact with steri-strips in place. Treatment continued as aforementioned. R35's Wound Data Collection dated 3/14/21, identified the outer ankle surgical incision; no measurements were included. The assessment indicated the wound margins were pink and intact with steri-strips in place. Treatment continued as aforementioned. R35's progress note dated 3/15/2021, included "incision line is clean and dry and free of signs of infection." R35's did not include an assessment of the surgical incision on 3/16/21. R35's Wound Data Collection dated 3/17/2021 (after surveyor reported skin concern to facility) identified the right ankle surgical incision; incision measured 8.5 cm x 1.0 cm. In the section Daily Monitoring included, "open area measured 1.0 cm x 0.2 cm depth of dehiscence 0.2 cm." The assessment indicated the wound had minimum	F 684		

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serous drainage. The assessment also included, "steri-strips 3 in place, cleansed with saline, applied telfa, soft gauze for padding, and secured with kerlix".

During an observation on 3/17/21, at 3:22 p.m. R35 sat in her room with her cam boot off and right foot elevated. R35's incisional area was open to air. R35 stated staff had not cleaned the open area on the incision and nobody had looked at it.

During an interview on 3/17/2021, at 3:42 p.m. registered nurse (RN)-C stated R35 started wearing the Cam boot last week after her cast was removed. RN-C observed R35's right foot/ankle and verified the open area within the incisional line. RN-C indicated she had not been aware that some of the steri-strips had fallen off and had not seen the incision since Friday (3/12/21). RN-C stated a few days ago, R35 had asked for the steri-strips to be pulled off; RN-C stated she provided education to R35. RN-C stated she had thought the strips may have fallen off during her shower the other day.

During an interview on 3/17/2021, at 3:56 p.m. registered nurse (RN)-D indicated she was the nurse assigned to the unit where R35 resided. RN-D stated she had not looked at her ankle incision yesterday or today; the last day she saw it was probably last Wednesday.

During an interview on 3/18/21, at 8:23 a.m. nursing assistant (NA)-E indicated she had thought R35's had steri-strips in place on Monday, and thought R35 had a shower that day.

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During an interview on 3/18/21, RN-C stated she had talked to the nurse that provided the shower to R35 on Monday. RN-C indicated the nurse indicated some of the steri-strips had fallen off during the shower, and had not noticed the open area. RN-C indicated the incision was supposed to be monitored and documented on daily, if steri-strips had fallen off that area should be looked at to make sure the incision was closed. Stated if nursing assistants had seen open areas they should have reported it to the nurse.

During an interview on 3/22/21, at 9:47 a.m. director of nursing (DON) stated expectation that nurses are monitoring and documenting on R35's incision daily; assessing for any impaired skin integrity and signs and symptoms of infection. DON indicated if there were any areas of impairment nurses were supposed to complete the wound data collection, provide treatment and interventions, and notify appropriate parties. In reference to R144 the DON said an expectation of wound assessments be completed upon admission or identification, the care plan should identify the wounds, and wounds should be monitored with dressing changes for changes, and assessed weekly. DON stated dressing changes should be completed per physician orders.

R41 EDEMA MONITORING

R41's admission Minimum Data Set (MDS) assessment dated 2/23/2021, indicated R41 did not have cognitive impairment or rejection of care behavior. The MDS identified R41 required extensive assistance from two or more staff for

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dressing and required administration of a diuretic medication.

During an observation and interview on 3/16/2021, at 2:17 p.m. R41 sat in her wheelchair with her feet in the dependent/down position; both of R41's feet/ankles/shin area were swollen. R41 indicated the yellow socks she wore provided some compression. R41 stated she typically had some swelling in her lower extremities, "but not this bad". R41 stated it didn't help that she was sitting more with her legs down and was not walking a lot since being admitted to the facility. R41 stated the staff were not measuring the edema by pushing on the swollen areas, compression wraps and or socks had not been attempted. R41 indicted she was not being weighed daily and wasn't sure how often her weight was supposed to be taken.

R41's face sheet, identified R41 had diagnoses that included localized edema and chronic kidney disease.

R41's care plan dated 2/27/21, included: The resident has renal insufficiency related to chronic kidney disease. Corresponding interventions directed staff to monitor/document report to health care provider as needed the following signs and symptoms: edema weight gain of over 2 pounds a day, neck vein distention, difficulty breathing ... monitor breath sounds for crackles.

R41's physician orders included Furosemide (diuretic medication) 20 milligrams (mg) one time a day related to edema.

R41's hospital discharge summary dated

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2/18/2021, the physical examination on 2/18/21, included "no peripheral edema".

R41's progress notes reviewed from admission to 3/22/2021. Daily progress notes since 2/18/2021 included "[R41] weight is monitored for wt [weight] gain or loss."

R41's nutritional progress note dated 3/2/2021, included "Expected weight loss related to diuretic therapy."

R41's weight record was reviewed the only weights evident in the record included:
-On 2/18/21 weight was 232.2 pounds
-On 3/10/21 weight was 233.8 pounds

R41's record lacked evidence of edema monitoring.

During an observation on 3/18/2021, at 1:24 p.m. R41 sat in her room with her legs in the dependent position; both lower legs were edematous. R41 had on the same yellow socks as from the observation on 3/16/2021.

During an interview on 3/19/21, 9:54 a.m. registered nurse (RN)-C reviewed R41's record, confirmed lack of edema monitoring. RN-C indicated the care plan directed to monitor for a two pound weight gain daily however, weights were not completed daily. RN-C stated if residents had a diagnosis of congestive heart failure or if prescribed diuretics nurses should be assessing for edema when they are doing vital signs and documenting in the skilled charting.

R41's progress note dated 3/22/2021, at 9:59

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a.m. included "resident has noted edema in her lower extremities plus 2 resident is encouraged to elevate her legs, but spends her day with her legs dependent.

R33 Edema monitoring
During an observation on 3/16/21, at 5:55 p.m. R33 sat at the dining room table; R33's right lower extremity was observed to be edematous. R33 indicated that the swelling comes and goes.

R33's face sheet, identified R33 was admitted to the facility on 2/5/2021, with diagnoses that included congestive heart failure, peripheral vascular disease, and hypertensive kidney disease.

R33's physician orders included
-hydrochlorothiazide (diuretic) 25 mg (milligrams) one time of day (start date 2/8/21)

R33's care plan dated 2/22/2021, included "The resident has Congestive Heart Failure", corresponding interventions included "Monitor/document/report to health care provider PRN any s/s of Congestive Heart Failure: dependent edema of legs and feet, periorbital edema, SOB upon exertion, cool skin, dry cough, distended neck veins, weakness, weight gain unrelated to intake, crackles and wheezes upon auscultation of the lungs, Orthopnea, weakness and/or fatigue, increased heart rate (Tachycardia) lethargy and disorientation." In addition the care plan also directed to "Monitor/document/report to health care provider PRN [as needed] the following s/s [signs/symptoms]: Edema; weight gain of over 2 lbs. a day."

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R33's physician visit note dated 2/26/2021, included "Loss Weight significant differences in hospital weight versus nursing home weights. Unclear if this is related to incorrect weight is being obtained, fluid overload during hospitalization, or weight loss. Weight has been verified by nursing staff." The visit note indicated R33 did not have any lower extremity edema.

R33's physician visit note dated 3/9/2021, included the aforementioned information pertaining to weight loss with the addition of, "3/09: he continue to have much variation in weights- first week of March he was steady at 163-166 lb. [pound] past 2 days he is recorded at 193, which I can only think spurious. He has been down trending since February."

A corresponding faxed communication dated 3/10/2021, included the order "Offer TEDS for lower extremity compression given history of orthostatic, on in the morning, can remove at night"
R33's record lacked evidence the stockings were applied and monitored for effectiveness.

R33's record lacked reviewed between 2/26 to 3/16/2021, lacked evidence of edema monitoring and evaluation.

R147 edema monitoring
R147's face sheet, identified R147 was admitted to the facility on 3/4/21, with diagnosis that included congestive heart failure, atherosclerotic heart disease, and chronic kidney disease.

R147's admission Minimum Data Set (MDS) assessment dated 3/10/21, indicated R147 did

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not have cognitive impairment or rejection of care behaviors. The MDS indicated R147 required extensive assistance from one staff for personal hygiene and dressing. The MDS also indicated R147 was administered a diuretic medication.

R147's hospital discharge summary dated 3/4/2021, included section Active Issues Requiring Follow Up that directed "1. Monitor daily weights. Continue low sodium diet."

R147's physician orders included
-Reduced sodium diet (start date 3/11/21)
-Ace wraps to bilateral lower extremities one time a day for edema (start date 3/11/2021)
-Weigh daily. Call physician if weight gain of 2-3 pounds or more per day over a two day period or 5 pounds in a week (start date 3/4/2021)
-Furosemide 20 mg (milligrams) one time per day (start date 3/4/2021).

R147's base line Care plan dated 3/16/2021, identified R147 had altered cardiac status and directed staff to "Monitor/document/report to heal care provided as needed any signs/symptoms of coronary artery disease" Symptoms to monitored included dependent edema, capillary refill, and shortness of breath.

R147's Nursing Admit R-Admit Data Collection dated 3/4/2021 identified R147 had 3+ pitting edema in both feet, and edema in locations in both legs.

R147's record lacked edema monitoring between 3/5/2021 to 3/7/21.

R147's Wound Data Collection dated 3/8/2021,

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included "Resident has 4 plus edema noted in bilateral feet. Top of right foot is redden in color measures approximately 7 x 8 cm [centimeters]"

R147's physician note dated 3/8/2021, indicated upon physical exam R147's lower extremities had in "Right lower leg: 2+ pitting edema present. Left lower leg: 2+ pitting edema present", identified a dry weight of 180-184 pounds, and indicated the physician gave orders which included, "Daily weights for CHF [congestive heart failure]"

R147's progress notes reviewed between 3/8/21 to 3/16/2021, identified R147 had edema however did not identify the amount of edema and/or evaluation of effectiveness of the ace wraps to lower extremities and/or diuretic medication.

During an observation on 3/17/2021, at 1:06 p.m. R147 sat in his wheelchair. R147 was observed to have ace wraps; both legs were edematous.

During an observation on 3/18/21, at 7:16 a.m. R147 sat in his wheelchair. R147 did not have ace wraps on; both legs were edematous, right leg worse than the left. R147 stated wraps had not been put on yet.

During an observation on 3/18/2021, at 10:43 a.m. R147 sat in his wheelchair. R147 did not have ace wraps on. Registered nurse (RN)-E was in R147's room to change dressing to the top of R147's left foot, RN-E stated ace wraps were supposed to go on in the morning and taken off at night. RN-E indicated both of R147's legs were edematous; RN-E stated R147 left leg ankle aspect had 4+ pitting edema, had +2 pitting

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edema from top of foot up to the knee. RN-E stated right foot had 4+ pitting edema, from top of ankle to mid shin had +2 edema, and just below the knee had 1+ pitting edema.

During an interview on 3/19/21, at 10:22 a.m. RN-C reviewed R147 record, confirmed the record lacked edema monitoring and assessment. RN-C stated that edema monitoring should be done daily, nurses should measure the edema, and determine if worsening and improving.

During an interview on 3/19/2021, at 2:15 p.m. certified dietary manager (CDM), stated she had only been at the facility for a couple of weeks and had just become aware that the facility did not have and was not using menu extensions for therapeutic special diets, so all residents were being served regular diets.

During an interview on 3/22/2021, at 10:27 a.m. director of nursing (DON) stated an unawareness that residents were not being served diets according to physician orders. DON stated an expectation that therapeutic diets be provided per the physician order and the expectation for residents who have a diagnosis of congestive heart failure or administered diuretic medications, edema be monitored/evaluated and documented daily.

Facility policy Pressure Ulcers dated 2/10/2021, included, Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure

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F 684	Continued From page 43 ulcers does not develop a pressure ulcer unless that individual's clinic condition demonstrates that this was unavoidable. Residents will receive appropriate assessments and services to promote and maintain skin integrity. The facility policy included instructions for measuring edema and documentation requirements of the assessments. Facility policy Skin Assessment Pressure Ulcer Prevention Documentation Requirements dated 11/17/2020, included purpose of policy; to systematically assess residents with regard to risk of skin breakdown, to accurately document observations and assessments of residents, to appropriately use prevention techniques and pressure redistribution services on those residents at risk for pressure ulcers. A comprehensive assessment, which includes Resident Assessment Instrument will be completed by the registered nurse evaluating the resident's risk factors, the resident's skin condition and nature of the pressure to which the resident may be subjected. The assessment should identify which risk factors can be removed or modified. A systemic skin inspection will be made daily by nursing assistants assigned to those residents at risk for skin break down. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. Assessment and Documentation of Bruises/Contusions/Skin Tears/Abrasions, The bruise/contusion/skin tear/abrasion should be monitored weekly and any changes and/or progress toward healing should be documented on the skin observation and on the resident's care plan.	F 684		

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F 684	Continued From page 44 Facility policy Edema Checks dated 12/11/2020, included; Edema is an abnormal accumulation fluid in the intercellular body spaces. Any resident who shows signs of edema should have the area measured on a routine basis. Baseline data for edema should be part of the resident's medical record. Procedure: A good rule is to measure weekly to detect swelling and daily to monitor swelling and any response to treatment.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to identify and monitor an orthotic device (cam boot) as pressure ulcer risk factor, and failed to identify the presence of stage I pressure ulcers caused by the device for 1 of 3 residents (R35) reviewed for pressure ulcers. Furthermore, the facility failed to provide interventions to reduce the risk of pressure ulcer development according to the care plan for 1 of 3 residents (R144) reviewed for pressure ulcers.	F 686	F686 Treatment/Svcs to Prevent/Heal Pressure Ulcer 1. Wound data collection and wound RN assessment completed for R35□s right toes. Prompt added to eTar to Check for reddened skin to right lower extremity/toes related use of CAM boot. R144 was discharged on 4/6/21. 2. All residents with orthotic devices	4/30/21

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F 686	Continued From page 45 Findings include: R35's admission Minimum Data Set (MDS) assessment identified R35 did not have cognitive impairment and required extensive assistance from one staff for dressing. The MDS also identified R35 was at risk for pressure ulcers, did not have pressure ulcers and did not have any skin concerns. During an observation on 3/16/21, at 2:00 p.m. R35 sat in her room in her wheelchair with her right foot elevated without a sock on; observed first three toes had small (pencil eraser sized) red areas. When R35 was asked to push on the red areas they did not blanch and stayed red. R35 stated she recently had her cast removed and had to start wearing an orthotic boot (cam); she stated the plastic insert pushes on the top of the toes wear the red areas are. R35 stated staff were not monitoring the area, staff had not altered the orthotic piece or applied bandages that would protect the skin from pressure. The red areas were from the piece of the orthotic boot (cam) she had to wear to keep her ankle straight and a reminder to not put weight on that foot. R35's face sheet, included diagnosis of displaced malleolar (ankle bone) fracture of right lower leg, and subsequent encounter for closed fracture with routine healing. R35's care plan indicated R35 had an alteration in musculoskeletal status related to right ankle fracture. Corresponding interventions directed staff to apply Cam boot to right lower extremity.	F 686	have the potential to be affected. A review of all residents with orthotic devices was completed by the nurse manager and care plans and eTars updated as necessary. 3. Education will be provided to licensed nursing staff on identifying, monitoring, and care planning interventions for residents with devices that have the potential to cause pressure ulcers by the DON or designee. 4. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure skin is being monitored under orthotic devices and repositioning is occurring per the care plan. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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May remove for bathing and for resident to do "ABC" range of motion exercises. Resident has been taking boot off and putting it back on for her exercises.

R35's record reviewed between 3/1/21 to 3/16/21, lacks evidence the redness to the toes was identified prior to surveyor reporting the redness to the nurse.

During an interview on 3/17/2021, at 3:42 p.m. registered nurse (RN)-C stated R35 started wearing the Cam boot last week after her cast was removed. RN-C observed R35's right foot and verified the redness to the first three toes; indicated the redness was probably from the "L" shaped plastic piece of the boot. RN-C stated she had seen her toes yesterday morning and did not see any redness, but could have gotten worse during the day. RN-C stated she had not been made aware of the any redness to R35's toes; expected nursing assistants to report any skin concerns to the nurses so the impaired skin integrity could be assessed and appropriate interventions be put into place.

During an observation and interview on 3/18/21, at 8:18 a.m. R35 sat in her wheelchair, Cam boot was on right foot. The Cam boot was lined with lamb's wool. R35 stated it felt better. R35 stated again, nurses had previously not been looking at her toes.

During an interview on 3/18/21, at 8:23 a.m. nursing assistant (NA)-E indicated since R35 started wearing the Cam boot, on somedays her toes were pink. NA-E stated on Monday (3/15/21), the toes were a little pink.

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F 686	Continued From page 47 During an interview on 3/22/21, at 9:47 a.m. director of nursing (DON) stated if R35's toes were noticed to be pink it should have been reported to the nurse; stated nurse should then assess the area, determine root cause, and put appropriate interventions in place to remove the risk, promote healing, and prevent further pressure ulcer development. R144 R144's admission Minimum Data Set (MDS) assessment dated 3/2/21, identified R144 had severe cognitive impairment and did not have rejection of care behaviors. The MDS indicated R144 required extensive assistance from two or more staff for bed mobility, transfers, and toileting. The MDS indicated R144 was occasionally incontinent of urine and always incontinent of bowel, and was not on a toileting program for bladder or bowel. The MDS also indicated R144 was at risk for pressure ulcers and required pressure reducing device for chair/bed and a turning/repositioning program. The MDS indicated R144 did not have moisture associated skin damage. During an observation on 3/16/2021, at 1:29 p.m. R144 laid in her bed with her eyes closed, R144's room had a foul strong urine/bowel odor. R144 had an air mattress on her bed. During a subsequent observation R144 laid in her bed with her eyes closed, R144's room continued to have the foul odor. R144's face sheet, identified R144 was admitted to the facility on 2/26/21, with diagnoses that included, hypertensive kidney disease and	F 686		

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F 686	Continued From page 48 anxiety disorder. R144's Pressure Ulcer/Injury Care Area assessment (CAA) signed and completed on 3/8/2021, identified R144 was at risk for pressures related to immobility, altered mental status, cognitive loss, incontinence, hemiparesis, peripheral vascular disease, chronic end stage renal failure, and functional limitations in range of motion. The CAA identified R144 required a special mattress or seat cushion to reduce or relieve pressure. R144's care plan and/or baseline care plan did not include a plan of care for pressure ulcers and did not identify an individualized repositioning schedule based on R144's risk factors. R144's activities of daily living care plan dated 2/26/21, for bed mobility R144 required assistance from two staff using total mechanical lift with a positioning sling that stays on the bed and grab bars on bed for her to hold onto for her feeling of security. R144's progress note dated 3/14 and 3/15/2021, included, "res [resident] prefers to stay in bed, repositioning every 2 hours to prevent pressure areas." R144's record lacked evidence of an assessment/evaluation to determine an individualized repositioning schedule. During an observation and interview on 3/18/21, at 7:19 a.m. R144 laid awake in her bed with nursing assistant (NA)-E and NA-F at bedside. NA's removed incontinent brief that was saturated with urine. NA-E stated it was an overnight brief and indicated it held more urine.	F 686		

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NA-E and NA-F stated R144 was always incontinent of both bladder and bowel. When NA's rolled R144 over to her side, it was observed that R144 had a long raised red excoriated area on her right inner gluteal fold. NA-E stated she had provided care on 3/15/21, and the red area was not there. NA-E applied barrier cream to the area and stated she would inform the nurse. NA's completed morning cares and transferred R144 to her chair at 7:45 a.m., a pillow was placed along the side of R144's right side for positioning.

During a continuous observation that began at 7:45 a.m. and was completed at 11:15 a.m. R144 remained in her wheelchair in the same position; R144 was not offered and/or attempts made to reposition.

During an interview on 3/18/21, at 11:03 a.m. registered nurse (RN)-E was informed R144 remained in the same position since 7:45 a.m. RN-E stated that was too long not to be repositioned and should have been repositioned at least every two hours. RN-E stated she would have the nursing assistants go reposition and check on her.

During an interview on 3/18/21, at 11:07 a.m. NA-F confirmed R144 had been sitting in the same position since 7:45 a.m. this morning and had not been repositioned. NA-F stated residents were supposed to be repositioned, offered toileting, or checked and changed every two hours. NA-F stated R144 was not offered toileting and/or repositioned because the unit was busy and hadn't been able to reposition or offer toileting. NA-F indicated staff were not always

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able to get to residents when they needed to because there wasn't enough staff.

During an interview on 3/19/21, at 9:31 a.m. RN-C indicated R144's care plan did not address repositioning until undated on 3/17/21, and R144 required every two hour repositioning. RN-C indicated the repositioning schedule was determined by R144's risk factors for pressure ulcer development. RN-C indicated R144 should have been toileted/checked at least after two hours. RN-C indicated R144 was always incontinent of both bladder and bowel.

During an interview on 3/22/2021, director of nursing (DON) stated excoriation was caused by incontinence/moisture and could be caused from wiping. DON indicated an expectation the care plan identify interventions for pressure ulcers and expected staff to reposition residents at least every two hours or in accordance with their care plan.

Facility policy Skin Assessment Pressure Ulcer Prevention Documentation Requirements dated 11/17/2020, included purpose of policy; to systematically assess residents with regard to risk of skin breakdown, to accurately document observations and assessments of residents, to appropriately use prevention techniques and pressure redistribution services on those residents at risk for pressure ulcers. A comprehensive assessment, which includes Resident Assessment Instrument will be completed by the registered nurse evaluating the resident's risk factors, the resident's skin condition and nature of the pressure to which the resident may be subjected. The assessment

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F 686	Continued From page 51 should identify which risk factors can be removed or modified. A systemic skin inspection will be made daily by nursing assistants assigned to those residents at risk for skin break down. The nursing assistant responsible for this will report any abnormal findings or signs of skin impairment to the licensed nurse. Residents who are unable to reposition themselves independently, as indicated on the Sit-Stand-Walk tool, should be repositioned as often as directed by the care plan approaches. Developing an individualized repositioning schedule is required for those residents unable to position themselves and is based on nutrition, hydration, and incontinence diagnosis of mobility and observation of the resident's skin over a period of time. When a pressure ulcer is present daily monitoring instructed required documentation. Facility policy Pressure Ulcers dated 2/10/2021, included, Based on the resident's comprehensive assessment, the location will use prevention and assessment interventions to ensure that a resident entering the location without pressure ulcers does not develop a pressure ulcer unless that individual's clinic condition demonstrates that this was unavoidable. Residents will receive appropriate assessments and services to promote and maintain skin integrity.	F 686		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical	F 690		4/30/21

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F 690	Continued From page 52 condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to complete a comprehensive assessment for an individualized toileting program for 1 of 1 (R144) resident reviewed for bowel and bladder. Findings include:	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI 1. R144 discharged on 4/6/21. 2. All residents with incontinence were reviewed to ensure a comprehensive bladder assessment was completed and	

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F 690	Continued From page 53 R144's admission Minimum Data Set (MDS) assessment dated 3/2/21, identified R144 had severe cognitive impairment and did not have rejection of care behaviors. The MDS indicated R144 required extensive assistance from two or more staff for bed mobility, transfers, and toileting. The MDS indicated R144 was occasionally incontinent of urine and always incontinent of bowel, and was not on a toileting program for bladder or bowel. The MDS also indicated R144 was at risk for pressure ulcers and did not have moisture associated skin damage. During an observation on 3/16/2021, at 1:29 p.m. R144 laid in her bed with her eyes closed, R144's room had a foul strong urine/bowel odor. During a subsequent observation R144 laid in her bed with her eyes closed, R144's room continued to have the foul odor. R144's face sheet, identified R144 was admitted to the facility on 2/26/21, with diagnoses that included, hypertensive kidney disease and anxiety disorder. R144's hospital discharge summary dated 2/26/21, included diagnosis of over active bladder and recurrent urinary tract infections. R144's associated Urinary Incontinence Care Area Assessment (CAA) that was signed and completed on 3/8/202. The CAA identified R144 was at risk for incontinence related to restricted mobility, urinary urgency, and was administered antidepressant and anticholinergics (can lead to overflow incontinence) medications. The	F 690	appropriate interventions were implemented. 3. Upon admission and when a change in continence is noted to the facility, a 72 hour bowel and bladder assessment will be completed and appropriate interventions will be implemented. Re-education will be provided to nursing staff on GSS policy and procedure for comprehensive bladder assessments and care planning interventions. 4. Audits will be conducted by the Quality Assurance Coordinator or designee to weekly x 4 and monthly x 2 to ensure comprehensive bladder assessments are being analyzed and toileting plans are being developed if there is a clinical need. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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F 690	Continued From page 54	F 690		

indicated the overall objective as to minimize risks. No interventions to reduce the risk of incontinence was identified.

R144's physician orders included, Solifenacin succinate (used to treat over active bladder) 5 milligrams (mg) daily for urine leakage (start date 2/26/21).

R144's Nursing Admit Re-admit Data Collection dated 2/26/2021, included Bowel and Bladder sections; sections identified R144 was not usually continent of bladder and bowel and used laxatives or enema's two or more times a week.

R144's activities of daily living care plan dated 2/27/21, indicated for toileting R144 required 2 staff assist using mechanical lift with full body medium size sling. R144's care plan did not address R144's bowel or bladder incontinence and did not identify an individualized toileting program.

R144's bladder assessment dated 3/1/21, identified R144 had overflow incontinence. The area for recommendations was left blank.

R144's record lacked evidence the facility assessed and/or evaluated R144's voiding/bowel patterns in order to determine appropriate management program.

During an observation and interview on 3/18/21, at 7:19 a.m. R144 laid awake in her bed with nursing assistant (NA)-E and NA-F at bedside. NA's removed incontinent brief that was saturated with urine. NA-E stated it was an overnight brief and indicated it held more urine.

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NA-E and NA-F stated R144 was always incontinent of both bladder and bowel. NA's completed morning cares and transferred R144 to her chair at 7:45 a.m., a pillow was placed along the side of R144's right side for positioning. Neither NAs offered and/or attempted to put R144 on the toilet.

During a continuous observation that began at 7:45 a.m. and was completed at 11:15 a.m. R144 remained in her wheelchair in the same position; R144 was not offered toileting and/or her incontinent garment was checked for incontinence.

During an interview on 3/18/21, at 11:03 a.m. registered nurse (RN)-E was informed R144 remained in the same position since 7:45 a.m. RN-E stated that was too long not to be repositioned or checked and would have the nursing assistants go reposition and check on her.

During an interview on 3/18/21, at 11:07 a.m. NA-F confirmed R144 had been sitting in the same position since 7:45 a.m. this morning and had not been repositioned or toileted. NA-F stated residents were supposed to be repositioned, offered toileting, or checked and changed every two hours. NA-F stated R144 was not offered toileting and/or repositioned because the unit was busy and hadn't been able to reposition or offer toileting. NA-F indicated staff were not always able to get to residents when they needed to because there wasn't enough staff.

During an interview on 3/19/21, at 9:31 a.m.

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F 690	Continued From page 56	F 690		

RN-C indicated R144 should have been toileted/checked at least after two hours. RN-C indicated R144 was always incontinent of both bladder and bowel. RN-C reviewed R144's record and confirmed the record lacked a comprehensive bowel/bladder assessment and the care plan lacked identification of R144's incontinence. RN-C stated upon admission residents were put on a 72 hour voiding/bowel diary that was used to determine a toileting and/or check and change schedule in addition to the bowel/bladder assessment and the 72 hour toileting diary. RN-C referenced R144's record, and stated the diary was not completed and should have been.

During an interview on 3/22/2021, director of nursing (DON) said expectation that bowel/bladder assessments that included the 72 hour toileting diary be completed upon admission. DON indicate the information was then analyzed to develop and an individualized care plan for toileting.

Facility Policy Bowel and Bladder Assessment, Evaluation, and Retraining dated 12/11/2020 included; Based on the resident's comprehensive assessment the location will ensure that each resident with bowel or bladder incontinence will receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. Every new resident will be observed for 72 hours for bladder and bowel incontinence and then evaluated for feasibility in retraining for bladder and bowel control. The policy indicated based on the 72 hour data collection and other factors affecting incontinence. Determine the appropriate toileting

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F 690	Continued From page 57 program. The policy indicated the toileting program should be in the care plan along with individualized interventions.	F 690		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure adequate nursing staff to ensure necessary assessments	F 725	F725 Sufficient Staffing 1.& 2. All residents have the potential to	4/30/21

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F 725	Continued From page 58 were completed in order to determine and provide the appropriate care and treatment of pressure ulcers, non-pressure related skin injuries, edema management, and accurate transcription of medications to prevent significant medication errors. In addition, the facility failed to ensure adequate staffing to ensure therapy restorative/maintenance were provided to residents and failed to ensure adequate staff for housekeeping. Findings include: The facility identified there was not always enough staff to complete the expected restorative services that were recommended by therapy. SEE F676 The facility failed to ensure comprehensive skin assessments and monitoring were completed, in addition failed to complete dressing changes per physician orders for 1 of 1 (R144) resident who had a daily dressing change. Furthermore, the facility failed to monitor and evaluate edema. SEE F684 The facility failed to assess pressure ulcer risk factors for 1 of 1 resident and failed to identify stage I pressure ulcers, failed to assess and monitor pressure ulcer, failed to assess and develop individualized re-positioning program to prevent and/or reduce the risk for pressure ulcers, and failed ensure timely repositioning for 1 of 1 residents who was at risk for pressure ulcers who had moisture related skin damage. SEE F686 The facility failed to complete a comprehensive	F 725	be affected. 3. Staffing and delegation of duties have been reviewed and updated to ensure that necessary assessments are completed, therapy restorative/maintenance is provided to residents per functional maintenance plans and housekeeping has been adequately staffed. Systematic changes in nursing structure have been implemented to include having the nurse manager or designee do the order entry for new admissions and physician rounding. Charge nurses will be responsible for completing assessments timely and accurately with assistance from leadership as needed. Restorative nursing program has been revamped to include care planned approaches that will be completed by nursing and activity staff that meet the individual resident's needs for restorative care. Housekeeping Supervisor has created a daily cleaning task list with designated duties by discipline that will be completed by housekeeping, maintenance, and nursing staff as appropriate. Training will be completed by Administrator, DNS and Environmental Services Director for all staff on the above-mentioned process changes by 4-30-21. 4. Audits will be conducted by Administrator or designee to ensure order entry is being done accurately,	

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F 725	Continued From page 59 assessment in order to determine an individualized toileting program, and failed to provide timely toileting/check and change for 1 of 1 residents who had urinary incontinence. SEE F690 The facility failed to ensure residents were free from significant medication errors. SEE F760 Facility Assessment was not dated. Facility Assessment identified the facility had 44 residents bed. Population of residents was identified which included but was not limited to, 14 residents who had diagnosis of congestive heart failure, 9 residents who had diagnosis of diabetes, 9 residents who had diagnosis of Alzheimer's Dementia, 11 residents with anxiety disorder, 21 residents with depression, and 10 residents with respiratory conditions. The resident assessment also identified 30 resident required extensive assistance for bed mobility 20 of those required two staff, 26 residents required extensive assistance for transfers 16 of those required two staff assist, 33 residents for dressing required extensive assist 14 of those required extensive assistance from 2 staff, for toileting 31 residents required extensive assistance 20 of those required assistance from 2 staff. Facility assessment did not identify a staff planning and/or formula to determine staffing needs, minimum staffing need was not identified. The assessment indicated the facility had appropriate staffing to meet the needs of the residents. In response to the question on the form "How do you staff to meet acquity [sic] and needs of residents" the typed answer was "Assess and staff appropriately." The assessment further identified, "All departments	F 725	assessments are completed timely, restorative nursing programs are completed as care planned and cleaning tasks have been completed. These audits will be done weekly X 3 then monthly X 2 with results taken to Quality Committee for further recommendations. 5. 4/30/21	

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utilize block schedules to ensure reasonable consistent staffing." In response to question "If continuity of care is not established, what is the plan to improve tools and processes to ensure continuity of care for residents?" the typed answer was "n/a [not applicable].

During an interview on 3/19/2021, at 3:02 p.m. scheduling coordinator (SC) stated she could staff up to two aides per day. SC stated the staffing goal for day and evening shift was one aide and one nurse per unit. Otherwise would take as many people as possible to get up to the allowed staff per unit. SC stated always try to get a float so that it would be 1.33 aides per unit for day and evening shift. SC indicated staff levels were not based on acuity, the amount of staffing did not change if census went up or down or the level of care residents required. SC stated if there was a restorative aide scheduled they help on the floor, and when there was only one aide and one nurse, the nurse would help the aides with resident care.

Resident interviews
During an interview on 3/22/2021, at 9:24 a.m. unidentified facility resident (UFR)-1 stated the staffing is pretty bad, "from 2:30 p.m. to 4:00 p.m. we don't even have an aide, it's just a nurse." UFR stated she often times has to wait 15-20 minutes to have her call light answered to request a pain pill then it takes another 20-20 minutes to get the pain pill. UFR-stated "I am afraid they are so overworked that they are quitting."

During an interview on 3/16/2021, at 4:01 p.m. R6 stated she has had to wait a long time, like 30

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minutes, to get help to go to the bathroom, and as a result couldn't hold her urine, was incontinent and wore pads. R6 indicated all shifts seemed busy, right now there was not a nursing assistant until 5:00 p.m. on this unit. R6 stated on the weekends, staff was terrible, and there was not hardly anyone working.

During an interview on 3/16/2021, at 6:40 p.m. family member (FM)-D stated the facility did not have enough staff especially on the weekends. FM-D stated she has been here when her family member has had to wait for cares. FM-D stated it seems that there is no one around and residents are left on their own. FM-D was not able to articulate specific dates when she thought there wasn't enough staff.

During an interview on 3/17/2021, at 9:34 a.m. R11 indicated there was not enough staff, had to wait sometimes to get help. R11 stated she has had to scream to get help.

Interviews were conducted throughout the survey with multiple staff who wanted to remain anonymous related to fear of retaliation from administration. Date, time, and titles were intentionally omitted.

During an interview unidentified staff member (USM)-1 stated the staffing was absolutely horrible. USM-1 stated for day and evening shift the units were staff with one nurse and one aide. For night shift it varied, two nurses and two aides, or one nurse and one TMA; it doesn't work to only have one nurse for the whole building, they are usually down in the rehab unit. We are lucky if we get an aide to float on days and

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evenings; then it was only for 4 hours. The float person can't keep up and often doesn't have time to help on all the units. USM-1 stated as a result of only having 1.33 aides scheduled during the day and evening shifts the nurses are on the floor helping the aides answer lights and providing direct care. USM-1 stated because the nurses are on the floor, assessments are not getting done like they should be "it's completely a time issue", care plans are not getting revised, treatments are not getting done, medications are not getting passed on time, and orders are not getting transcribed accurately. The facility does not allow for overtime. "The nurses are continuously getting interrupted to help provide resident cares which contributes to the medication error rate. It's a domino effect. Basically the nurses don't have time to get done do what they need to do within there scope" USM-1 because there was only one nurse and one aide on units, repositioning and toileting is not being done. USM-1 stated the facility hires new staff, but because we are short, there is not adequate time for training and the new staff don't last because they don't want to work short "nurses are too busy to properly train and orientate staff."

During an interview USM-2 indicated there was not enough staff. USM-2 stated during the day and evening there was only one aide and one nurse scheduled for each unit. "The staffing level never changes no matter how many residents are here or how heavy of cares they have." USM-2 stated the staff have asked for more staff however administration says that the facility is staffed according to the state regulations. USM-2 stated a lot of the nurses were really good about

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helping out on the floor but then wound assessments were not getting completed, dressing changes are not getting done, nurses can't do what they need to do. USM-2 stated medications were not being administered on time, and because of continuous interruptions thought that medications were not transcribed accurately causing medication errors. USM-2 stated routine documentation and monitoring isn't getting done and there was a lack of communication because there was not time. USM-2 stated administration scolded us for not having things done the way they should do, however administration has not come up with a fix to resolve the root cause of not enough staff.

During an interview USM-3 stated during the day and evening shift there was only one nurse and one aide scheduled, stated sometimes a float person. USM-3 the schedule never changes according to how many residents are in the building or how much care they required. USM-3 stated when there was a float nursing assistance scheduled it was better, but the float could not always get around to help on other units. USM-3 stated nurses had to help on the floor a lot and weren't able to get their work done. USM-3 stated when residents required two assist for cares, the nurse is pulled and the residents had to wait. When residents wait, sometimes they were incontinent and would not have been. USM-3 stated sometimes residents were not getting repositioned on time and their baths were not getting done per their preference.

During an interview USM-4 stated staffing was horrible here, there is no time to get everything done. USM-4 stated the day and evening shift

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was only staffed with one nurse and one nursing assistant; about 90% of the time there was not a float scheduled. USM-4 indicated the nurses had to assist NAs with resident care, there was a lot of two assist residents. USM-4 stated residents get upset because they have accidents because we can't get to them on time. USM-4 stated documentation was not being completed because there was not time for that. USM-4 indicated the housekeeping was impossible to get done but the facility expected nurses/NA's to do that too. USM-4 stated when staff were hired, they didn't last because there was no time for training and because of our staffing levels.

During an interview USM-5 stated the facility was short staffed, during the day and evening shifts there is usually only one aide and one nurse on each unit. USM-5 stated residents have to wait a longer than they should to have their call lights answered. USM-5 stated a lot of residents are two person assist and she had to run all over the building to try and find help. USM-5 stated "sometimes there's an increase in incontinence as a result of only having one person." USM-5 stated we have asked administration for more staff, they tell told we have enough staff, and there hasn't been anything done to improve staffing levels. USM-5 stated staff were not able to accommodate resident choices such as providing baths when residents want or they get showers instead of whirlpools.

During an interview on 3/19/2021, at 1:37 p.m. clinical learning and development specialist (CLDS) indicated he was responsible for providing education to staff and assisted with medication audits to help with quality assurance

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activities. CLDS stated the facility "had a lot of medication transcribing errors coming in." CLDS indicated the errors happened in the rehab unit. CLDS indicated when he watched nurses transcribe medication into the record, the nurse was interrupted once. CLDS stated when the nurse came back she had to start all over again from the beginning. CLDS stated the standard when transcribing medications is "avoid all interruptions" and indicated interruptions increase the risk for errors, back in the rehab unit there was a "high need" cliental, one nurse and one aide, made interruptions likely unavoidable. When asked how the facility could avoid interruptions when nurses are transcribing medications, CLDS stated "staffing pattern changes, add a CNA [certified nursing assistant], might be better". CLDS stated that a recommendation to add staff had been made to administration.

During an interview on 3/22/2021, at 12:50 p.m. director of nursing (DON) was asked, "How do you determine staffing levels? DON responded that during the day at bare minimum there is one nurse and one NA per unit, and a lot of times there was a float that would go in-between neighborhoods. DON was then asked, "How do you know where to send the float to?" DON responded, "through word of mouth from staff." DON stated the facility was union, staff had block schedules so some days there was more staff than others because of their union contract. DON stated the facility would cut hours if the census was low or send the person the area of need. DON indicated the facility did not staff to acuity, stated an unawareness of how to determine acuity levels of the residents that resided in the

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F 725	Continued From page 66 facility, stated there the facility did not have evidence staffing levels based on acuity level of residents. DON indicated an unawareness of the facility's assessed baseline staffing needs, and could not articulate staffing hours per resident day. DON stated the facility has made efforts to hire more nursing assistance; DON indicated two new staff would be starting within the next week. During an interview on 3/22/2021, at 1:32 p.m. administrator provided the facility assessment that included the facility's resident population into categories of diagnoses classes and amount of assistance. Administrator was asked if the facility assessment identified staff levels based on the resident population, administrator said every morning there was an interdisciplinary team meeting where the team reviewed needs of residents daily and staff were moved around. During an interview on 03/17/21 at 09:42 a.m., NA-C stated that almost all residents have a restorative program. NA-C stated she ideally works restorative aide duties daily but there has been staffing issues. NA-C stated there is usually 2 aides scheduled to work the floor but lately only 1 so has to float or work as second aide on the floor and is not able to work as restorative aide. During an interview on 03/18/21 at 08:47 a.m., R8 stated it depends on staffing whether restorative aide comes a couple times a week.	F 725		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis:	F 732		4/30/21

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F 732	Continued From page 67 (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure the posted nursing hours were updated when there was a change to staffing levels. The affected all	F 732	F732 Posted Nurse Staffing Information 1. On 4/12/2021, the facility posted the Nurse Staffing Information at the front desk to show the facility name, current	

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F 732	Continued From page 68 residents who resided at the facility. Findings include: During an observation on 3/16/2021, at 12:45 p.m. the Daily Staffing hours were posted in the main entrance area visible to all residents and visitors. The Daily Staffing hours form was reviewed in conjunction with staff schedules from 2/1/2021 to 3/19/21, the forms consistently lacked revision when the staff schedule changed. During an interview on 3/19/21, at 3:02 p.m. scheduling coordinator (SC) stated she was responsible for completing the nursing schedule and, for completing and posting the nursing hours. SC indicated an unawareness that the nursing hours had to be changed if there was reduction/addition to nursing hours for the resident's reference. SC stated she completes the nurse staffing hours every morning and takes the other one from the previous day down and throws it away because there is an electronic copy. SC indicated the paper posting and the electronic version were not changed when there was a change in the schedule such as when staff were added, sick calls, or when staffing was reduced related to low census.	F 732	date, total number and actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift. It was updated to reflect changes on 4/12/21. 2. All residents who reside in the facility have the potential to be affected. 3. The Director of Nursing will provide education to the scheduler and nurse managers on the requirements of the Nurse Staffing Information. All nurses will be educated by the DON or designee on the requirements of the posting of the Nurse Staffing Information and ensuring it is updated as changes in census or staffing occurs and who is designated to be responsible for making those changes each shift. 4. The Director of Nursing or designee will audit the Nurse Staffing Information posting 3 times weekly x 4 weeks then monthly x 2 to ensure compliance with posting requirements. Results of each audit will be reviewed in monthly QA committee meetings for further recommendations. 4. 4/30/21	
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any	F 757		4/30/21

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F 757	Continued From page 69 drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to offer and/or provide non-pharmacological interventions prior to administration of as needed (PRN) pain medications for 1 of 5 (R41) residents reviewed for unnecessary medications. Findings include During an interview on 3/18/21, at 1:24 p.m. R41 sat in her wheelchair in her room. When asked if she had any questions or concerns about any of the medication she was administered, R41 stated "I think I am getting too much oxycodone, but I'm not sure." R41 stated was prescribed oxycodone during hospitalization for kidney infection and had lower flank pain. R41 indicated she had to ask	F 757	F757 Drug Regimen is Free from Unnecessary Drugs 1. Non-pharmacological interventions were added to R41□s care plan. Prompt to Attempt non-pharmacological pain intervention before administering PRN narcotic pain medication added to eMAR. 2. All residents who experience pain and have orders for PRN pain medication have the potential to be affected. A review of all residents who are prescribed PRN narcotic pain medication and a review of their care plans for non-pharmacological interventions will be completed by 4/23/21.	

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F 757	Continued From page 70 for the pain medication because it was PRN, but didn't know if she was getting the right kind or the amount. R41 stated she would ask for pain medication before therapy and before she went to bed. R41 stated staff had not talked to her about different ways should could use the Tylenol in conjunction with the Oxycodone and/or non-medicinal ways of relieving pain. R41 indicated she would just ask for the oxycodone because that's what she thought she was supposed to do. R 41 face sheet, identified R41 was admitted to the facility on 2/18/21 with diagnoses that included urinary tract infection, cyst of the kidney, paraplegia, and multiple sclerosis. R41's admission Minimum Data Set (MDS) assessment dated 2/23/21, identified R41 did not have cognitive impairment and did not have rejection of care behaviors. The pain assessment portion of the MDS was not completed however, identified R41, received scheduled pain medication, received PRN pain medication, and received non-medication interventions for the pain. The MDS further identified R41 was administered opioid pain medication during the assessment period. R41's care plan dated 2/18/2021, included: The resident has chronic back pain related multiple sclerosis evidenced by muscle spasms. Has an implanted Baclofen pump. The interventions included: -Resident is able to: call a for assistance when in pain, ask for medication, tell you how much pain is experienced, tell you what increase or alleviates pain	F 757	3. Policy Pain Management will be reviewed by the DON or designee with all nurses and trained medication aides by 4/30/21. 4. Audits will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and monthly x 2 ensure non-pharmacological interventions are being attempted before PRN narcotic pain medication administration. Audit results will be brought to the monthly QA meeting. 5. 4/30/21	

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F 757	Continued From page 71 -Evaluate the effectiveness of pain interventions. Review for compliance, alleviating of symptoms, dosing schedules and resident satisfaction with results, impact on functional ability and impact on cognition. -Monitor and document side effects -"PAIN: Attempt non-pharmacological interventions (SPECIFY)." R41'S care plan did not "specify" individualized non-pharmacological pain interventions. R41's physician orders included, Acetaminophen 1000 milligrams (mg) every six hours as needed for pain (start date 2/18/21) Oxycodone (opioid pain medication) 10 mg every four hours as need for pain for 14 days (start date 3/10/21) The physician orders did not identify parameters and/or direction for administration and did not address if the analgesics were for acute pain/chronic pain/or for location of pain. R41's eAdmin (electronic medication administration) dated 3/15/2021, at 2:45 p.m. indicated R41 was administered 10 mg of Oxycodone, MAR indicated pain level of 8. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered. R41's eAdmin note dated 3/15/2021, at 9:40 p.m. indicated R41 was administered oxycodone 10 mg, MAR indicated pain level of 9. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions	F 757		

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were attempted or offered.

R41's eAdmin note dated 3/16/21, at 7:51 a.m. indicated R41 was administered oxycodone 10 mg, MAR indicated pain level of 7. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered.

R41's eAdmin note dated 3/17/21, at 8:09 a.m. indicated R41 was administered oxycodone 10 mg, MAR indicated pain level of 4. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered.

R41's eAdmin note dated 3/17/21, at 8:01 indicated R41 was administered oxycodone 10 mg, MAR indicated pain level of 7. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered.

R41's eAdmin note dated 3/18/21, at 7:07 a.m. indicated R41 was administered oxycodone 10 mg, MAR indicated pain level of 0 (zero). A subsequent note at 8:25 a.m. indicated the medication was effective with a pain level of 6. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered.

R41's eAdmin note dated 3/18/2021 at 7:55 p.m. indicated R41 was administered oxycodone 10

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F 757	Continued From page 73	F 757		

mg, MAR indicated pain level at 7. The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered.

R41's eAdmin note dated 3/19/2021, at 7:15 a.m. indicated R41 was administered oxycodone 10 mg "per resident request", MAR indicated pain level of 0 (zero). The record did not specify location of R41's pain, what aggravates or alleviates pain, and lacked evidence non-pharmacological interventions were attempted or offered.

During an interview on 3/19/21 at 9:54 a.m. registered nurse (RN)-C reviewed R41's record and confirmed R41's care plan did not identify individualized non-pharmacological interventions, and the notes did not include location of pain, nor evidence non-pharmacological interventions were attempted or offered. RN-C indicated the documentation should include the pain location, pain level, and attempts made and/or offered of non-pharm interventions and the effectiveness of those interventions.

During an interview on 3/22/2021, at 10:27 a.m. director of nursing (DON) stated an expectation the care plan include non-pharmacological interventions be identified, and a pain assessment be completed prior to the administration of PRN pain medication. DON indicated non-pharmacological interventions should be attempted prior to the administration and documented which interventions was attempted and the effectiveness.

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F 757	Continued From page 74 Facility policy Pain Management dated 11/10/2020, included in the Purpose statement: To use non-pharmacological interventions as identified by the resident to promote comfort. Non-pharmacological interventions should be attempted first; however, in the event they are not successful, they may be combined with pharmalogical regimen. Develop a care plan including pain focus, goal, and interventions, including non-pharmacological interventions that allow documentation.	F 757		
F 760 SS=E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to prevent and/or reduce the risk for medication transcription errors in the electronic health record (EHR) which resulted in a pattern of significant medication errors for 8 of 8 resident (R27, R148, R94, R149, R97, R98, R95, R41, R33, and R147) significant medication errors reviewed Findings include During review of the facility's significant medication errors a transcription trend/pattern was identified. Although the residents did not suffer serious outcomes the facility failed to put a sustainable system in place to reduce the root cause of interruptions which put residents at continuous risk for significant medication errors with the potential to result in a serious outcome	F 760	F760 Residents are Free of Significant Med Errors 1. R27 □ incident was reported to OHFC on 4/11/20, thorough investigation was conducted, error was corrected, corrective action was issued to the nurse making the medication error. R148 □incident was reported to OHFC on 4/28/20, thorough investigation was conducted, error was corrected, corrective action was issued to the nurse making the medication error. R94 □incident was reported to OHFC on 10/15/20, thorough investigation was conducted, error was corrected, corrective action was issued to the nurse making the medication error, new end of shift checklist was implemented. R149 □incident was reported to OHFC on	4/30/21

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F 760	Continued From page 75 adverse outcome. R27 R27's facility face sheet indicated R27 had diagnosis of atrial fibrillation. R27's anticoagulant clinic physician order included, Coumadin 5 mg today (4/7/2020); then Coumadin 3.75 mg Tuesday, Thursday, and Saturday; 2.5 mg all other days of the week. R27's physician orders identified the aforementioned order, however identified the start date for the 2.5 mg dose as 4/27/2020. R27's medication administration record (MAR), identified R27 was not administered Coumadin on 4/8 and 4/10/2021. R27's Medication Error report dated 4/11/2020, included "Noticed 2 Coumadin pills [anticoagulant medication] still in bubble pack that did not have signatures by them. Looked up Coumadin order and noticed the start dated and the stop date for the 2.5 mg [milligram] dose was not supposed to start until 4/27/21. That is also the date the Coumadin was to be stopped." The report indicated the nurse manager, director of nursing, and pharmacy; in addition INR (international ratio- lab test that measures viscosity of blood) was 1.2. Facility Reported Incident (FRI) reported to the State Agency on 4/11/21, included "During medication pass on 4/11/20, [name of nurse] observed [R27] may not have received Coumadin 2.5 mg on 4/8/20 or 4/10/20. No adverse effects noted. Physician notified. Internal investigation initiated. The investigative summary	F 760	8/14/20, thorough investigation was conducted, error was corrected, corrective action was issued to the nurse making the medication error. R97 □incident was reported to OHFC on 8/22/20, thorough investigation was conducted, error was corrected, training was done with all nurses and trained medication aides. R98 □incident submitted to OHFC on 12/5/20, thorough investigation was conducted, error was corrected, corrective action was issued to the nurses making the medication error, nurses audited x 2 weeks. R95 □incident reported to OHFC on 3/2/21, thorough investigation was conducted, error was corrected, new folders were placed at the desk that were labeled ATTENTION NURSING: This folder contains new orders. Providers: Please place new orders in this folder. 2. All residents who take medications have the potential to be affected. 3. Education on transcribing medication orders will be done with all nurses by 4/30/21. The DON or designee will ensure staffing is adequate to meet the needs of residents and duties will be reorganized to ensure workload is appropriate. 4. Audits will be conducted by the Quality Assurance Coordinator or designee weekly x 4 and monthly x 2 to ensure accurate order transcription. Audit	

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F 760	Continued From page 76 dated 4/17/2021, indicated a nurse had entered the start date of the Coumadin 2.5 mg tablets as 4/27/21 and end date 4/27/20, when the start date should have 4/7/20 and the end date should have been 4/27/20 as 4/27/20 was when the next INR was originally ordered. The report indicated R27's INR was obtained on 4/11/20 and was 1.2. The action taken to prevent reoccurrence was "orders correctly entered in Point Click Care (electronic health record system), corrective action, which included re-education and direction to the nurse that made the transcription error to double check Coumadin orders when entering and have another verify the order." The facility lacked evidence of ongoing audits of the double check system for transcription accuracy. R148 R148's facility face sheet indicated R148 had diagnosis of history of stroke and hypertensive kidney disease. R148's hospital discharge medication list dated 4/16/2020, included order for Aspirin 81 mg twice a day for 35 days until May 21, then resume 1 tablet daily. R148's facility physician orders did not include the order for Aspirin; medication administration record identified R148 did not receive Aspirin as prescribed. R148's Medication Error report dated 4/28/2020, included "Transcription error noted." Order on admission read: ASA [aspirin] MG give 1 tablet twice daily for 35 days, then change to once	F 760	results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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daily. It was entered as Aspirin 81 MG give 1 tablet daily, but with a start date of 5/22/2020. No Aspirin has been given since admission. Immediate action taken was reported to pharmacy and vitals taken, and order corrected.

FRI submitted to the state agency on 4/28/2020, included the aforementioned medication error and indicated the pharmacist had identified the error during medication review. The report indicated no adverse reactions as a result. The investigative summary dated 5/5/2020, indicated that the orders for the twice a day dose was not entered in the EHR and the order for once daily aspirin with the wrong start date. The summary indicated R148 missed 24 doses of aspirin, however, ultimately the error acted in favor of the resident because on 4/30/2020, R148 was admitted to the hospital for a gastrointestinal bleed. The action taken to prevent reoccurrence indicated rehab nurse manager "do a third check on orders for new admissions to prevent a similar error, and the director of nursing "spoke with nurse responsible for error on 5/4/2020."

The facility lacked evidence of ongoing audits of the third check system for new admission for transcription accuracy. .

R94
R94's facility face sheet indicated R94 had diagnosis of paroxysmal atrial fibrillation and chronic kidney disease.

R94's faxed physician orders dated 10/7/2020, included 1. Increase Lasix (diuretic medication) to 40 mg twice per day.

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R94's electronic physician orders identified the order was not transcribed into the electronic health record (EHR) until 10/14/2020. R94's EHR identified an order for

R94's medication administration record (MAR) had the physician order for Lasix 40 mg once daily, that had a stop date of 10/14/2021, and identified R94 was only administered the Lasix 40 mg once daily from 10/7 to 10/13.

R94's weight record that was reviewed identified a weight gain prior to the physician prescribing an increase to Lasix;
On 9/28/2020, weight was 208.4 lbs.
On 9/29/2020, weight was 211.8 lbs.
On 10/1/2020, weight was 213.4 lbs.
On 10/5/2020, weight was 214.4 lbs.

R94's Medication Error Report dated 10/15/2020, indicated the physician "wrote on his orders on 10/14/2020 that he had sent orders on 10/7/2020 to increase Lasix to 40 mg twice a day and that it appears it was missed and the is still taking 40 mg once a day. He wrote if that is the case to see the following order: increase Lasix to 40 mg BID [twice per day]. The report indicated upon review the order from 10/7/2020 was not transcribed into the orders. R94 received Lasix 40 mg once per day from 10/7 to 10/14/2020. Immediate action taken indicated R94 changed from being checked weekly to daily.

FRI submitted to the State Agency on 10/15/2020, identified the aforementioned medication error, with the immediate action of verification of the correct order was entered into EHR with another nurse. The investigative

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summary dated 10/21/2020, indicated the physician order was "noted" by (name of nurse) however was not transcribed into the EHR. R94 missed 6 doses of the Lasix, weight remained stable, and no adverse side effects. The action take to prevent reoccurrence included, "corrected order in Point Click Care also updated end of shift checklist and added a "new orders" section as a "double check" section for Rehab Unit. Education give to the nurse making the error" Education provided to the nurse included, "Discussed importance of minimizing interruptions when noting and entering orders."

The facility lacked evidence of completed audits of the checklist as a double check system for transcription accuracy.

R149

R149's face sheet indicated R149 had diagnosis paroxysmal atrial fibrillation and congestive heart failure.

R149's faxed physician order dated 8/12/2020, included "continue to hold Eliquis [apixaban] for now."

R149's electronic physician orders identified the order; Apixaban give 5 mg by mouth two times a day, "hold" the medication from 8/3 to 8/6 and from 8/6 to 8/13/2020. Medication administration record identified the Apixaban 5 mg at bedtime on 8/13, and the morning dose was administered on 8/14/2020.

R149's Medication Error report dated 8/16/2020, included "Order states to continue to hole

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apixaban. Nurse read continue apixaban. Apixaban was on hold so nurse took med off of hold Thursday. Resident was given two doses of apixaban. During doctor rounds on Friday with nurse practitioner apixaban was discussed and nurse realized mistake and discontinued medication by verbal order.

FRI submitted to the State Agency on 8/15/2020, included the aforementioned error and R149 did not suffer any adverse side effects. The investigative summary was not provided. Review of the education provided to four nurses and individual re-education to nurse responsible for error indicated education was provided pertaining to use of the double check system with a 2nd nurse and avoid interruptions and take time when entering orders.

The facility lacked evidence of completed audits of the double check system for transcription accuracy.

R97
R97's facility face sheet indicated R97 had diagnoses that included dysphagia, diabetes, and chronic kidney disease.

R97's hospital discharge summary dated 8/5/2020, included "Stop taking sodium zirconium cyclosilicate 10 gram powder packets for hypokalemia."

Review of R97's physician ordered identified the Sodium zirconium cyclosilicate was on hold until 8/5/2020, the order to discontinue the medication was per the hospital discharge summary was not transcribed into the EHR. Medication

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administration record identified R97 was administered the medication on 8/7 through 8/22/2020.

R97's Medication Error report dated 8/22/20/2020, included "Resident medication sodium zirconium cyclosilicate 10 grams daily was placed on hold on 8/18/21 for 5 days, resident was sent to hospital on 7/31/2020, came back on 8/5/2020 medication was to be stopped per discharge paperwork from the hospital, order was not discontinued, order was not resumed either. The medication was kept on hold. The order resumed itself on 8/6/2020 after 5 days of being held. Medication was administered on 8/7-8/22." Immediate action taken was notification to provide, medication was discontinued, DON, administrator, and resident were notified.

FRI submitted to State Agency on 8/23/2020, included the aforementioned medication error, immediate action taken was notified provider and medication was discontinued. The investigative summary dated 8/28/2020, reiterated how the medication was not transcribe correctly upon hospital return, physician discontinued to medication for potassium level of 3.9 (normal level) labs were also ordered for 8/26/2020. Action taken to prevent reoccurrence was "med error education to be provided to all nurses specifically regarding when medication should be put on hold and when they should be discontinued.

Facility provided evidence of re-education to nurses and trained medication assistants on 9/20/2020, that included "There have an increase

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in medication errors especially those involving anticoagulants or new orders not being noted/put into the computer" and "We are having too many medication errors where the physician is sending them, nobody is noting them, or putting them on the computer. It is everyone's responsibility to be checking faxes throughout your shift. Remember they are time stamped. I will be looking closely at what time they are being faxed back and when they are actually received."

The facility lacked evidence of ongoing audits for transcription accuracy.

R98
R98's facility face sheet indicated R98 had diagnosis of diabetes

R98's faxed physician order dated 12/3/2021, included 2. Sliding scale Novolog insulin 10 units subq based on q.i.d. (four times a day) glucose check: For glucose less than 200: no insulin, 201-250: 2 units, 251-300: 4 units, For 201-350: 6 units, for 351-400: 8 units, for glucose over 400: 10 units.

R98's electronic physician orders was not consistent with the faxed physician order in that the EHR physician order identified the correction scale but only for three times a day instead of four.

R98's blood sugars were reviewed and identified blood sugars were checked at bedtime however, according to the medication administration record insulin was not administered to correct the blood sugar because of the transcription error.
-On 12/3 at 8:43 p.m. blood sugar was 373; R98

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should have received but was not administered 8 units of insulin.
-On 12/4 at 9:14 p.m. blood sugar was 389; R98 should have received but was not administered 8 units of insulin.

R98's Medication Error report dated 12/5/2021, included "Error found in transcription of Novolog sliding scale order. Novolog sliding scale was transcribed by nurse to administer sliding scale TID [three times per day], physician orders from Dec 3 2020 read #2. "sliding scale Novolog insulin subcu [sic] based on q.i.d [four times a day] glucose checks." Immediate action taken; orders updated in HER to reflect sliding scale Novolog based on q.i.d glucose checks.

FRI submitted to the State Agency on 12/5/2020, identified the aforementioned medication error. The report indicated R98 potentially missed two bed time doses of Novolog on 12/3 and 12/4, no adverse side effects, and R98 had not shown symptoms of hyperglycemia. Immediate action taken was order corrected and nurse suspended pending investigation. The investigative summary on 12/11/21, indicated the order was not transcribed correctly into the EHR, "transcription error occurred because Novolog sliding scale is typically only ordered three times daily. It is not usual for sliding scale Novolog to be ordered at bedtime." Action to prevent reoccurrence included corrective action given to nurses who made the error, nurses who made the error were observed passing mediation once per week for two weeks. Both nurses were re-educated on polices and procedure regarding medication administration and order entry. Facility provided education to 7 nurses that included minimizing

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F 760	Continued From page 84 interruption during medication transcription. Although the nurses were audited for two weeks for order entry, the facility lacked evidence of ongoing audits and/or monitoring. R95 R95's facility face sheet indicated R95 had diagnosis of cerebral infarction (stroke). R95's physician orders included Heparin 1 ml [milliliter] (anticoagulant medication) every 12 hours for cerebral infarction, order start date 2/23/2021. R95's hand written physician order dated 2/26/2021, included discontinue heparin. R95's medication administration record identified R95 was administered heparin twice a day from 2/26/2021 to 2/28/21, and the morning dose on 3/1/2021. R95's Medication Error report dated 3/1/2021, included "Orders from 2/26/2021 found on desk for heparin to be discontinued." The report indicated the immediate action take was that the nurse manager, DON, physician and resident notified of error. Order changed immediately. FRI reported to the State Agency on 3/1/2021, indicated a nurse found an order to discontinue heparin left at the nurse's station by the nurse practitioner on 2/26/2021; nurses were not aware the order had been left by NP. R95 received 6 doses of heparin. "Provider reports that she had written orders to discontinue the medication after 14 days since the patient was more mobile.	F 760		

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F 760	Continued From page 85 States, "Not a big deal at all." No new orders." Investigative summary dated 3/9/2021, indicated the NP had completed physician rounds on 2/26/2021, left new orders, but did not communicate them with nursing staff. No adverse side effects resulting from error. Action to prevent reoccurrence indicated a clearly labeled folders for new orders were placed at nursing stations. Facility lacked evidence of audits/monitoring for receipt and transcription of medication orders R147 R147 facility face sheet identified R147 was admitted to the facility on 3/4/2020, with diagnoses that included atrial fibrillation. R147's anticoagulation clinic faxed order dated 3/12/2020, included "Bridging with Enoxaparin needed: Yes, Continue Enoxaparin 40 mg SQ daily". R147 EHR physician's orders included the aforementioned order however, the start date was not until 3/15/2021, Medication administration record identified R147 did not receive the Enoxaparin on 3/13 and 3/14/21. R147's Mediation error report dated 3/15/2020, included "Transcription error. Enoxaparin not transcribed so resident missed enoxaparin dose on 3/13 and 3/14 as a result. Immediate action taken was original order located and corrected in the EHR. A subsequent medication error report dated 3/16/2020, indicated Lovenox had been administered even though the order was in the medication que awaiting 2nd nurse verification of order accuracy.	F 760		

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FRI submitted to the State Agency included, "On 3/15/2021 at approximately 1:30 p.m. [name of nurse] noted that [R147's] last orders form the anticoagulation clinic were entered incorrectly and one order was omitted. Enoxaparin 40 mg SQ daily was supposed to be continued per physician orders on 3/12/21 however, this order was not entered in the eMAR [electronic medication administration record]. He missed 2 doses of enoxaparin on 3/13 and 3/14/21. He did receive Warfarin per orders. The investigative summary was not completed at the time of survey.

During an interview on 3/19/21, at 10:33 a.m. registered nurse (RN)-E indicated she was the one who made the medication error with the Enoxaparin for R147. RN-E articulated the double check system with the second nurse, third check was an honor system. RN-E stated she was going to put the order, however was interrupted, got busy and forgot about it. RN-E stated that medications sat in the que because nurses didn't always check or weren't aware medications were in the que waiting to be verified, RN-E stated there were times when it was too difficult to find another nurse to verify orders so nurses were not using the second nurse check system to verify order entry accuracy.

During an interview on 3/19/2021, at 1:37 p.m. clinical learning and development specialist (CLDS) indicated he was responsible for providing education to staff and assisted with medication audits to help with quality assurance activities. CLDS stated the facility "had a lot of

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medication transcribing errors coming in." CLDS indicated the errors happened mostly in the rehab unit with the root cause of interruptions during transcription. CLDS indicated the interruptions was the result of not enough nursing assistants and nurses pulled away to assist with resident care. CLDS indicated when he watched nurses transcribe medications into the record, the nurse was interrupted once to assist with a resident. CLDS stated when the nurse came back she had to start all over again from the beginning. CLDS stated the standard when transcribing medications is "avoid all interruptions" and indicated interruptions increase the risk for errors, back in the rehab unit there was a "high need" cliental, one nurse and one aide, made interruptions likely unavoidable. When asked how the facility could avoid interruptions when nurses were transcribing medications, CLDS stated "staffing pattern changes, add a CNA [certified nursing assistant], might be better". CLDS stated that a recommendation to add staff had been made to administration however, indicated that had not happened yet.

During an interview on 3/22/2021, at 12:28 p.m. director of nursing (DON) stated a lot of the mediation errors involved anticoagulant medication and occurred back on the rehab unit; "I think people are rushing and not reading the orders as they should." When asked, "Why do you think the nurses are rushing?", DON indicated the nurses were busy, from interruptions, and the anticoagulant order format changed. DON indicated nurses were also not following the double check system where a second nurse verifies the order. DON indicated to

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F 760	Continued From page 88	F 760		

ease the burden and reduce the risk for transcription errors, she had started transcribing orders for new admission, however indicated that system was not very sustainable. DON stated the facility was working on the staffing issue and had two new hires starting within the next week. DON indicated that there quality assurance subcommittee for medication errors; the committee had identified the pattern/trend of the medication errors related to transcription error and the correlation with interruptions. DON indicated the committee has attempted to put interventions in place to prevent reoccurrence.

As a result of staffing please refer to 725 for insufficient staffing as it relates to medication errors.

Facility policy Physician/Practitioner Orders-Rehab Skilled dated 11/20/21, included Physician/Practitioner orders are a critical component to providing quality care to residents. Accurate processing of physician/practitioner orders is important.
Admission Orders Process. Admission order and orders received throughout the resident's stay are processed and transcribed into PCC-Clinical-Orders, immediately upon receipt of the order. The orders must be noted by the licensed nurse who has processed the order and filed the central supervised location for scanning/indexing
Maintaining Physician Orders/Practitioner Orders Transcribing/Processing Orders Orders are processed and transcribed into PCC-clinical-orders immediately upon receipt of the order. Prescriber entered orders must be confirmed by a licensed nurse.

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	245317	A. BUILDING _____ B. WING _____	C 03/22/2021

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F 803 SS=E	Menus Meet Resident Nds/Prep in Adv/Followed CFR(s): 483.60(c)(1)-(7) §483.60(c) Menus and nutritional adequacy. Menus must- §483.60(c)(1) Meet the nutritional needs of residents in accordance with established national guidelines.; §483.60(c)(2) Be prepared in advance; §483.60(c)(3) Be followed; §483.60(c)(4) Reflect, based on a facility's reasonable efforts, the religious, cultural and ethnic needs of the resident population, as well as input received from residents and resident groups; §483.60(c)(5) Be updated periodically; §483.60(c)(6) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy; and §483.60(c)(7) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide therapeutic diets as prescribed by the physician for 2 of 2 (R41 and R35) this effected 16 additional residents who resided at the facility who were prescribed therapeutic diets by the physician. Findings include	F 803	F803 Menus Meet Resident Nds/Prep in Adv/Followed 1. R35 and R41s diets were care planned and immediate education was done with dietary staff on ensuring diets are followed as ordered by prescriber. R35 and R41□s diets were added to their	4/30/21

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F 803	Continued From page 90 During an interview on 3/16/2021, at 2:17 p.m. R41 sat in her room in her wheelchair. R41 stated she did not think she was getting a low carbohydrate diet like she was supposed to be. R41 stated she was supposed to eat a low carb diet because she was diabetic, and she had been really trying to adhere to that diet prior to being admitted to the facility. R41 stated for lunch today they had mashed potatoes with gravy and bread, "that's all carb!" R41 stated she was not offered alternatives, was not provided a menu with carb replacements, and would have to tell staff to serve less of the main entre. R41 indicated her blood sugars seem to remain stable so far. During an observation and interview on 3/16/2021, at 5:43 p.m. R41 sat in her wheelchair with her meal tray in front of her. Resident stated she had about 1.75 cups of egg noodles on her tray with meatballs, corn, vanilla pudding with Oreo cooking crumble on top of it. R41 stated she would not consider the food to be low carb, would not eat all the noodles, and would not eat the desert because it was not sugar free. R41 stated the staff did not have anything to replace the high carb food items. R41 face sheet provided by the facility on 3/22/21, identified R41 was admitted to the facility on 2/18/21, with diagnosis that include diabetes type II and body mass index of 40.0 to 44.9. R41's admission Minimum Data Set (MDS) dated 2/23/21, indicated R41 did not have cognitive impairment, and was independent with eating after meal setup. The MDS also identified that	F 803	tray cards on 3/29/21. 2. All residents have the potential to be affected. A full review of every resident was done on 3/18/21 to ensure that all residents were care planned for the appropriate diet. 3. A process of using tray cards that list prescribed diets was started on 3/29/21. Extensions for therapeutic diets were implemented on 4/11/21. Education will be provided by the Dietary Manager of designee to all dietary employees on therapeutic diets and following physician orders for diets. 4. Audits will be conducted by the Dietary Manager or designee weekly x 4 and monthly x 2 to ensure appropriate diets are being served. Audit results will be brought to the monthly QA meeting for further recommendations. 5. 4/30/21	

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F 803	Continued From page 91	F 803		

R41 required a therapeutic diet.
R41's physician orders included "CCHO diet [The consistent (or controlled) carbohydrate diet helps people with diabetes keep their carb consumption at a steady level, through every meal and snack. This prevents blood sugar spikes or falls.] Regular texture, Regular fluid consistency" (Start date 2/18/21).

R41's nutritional care plan dated 3/2/2021, included R41 had nutritional problem or potential nutritional problem related to diagnosis of being diabetic, therapeutic diet, and obesity. The corresponding interventions directed staff to "offer diet per MD order of CCHO diet".

R35
During an interview on 3/16/21, at 4:14 p.m. R35 stated he was diabetic and the facility was not providing him with a low carbohydrate diet. R35 stated he has been eating regular meals like other residents.

During an observation on 3/16/2021, at 5:37 pm. R35 sat in the dining with his meal tray in front of him that contained, mashed potatoes and gravy, egg noodles with Swedish meatballs, and vanilla pudding with Oreo crumble.
R35's facility face sheet provided by the facility on 3/22/21, included diagnosis of diabetes type II.

R35's admission Minimum Data Set (MDS) dated 2/13/2021, indicated R35's cognition was not assessed. The MDS identified that R35 was independent with eating after setup an required a therapeutic diet.

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F 803	Continued From page 92 R35's nutritional care plan dated 2/21/21, indicated R35 had a nutritional problem or potential for related to diagnoses that included diabetes; corresponding intervention directed staff to offer diet per MD order of CCHO diet. R35's physician orders included, "CCHO diet regular texture, regular fluid consistency, low carbohydrates." (start date 2/8/21). During an interview on 3/16/2021, at 5:37 p.m. dietary assistant (DA)-A stated the dinner menu for tonight included Swedish meatballs over egg noodles, mashed potatoes with gravy, green beans, vanilla pudding with Oreo crumble. When asked what he would serve residents that had consistent carb diet, DA-A stated he would give that residents less egg noodles; instead of a serving 1.5 cups of noodles he would only give a about 1 cup of noodles. DA-A indicated the facility did not have other food prepared and/or menus that directed to serve residents with different food items based on prescribed diets. During an interview on 3/19/2021, at 2:15 p.m. certified dietary manager (CDM), stated she had only been at the facility for a couple of weeks and had just become aware that the facility did not have and was not using menu extensions for therapeutic special diets, so all residents were being served regular diets. During an interview on 3/22/2021, at 10:27 a.m. director of nursing (DON) stated an unawareness that residents were not being served diets according to physician orders. DON stated an expectation that therapeutic diets be provided per the physician order.	F 803		

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F 803	Continued From page 93 Facility Policy Acceptance of Therapeutic Diet-Food and Nutrition Services dated 5/12/2020, included; Therapeutic diets ordered by a healthcare practitioner as part of the treatment for a disease or medical condition to eliminate, decrease or increase certain substances in diet or to provide texture modified food and drinks when indicated. POLICY: The location provides a therapeutic diet, including texture-modified diets and diet interventions that meet the resident's goals and preferences. Guidelines F800: The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets his or her daily nutritional and special dietary needs, taking into consideration the preferences of each resident. Facility policy Society Menu Standards dated 1/17/2018, included; Centers will be responsible for generating extensions for combination diets to meet their centered needs. The policy listed diet types that were available for the extension menu.	F 803		
F 809 SS=E	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident	F 809		4/30/21

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F 809	Continued From page 94 group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure all residents were consistently offered and provided a substantial evening snack for 7 of 7 residents (R4, R32, R30, R16, R3, R15, R13) who voiced a concern while attending the resident council group meeting. This had the potential to affect all 40 residents residing in the facility. Findings include: During the resident council meeting held 3/18/21, at 10:00 a.m. during the survey, all 7 residents in attendance stated evening snacks were not being offered, that the facility stopped passing evening snacks in the evening. The residents stated after supper time staff used to go around asking the residents if they would like a snack. During an interview on 3/18/21, at 2:01 p.m. nursing assistant (NA)-A stated each unit had a box of various snacks, there was ice-cream in the freezer, pudding, and applesauce. NA-A stated residents will ask staff for a snack or they have own snack items in their rooms. NA-A stated if she was busy, and she was by herself on the unit she did not go room to room to offer residents snacks.	F 809	F809 Frequency of Meals/Snacks at Bedtime 1. Dietary staff prepare a snack cart that will be brought down to long term and short term units for nursing staff to distribute snacks. 2. All residents have the potential to be affected. 3. Dietary staff will prepare a snack cart that will be brought down to long term and short term units Nursing staff will distribute the snacks and document acceptance/refusal. Education on providing HS snack will be provided to nursing staff and dietary staff on snack procedures by 4/30/21. Education will be provided by the DON, Dietary Manager, or designee. 4. Audits will be conducted by the Dietary Manager or designee weekly x 4 and monthly x 2 to ensure snacks are being offered and documented. Audit results will be brought to the monthly QA meeting for further recommendations.	

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F 809	Continued From page 95 During an interview on 3/19/21, at 9:46 a.m. the director of nursing (DON) stated staff should be offering snacks in the evenings to every resident unless there was a specific medical reason, they should not be offered a snack. The DON stated even if a resident said no every night, they should be offering snacks. During an interview on 3/22/21, at 10:00 a.m. the certified dietary manager (CDM)-A stated she was told the kitchen staff stocked each neighborhood with snacks and she was told the nursing assistants passed the snacks. CDM-A stated the staff are supposed to be going around and asking the residents what they would like and then getting the snacks for the residents. CDM-A stated was not aware snacks were not being passed on the evening shifts. During an interview on 3/22/21, at 11:00 a.m. the administrator stated based on state operations manual, the expectation was a resident would be offered an evening snack. During an interview on 3/22/21, at 4:00 p.m. registered nurse (RN)-A stated she does not believe that anyone goes around with snacks and stated they used use to. RN-A stated they have snacks available upon request and all residents on this unit can request snacks. During an interview on 3/22/21, at 4:01 p.m. nursing assistant (NA)-D stated snacks were in the cupboard. NA-D stated there was not a scheduled snack pass and if gets busy it (offering snacks) is one of the things that falls through the cracks. NA-D Stated did not recall having an evening snack pass scheduled at the facility.	F 809	5. 4/30/21	

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F 809	Continued From page 96 The frequency of Meals and Snacks policy and reviewed/revised 5/12/2020 included, "Snacks Employees are responsible for ordering and preparing food/beverages for the snack cart. 2. Employees and/or nursing services are responsible for distribution of the snacks ...A snack is offered to all residents each night."	F 809		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment,	F 838		4/30/21

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F 838	Continued From page 97 services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview, and document review, that facility failed to include a complete comprehensive assessment of the facility staffing needs to ensure a plan was in place to deliver necessary care and services based on the	F 838	F838 Facility Assessment 1. The facility assessment will be reviewed and updated by the entire interdisciplinary team to ensure all resident demographics, procedures, and	

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F 838	Continued From page 98 facility's population. This deficient practice had the potential to affect all 40 residents residing at the facility. Findings include SEE F725 for insufficient staffing Facility Assessment was not dated. Facility Assessment identified the facility had 44 resident bed. Population of residents was identified which included but was not limited to, 14 residents who had diagnosis of congestive heart failure, 9 residents who had diagnosis of diabetes, 9 residents who had diagnosis of Alzheimer's Dementia, 11 residents with anxiety disorder, 21 residents with depression, and 10 residents with respiratory conditions. The resident assessment also identified 30 resident required extensive assistance for bed mobility 20 of those required two staff, 26 residents required extensive assistance for transfers 16 of those required two staff assist, 33 residents for dressing required extensive assist 14 of those required extensive assistance from 2 staff, for toileting 31 residents required extensive assistance 20 of those required assistance from 2 staff. Facility assessment did not identify a staff planning and/or formula to determine staffing needs, minimum staffing need was not identified. The assessment indicated the facility had appropriate staffing to meet the needs of the residents. In response to the question on the form "How do you staff to meet acquity [sic] and needs of residents" the typed answer was "Assess and staff appropriately." The assessment further identified, "All departments utilize block schedules to ensure reasonable consistent	F 838	operational strategies are fully represented in the assessment. 2. All residents have the potential to be affected. 3. The nursing staffing patterns sections were updated to reflect current staffing procedures for all three units. 4. The facility assessment will be updated when there are operational changes occurring in the center. This will be audited for compliance monthly x 3 with results taken to monthly QA committee for further recommendations. 5. 4/30/21	

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F 838	Continued From page 99	F 838		

staffing." In response to question "If continuity of care is not established, what is the plan to improve tools and processes to ensure continuity of care for residents?" the typed answer was "n/a [not applicable].

During an interview on 3/19/2021, at 3:02 p.m. scheduling coordinator (SC) stated she could staff up to two aides per day. SC stated the staffing goal for day and evening shift was one aide and one nurse per unit. Otherwise would take as many people as possible to get up to the allowed staff per unit. SC stated always try to get a float so that it would be 1.33 aides per unit for day and evening shift. SC indicated staff levels were not based on acuity, the amount of staffing did not change if census went up or down or the level of care residents required. SC stated if there was a restorative aide scheduled they help on the floor, and when there was only one aide and one nurse, the nurse would help the aides with resident care.

During an interview on 3/22/2021, at 12:50 p.m. director of nursing (DON) was asked, "How do you determine staffing levels? DON responded that during the day at bare minimum there is one nurse and one NA per unit, and a lot of times there was a float that would go in-between neighborhoods. DON was then asked, "How do you know where to send the float to?" DON responded, "through word of mouth from staff." DON stated the facility was union, staff had block schedules so some days there was more staff than others because of their union contract. DON stated the facility would cut hours if the census was low or send the person the area of need. DON indicated the facility did not staff to acuity,

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F 838	Continued From page 100 stated an unawareness of how to determine acuity levels of the residents that resided in the facility, stated there the facility did not have evidence staffing levels were based on acuity level of residents. DON indicated an unawareness of the facility's assessed baseline staffing needs, and could not articulate staffing hours per resident day. DON stated the facility has made efforts to hire more nursing assistance; DON indicated two new staff would be starting within the next week. During an interview on 3/22/2021, at 1:32 p.m. administrator provided the facility assessment that included the facility's resident population into categories of diagnoses classes and amount of assistance. Administrator was asked if the facility assessment identified staff levels based on the resident population? The administrator responded by indicating every morning there was an interdisciplinary team meeting where the team reviewed needs of residents daily and staff were moved around.	F 838		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 9, 2021

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

Re: State Nursing Home Licensing Orders
Event ID: 4I8I11

Dear Administrator:

The above facility was surveyed on March 16, 2021 through March 22, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

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

Please 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.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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

PRINTED: 04/21/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**03/17/2021**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey Good Samaritan Society Comforcare was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections	K 000		

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

Electronically Signed | 04/19/2021

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: fc.hc.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Comforcare, is a 1-story building with no basement. The building was constructed in 2007 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification. There are smoke alarms in all resident rooms that are monitored by the nurse call system and light outside each resident room. The facility has a capacity of 45 beds and had a census of 40 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 2 NOT MET as evidenced by:	K 000		
K 912 SS=F	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on document review and staff interview, the facility failed to complete annual testing of electrical outlets in resident rooms in accordance with the Healthcare Facilities Code NFPA 99-2012 (6.3.3, 6.3.4.1.3). This deficient practice could affect all 45 residents. Findings include: On facility tour at 10:00 AM on 03/18/2021, documents review and staff interview revealed the following: During documentation review no records were provided to confirm that the facility had completed -or- vendor contracted, annual electrical receptacle testing. This deficient practice was confirmed by the Facility Maintenance Director and Administrator at the time of discovery.	K 912	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1) All receptacles were tested and documented to be working in all resident rooms on 3/25/21. 2) Electrical outlets will be tested on an	3/25/21

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K 912	Continued From page 3	K 912	annual basis or as needed by the Director of Environmental Services or designee.	