CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4UW7 Facility ID: 00890

						<u> </u>
MEDICARE/MEDICAID PROVIDER (L1) 245279 2.STATE VENDOR OR MEDICAID NO. (L2) 138218700		3. NAME AND AD (L3) GOOD SAM (L4) 3815 WEST (L5) ROBBINSDA	ARITAN SOCI BROADWAY		CCIALTY CARE (L6) 55422	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint
5. EFFECTIVE DATE CHANGE OF OV (L9) 6. DATE OF SURVEY 04/23 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	/2018 (L34) (L10)	7. PROVIDER/SU 01 Hospital 02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	PPLIER CATEGO 05 HHA 06 PRTF 07 X-Ray 08 OPT/SP	RY 09 ESRD 10 NF 11 ICF/IID 12 RHC	02 (L7) 13 PTIP 22 CLIA 14 CORF 15 ASC 16 HOSPICE	7. On-Site Visit 9. Other 8. Full Survey After Complaint FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	96 (L18) 96 (L17)	Compliand1.		ram	And/Or Approved Waivers Of The2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SNF5. Life Safety Code * Code: A	6. Scope of Services Limit 7. Medical Director
14. LTC CERTIFIED BED BREAKDOV 18 SNF 18/19 SNF 96 (L37) (L38)	VN 19 SNF (L39)	ICF	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
16. STATE SURVEY AGENCY REMAI		E SHOW LTC CANCE):		
Susanne Reuss, Unit	Supervisor	Date :	05/29/2018	(L19)	Joanne Simon, Enfor	
P	ART II - TO BE	E COMPLETED	BY HCFA RE	EGIONAI	L OFFICE OR SINGLE STA	ATE AGENCY
DETERMINATION OF ELIGIBILIT 1. Facility is Eligible to P 2. Facility is not Eligible	articipate		IPLIANCE WITH GHTS ACT:	CIVIL		cial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513) :
22. ORIGINAL DATE OF PARTICIPATION 04/01/1985 (L24) 25. LTC EXTENSION DATE:	23. LTC AGREEM BEGINNING (L41)	DATE	4. LTC AGREEM ENDING DAT (L25)		26. TERMINATION ACTION: VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburseme 03-Risk of Involuntary Termination	05-Fail to Meet Health/Safety
	27. ALTERNATI A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)		n of Admissions:	(L44) (L45)		04-Other Reason for Withdrawal	
(L27) 28. TERMINATION DATE:	A. Suspension B. Rescind Sus	n of Admissions:	(L45)		04-Other Reason for Withdrawal 30. REMARKS	07-Provider Status Change
	A. Suspension B. Rescind Sus	n of Admissions:	(L45)	(L31)		07-Provider Status Change
	A. Suspension B. Rescind Sus	n of Admissions: spension Date:	(L45) CARRIER NO.			07-Provider Status Change 00-Active

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

C&T REMARKS - CMS 1539 FORM

STATE AGENCY REMARKS

An abbreviated standard survey was conducted to investigate case #H5279089.

On February 21, 2018 the Minnesota Department of Health, Office of Health Facility Complaints completed an Abbreviated standard survey of this facility and found the most serious deficiency to be at a S/S of "G" for tag F689. The facility also had a S/S of G at their previous 2 surveys.

As a result, the Department imposed the Category 1 remedy of State Monitoring, effective March 13, 2018.

In addition, we recommended the following enforcement remedy to the CMS RO for imposition:

CMP for deficiency cited at F689.

Discretionary Denial of Payment, effective May12, 2018.

On April 23, 2018 and April 30, 2018 this department and the Department of Office Health Facility Complaints completed a post certification revisit. Based on this revisit this facility has corrected the deficiencies.

As result of the post certification revisit, the Category 1 remedy of State Monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V office the following actions:

- CMP for deficiency cited at F689.
- Discretionary Denial of Payment, be discontinued.

Also, because substandard quality of care was found at the facility, it is prohibited from conducting NATCEP for 2 years.



Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245279

May 29, 2018

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

Dear Ms. Mattson:

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

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

Effective April 15, 2018 the above facility is recommended for:

96 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds located in rooms.

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered May 29, 2018

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

RE: Project Number S5279028 and H5279089

Dear Ms. Mattson:

On March 8, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 21, 2018. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), whereby corrections are required.

On March 8, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 13, 2018. (42 CFR 488.422)

Also, on March 8, 2018, The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 12, 2018.
- Civil money penalty for the deficiency cited at F689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 21, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On February 28, 2018 the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The standard survey found that your facility has not achieved substantial compliance with federal certification deficiencies. The most serious deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

Good Samaritan Society - Specialty Care Community May 29, 2018 Page 2

As a result of the standard survey findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 8, 2018:

- Civil money penalty, cited at F689 will be imposed. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 12, 2018, remain in effect. (42 CFR 488.417(b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy(ies):

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

On April 23, 2018, the Minnesota Department of Health completed a reveiw of your plan of correction, and on April 30, 2018, Minnesota Department of Health, Office of Health Facility Complaints completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on February 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 15, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on April 23, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 15, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of :

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), be discontinued as of May 15, 2018. (42 CFR 488.417(b))
- Civil money penalty. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

Also, we notified you in our letter of March 8, 2018, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from May 15, 2018.

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.

Good Samaritan Society - Specialty Care Community May 29, 2018 Page 3

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist

Minnesota Department of Health

Licensing and Certification Program

Program Assurance Unit

Health Regulation Division

Telephone: 651-201-4161 Fax: 651-215-9697

Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICALD CERTIFICATION AND TRANSMITT	AL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGEN	ICY

ID: 4UW7 Facility ID: 00890

MEDICARE/MEDICAID PROVIDE (L1) 245279	ER NO.	3. NAME AND AL			PECIALTY CARE COMMU	4. TYPE OF AC	CTION: <u>2</u> (L8)
2.STATE VENDOR OR MEDICAID N	viO.	(L4) 3815 WEST		JIL 1 1 51	Lenter i cinte commit	1. Initial	2. Recertification
(L2) 138218700	NO.	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \			(L6) 55422	3. Termination	
138218700		(L5) ROBBINSD	ALE, WIN		(L0) 33422	5. Validation 7. On-Site Visi	6. Complaint t 9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU			02 (L7) 13 PTIP 22 CLIA		After Complaint
	2/2010 (T24)	01 Hospital	05 HHA	09 ESRD			
	8/2018 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct	06 PRTF	10 NF 11 ICF/IID	14 CORF 15 ASC	FISCAL YEAR E	NDING DATE: (L35)
8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC	— ^(L10)		07 X-Ray			12/31	
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATION	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requi	rements:
To (b):			equirements		2. Technical Personnel	_ 6. Scope	of Services Limit
		•	e Based On:		3. 24 Hour RN	7. Medica	al Director
12. Total Facility Beds	96 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	NF) _ 8. Patient	Room Size
13. Total Certified Beds	96 (L17)	X B. Not in Con	npliance with Pros	zram	5. Life Safety Code	9. Beds/R	oom
	. ,		and/or Applied V	-	* Code: B*	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
96							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION I	DATE):			
An abbreviated standard survey	was conducted to	investigate case #H	15279089.	,			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Sandra Hick, HFE NE II		03/26/2	0010		Amy Johnson, Enforce	ment Specialist	04/05/2018
			2010	(L19)	- Turry Cormicorn, Emerce	mont opeciano	(L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RE	CGIONAL	OFFICE OR SINGLE S	TATE AGENCY	7
19. DETERMINATION OF ELIGIBIE	JTY		IPLIANCE WITH	H CIVIL	21. 1. Statement of Final		
1. Facility is Eligible to I	Participate	RIGI	HTS ACT:		3. Both of the Above	ol Interest Disclosure :	Stmt (HCFA-1513)
2. Facility is not Eligible	e						
	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 00	INVO	LUNTARY
04/01/1985					01-Merger, Closure	05-Fa	il to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fa	il to Meet Agreement
·							
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	on OTHI	ER
25. LTC EXTENSION DATE:		VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTH	<u>ER</u> ovider Status Change
			(L44)			OTH	ovider Status Change
25. LTC EXTENSION DATE: (L27)	A. Suspension		(L44)			07-Pr	ovider Status Change
	A. Suspension	n of Admissions:	(L44) (L45)			07-Pr	ovider Status Change
	A. Suspension B. Rescind St	n of Admissions:	(L45)			07-Pr	ovider Status Change
(L27)	A. Suspension B. Rescind St	n of Admissions: uspension Date:	(L45)		04-Other Reason for Withdrawal	07-Pr	ovider Status Change
(L27)	A. Suspension B. Rescind St	n of Admissions: uspension Date: O. INTERMEDIARY	(L45)	(L31)	04-Other Reason for Withdrawal	07-Pr	ovider Status Change
(L27) 28. TERMINATION DATE:	A. Suspension B. Rescind St	n of Admissions: uspension Date: D. INTERMEDIARY/ 00140	(L45) /CARRIER NO.		04-Other Reason for Withdrawal	07-Pr	ovider Status Change
(L27)	A. Suspension B. Rescind St	n of Admissions: uspension Date: O. INTERMEDIARY	(L45) /CARRIER NO.		04-Other Reason for Withdrawal	07-Pr	ovider Status Change
(L27) 28. TERMINATION DATE:	A. Suspension B. Rescind St	n of Admissions: uspension Date: D. INTERMEDIARY/ 00140	(L45) /CARRIER NO.		04-Other Reason for Withdrawal	01 Hi 07-Pr 00-Ac	ovider Status Change



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

March 15, 2018

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

RE: Project Numbers S5279028, H5279089

Dear Ms. Mattson:

On March 8, 2018, we informed you that the following enforcement remedy was being imposed:

• State Monitoring effective March 13, 2018. (42 CFR 488.422)

Also, on March 8, 2018, The Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 12, 2018.
- Civil money penalty for the deficiency cited at F689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an abbreviated standard survey completed on February 21, 2018. The most serious deficiencies were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Specialty Care Community is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 12, 2018. 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. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

Good Samaritan Society - Specialty Care Community March 15, 2018 Page 2

On February 28, 2018 the Minnesota Departments of Health and Public Safety completed a standard survey to verify that your facility had achieved and maintained compliance with federal certification deficiencies. The standard survey found that your facility has not achieved substantial compliance with federal certification deficiencies. The most serious deficiencies in your facility at the time of the standard survey were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567, whereby corrections are required.

As a result of the standard survey findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of March 8, 2018:

- Civil money penalty, cited at F689 will be imposed. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.41(a), effective May 12, 2018, remain in effect. (42 CFR 488.417(b))

Based on the findings of this visit, we recommended to the CMS Region V Office the following additional remedy(ies):

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

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please see the the electronically delivered CMS-2567.

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:

Susanne Reuss, Unit Supervisor Metro C Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health Good Samaritan Society - Specialty Care Community March 15, 2018 Page 3

85 East Seventh Place, Suite 220 P.O. Box 64900 Saint Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by a "F" tag), i.e., the plan of correction from the abbreviated standard survey completed on February 21, 2018 should be directed to:

Annette Winters, Supervisor
Office of Health Facility Complaints
Health Regulation Division
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Email: annette.m.winters@state.mn.us

Phone: (651) 201-4204 Fax: (651) 281-9796

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

Good Samaritan Society - Specialty Care Community March 15, 2018 Page 4

and,

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

The state agency may, in lieu of a 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:

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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 August 21, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal

Good Samaritan Society - Specialty Care Community March 15, 2018 Page 5 regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697 Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

PRINTED: 03/26/2018 FORM APPROVED OMB NO. 0938-0391

	UD DI ANI OF CODDECTION IDENTIFICATION NUMBER.			IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		02/	28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	(STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 00	00		
F 000	Emergency Prepare conducted 2/25/18 recertification surve with the Appendix Z Requirements. INITIAL COMMENT On 2/28/18, a stan your facility by the M Health to determine compliance with received 483, Subpart B, and	iance with CMS Appendix Z edness Requirements, was through 2/28/18, during a ey. The facility is in compliance Emergency Preparedness CS dard survey was completed at Minnesota Department of e if your facility was in quirements of 42 CFR Part d Requirements for Long Term	F 00	00		
F 561 SS=D	as your allegation of Department's accept bottom of the first property of an arevisit of your facility validate that substate regulations has been your verification. Self-Determination CFR(s): 483.10(f)(1) §483.10(f) Self-determination components and facility through support of the resident has the promote and facility through support of the resident that the support of the resident has the promote and facility through support of the resident has the promote and facility through (11) of the support of the resident has the promote and facility through (11) of the support	acceptable POC an on-site y may be conducted to antial compliance with the en attained in accordance with 1)-(3)(8) ermination. The right to and the facility must atter resident self-determination resident choice, including but ghts specified in paragraphs (f)	F 56	31		4/15/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Electronically Signed

03/24/2018

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

TITLE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		02/2	28/2018	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 561	waking times), hea care services cons assessments, and applicable provision §483.10(f)(2) The rechoices about asper facility that are sign §483.10(f)(3) The rewith members of the community activities facility. §483.10(f)(8) The reparticipate in other religious, and comminterfere with the rigitality. This REQUIREMED by: Based on observative review, the facility for facility for choices. Findings include: R77's diagnosis incomposition obtained from the activities of related to left ankled evidenced by pain,	s (including sleeping and lth care and providers of health istent with his or her interests, plan of care and other	F 56	Preparation and execution of this response and plan of correction do constitute an admission or agreem the provider of the truth of the facts alleged or conclusions set forth in statement of deficiencies. The plar correction is prepared and/or exect solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial complia with federal requirements of participation that constitutes the center allegation compliance in accordance with section of the State Operations Manual contents.	ent by s the n of uted . For the noce pation, on		

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F 561	On 2/27/18, 7:15 a. was observed wide leaving a message call her back imme suggested she was R77 appeared upse angry voice "She cawoke me up and word to use the toilet and had to go do the extold them I had refunct slept at night arfor a little more and had refused. I want At 7:19 a.m. R77 shelp to use the bath staff had told her shelp to use the bath staff had t	ensive assistance of one staff. m. the door to R77's room open. R77 was on the phone for her daughter, asking her to diately. R77 tone of voice upset. When approached, et, shaking and stated in a ame here at 6:46 a.m. and anted me to go do therapy. I eep well at night because I had d had pain and she told me I ercises. She left and went and used. All I told her was I had d needed to just stay in bed I she went and told lies that I et to tell her that was not true." eated she had been waiting for aroom. She stated the therapy he was going to find help for e needed to go to the ed surveyor to help her. ell light on and as surveyor from R77 stated "I didn't sleep of I told her I would not come. d I will come later. She did not At 7:24 a.m. nursing assistant transfer belt and transferred air and in the bathroom the toilet. At 7:30 a.m., after oilet NA-B transferred her to shed the chair to the bedside for by the bed. R77 asked apist was and still sounding not refuse. I told her I had not ast wanted to do it later." NA-B find out who the therapist	F 56	On 2/27/18 resident R77 ware-interviewed, she indicate preferred wake time was be but does have some days the sleep later; her care plan wand amended. On 2/27/18 the was shared with the Theraph and schedules were adjusted. Preferred wake times for all 1st floor will be reviewed an with therapy schedules to caccuracy. The Routine Practice Policy reviewed with all appropriated. The Director of Nursing Ser designee will be responsible compliance through routine conducted weekly x4, mont results will be taken to the Committee for further recommittee for further recommittees.	ed her etween 6-7am, hat she likes to as reviewed this information by Coordinator ed accordingly. I residents on and compared onfirm y will be e staff. rvices and/or e to ensure audits hly x3. Audit QAPI	

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F 561	therapist (OT) state at 6:45 a.m. and has stated R77 was no stated "she was no was going to sleep R77's waking prefix know as this was the with R77. OT also pre-completed befor R77 was the first to On 02/27/18, at 8:4 surveyor and asked the therapy staff the Surveyor told resid was wondering if si work with her and sasked about bedtin home R77 stated si watching television get out of bed arou asked about toilet in	age 3 7 a.m. the occupational ed she had been in R77's room ad introduced herself. The OT t ready to work with her. OT t happy I was there and she ." When asked if she knew erence, OT stated she did not ne first time she had worked stated her visit schedule was ore she got to the facility and or be seen that morning. 16 a.m. R77 approached d if she had found the name of at had been in her room. ent she had and the resident he was going to come back to surveyor stated "yes." When he and waking up when at tayed up late at night at night and stated, "I try to nd seven or eight." When heeds R77 stated when knew to go and would ask for	F 56	51		
	(DON) reviewed th Data Collection for the assessment ind time was 8:30 a.m. had access to the a stated "we have tal	6 a.m. the director of nursing e Nursing Admit Re-Admit m dated 2/24/18, and stated dicated R77's "usual waking " The DON stated therapy staff assessments. The DON further ked about this they may have e however, they should adjust preferred routine."				
	stated she thought	15 AM family member (FM)-C R77 was afraid of going to at night even at home. FM-C				

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F 561	in her chair. When time, FM-C stated 7:00 a.m. FM-C stated 7:00 a.m. FM-C stated requests regarding stated it was frustrated it was frustrated it was frustrated she comples chedules the prevision of the individual's control of	sit up and doze off as she sat asked about R77's usual rising R77 would not be up before ated she was having problems owing up on instructions or R77's cares and routine. She ating to the family. 59 p.m. the director of therapy sted the daily therapy rious day and sent the saff. She stated she erapists to ask the residents if ers and stated if a resident staff were supposed to leave are resident know they would red time. When asked if cocess to nursing assessment asking up time, she stated the eveloping a system to allow the at access to the resident and (ADLs)/Mnth Abilities (1)(b)(1)-(5)(i)-(iii) on the comprehensive esident and consistent with the end choices, the facility must early care and services to ent's abilities in activities of diminish unless circumstances elinical condition demonstrate on was unavoidable. This	F 56			4/15/18	

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F 676	of this section §483.24(b) Activitie The facility must pr accordance with pa activities of daily liv §483.24(b)(1) Hygie grooming, and oral §483.24(b)(2) Mobi including walking, §483.24(b)(3) Elimi §483.24(b)(4) Dinin snacks, §483.24(b)(5) Com (i) Speech, (ii) Language, (iii) Other functiona This REQUIREMED by: Based on interview	se specified in paragraph (b) s of daily living. ovide care and services in tragraph (a) for the following ing: ene -bathing, dressing, care, lity-transfer and ambulation, nation-toileting, tragraph (a) for the following ing: ene -bathing, dressing, care, lity-transfer and ambulation, nation-toileting, tragraph (b) I communication systems. NT is not met as evidenced or and document review, the	F 676	R285□s therapy documentation wa	
		vide rehabilitation services for 285) reviewed for activities of		reviewed and corrected on 3/22/201 R285 s MDS was modified to reflect accurate number of therapy minutes 3/22/2018.	ot
	R285's admission r indicated current di aftercare, absence dermatitis.	ecord, dated 2/22/18, agnoses of orthopedic of right leg below knee and		All therepy stoff will be re-educated	on d
	had limited physica	lated 2/27/18, indicated R285 I mobility due to edema to right ee amputation). The care plan		All therapy staff will be re-educated regarding documentation accuracy.	

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INAME OF I	THO VIDEN ON SOFF EIEN			3815 WEST BROADWAY	, _		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	ROBBINSDALE, MN 55422			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORR	ECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG		HOULD BE	COMPLETION DATE	
F 676	Continued From pa	ge 6	F 67	76			
F 676	directed staff to pro assistance with mo transfers and weigh Physical Therapy D 2/24/18, indicated p (PTA)-A provided the for 31 minutes. PTA-A note dated 2 indicated "There Exand endurance. Pt B (bilateral) LE (low ext, X15 reps, supin Cueing to perform oneeded. During an interview R285 stated on 2/2 and instructed R285 done the day before worked with the resulting an interview director of rehab vereatment and did the strengthening, enduexercises correctly. PTA-A did not work stated "I would say documentation, but his word vs her wore evidence that R285 re-approached. During an interview PTA-A stated he we R285 and that they	bility, use of a wheelchair for at bearing as tolerated. Faily Treatment Note dated obysical therapy assistant herapeutic exercises to R285 (2/24/18, at 11:23 a.m., a done to increase strength instructed and competed (sic) wer extremity) knee flex and he SLR, quad sets 12 reps X2. correct motions. Rest breaks (2/25/18, at 4:03 p.m., 4/18 PTA-A stood at the door 5 to do the exercises that were a and then left without having	F 67	The Therapy Coordinator and will be responsible to ensure of through routine audits conduct x4, monthly x3. Audit results to the QAPI committee for fur recommendations.	compliance ted weekly will be taken		
	her and was a docu During an interview	on 2/28/18, 2:45 p.m., the					
	administrator when	asked are facility staff					

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F 679 SS=D	when they did not sexpect anyone to far During an interview director of rehab in seen they are supprot seen and verificated refusarehab further indicated rehab further indicated rehability. Asked Questions reindicated "SYNERTX rehability. Activities Meet Interprote of the comprehensive and the preference program to support activities, both facility factivities, mental, a each resident, encand interaction in the This REQUIREME by: Based on observativity programming activity programming activities activity programming activities activity programming activities activity programming activities activity programming activity programming activities activity programming activities activity programming activity programming activities activities activities activity programming activities	ent that they saw a resident see them stated she would not alsify documents. y on 2/28/18, at 2:57 p.m., the dicated if residents are not sose to document resident was sed PTA-A was scheduled to 18 and there were no also no that day. Director of ated staff are provided with a suppose to carry them out. Station Clinical Frequently evised date of February 2018, TX required a daily note which smentation to support each well as documenting the to treatment." yes: facility must provide, based on a sasessment and care plan as of each resident, an ongoing the residents in their choice of ity-sponsored group and and independent activities, the interests of and support the not psychosocial well-being of ouraging both independence	F 679		S were erest be	4/15/18

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F 679	Boundary Waters Of February 2018, ideractivities: Sunday - game, uninews/devotions, wounit music and unit Monday - unit story toss, unit poems/sn Tuesday - unit exembible study, unit triv Wednesday - unit vworship, unit ball topoems Thursday - unit poems Thursday - unit trivingokes, ice cream so Friday - unit poems newspaper, bowling Saturday - unit gambingo, unit story tell During random obsthrough 2/28/18, the scheduled activities R3's Activity Interes 8/26/17, indicated Filistening to music, tell	ity's activity calendars titled community, dated January and ntified the following scheduled t ball toss, unit rship service in the chapel,	F 6	79	unit, Boundary Waters. An interdisciplinary team will review activity needs and develop a calend groups that are specific to these individuals. All applicable staff will be re-educathe Activity Program and Routine Policies. Activity Director and/or designee were sponsible to ensure compliance froutine audits conducted weekly xamonthly x3. Audit results will be tathe QAPI committee for further recommendations.	ted on ractice	

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F 679	11/16/18, indicated impaired and requil locomotion on the unit/22/17, indicated activities, cognitive interaction. The carthat included listent television and sperplan directed staff to participation and of During an observat R3 was in his room to be asleep. On 2/27/18, at At 9 entered the unit. As an activity off the unit activity. At 10:2 The television was the program. An activity of the door closed. A room with the door was scheduled in the invited R3 to attend During an interview family member (FM some activity programs been any music proof the music direction what he could entere was more music proof the results of the second in what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entere was more music proof the music direction what he could entered was more music proof the music direction what he could entered was more music proof the music direction where was more music proof the music direction was the proof the music directi	data set (MDS) dated he was severely cognitively red extensive assistance for unit. R3's care plan dated he was dependent on staff for stimulation and social re plan identified preferences ing to music, watching iding time with family. The care of encourage family fer pet visits. ion on 2/25/18, at 12:07 p.m. in a wheel chair. He appeared as 37 a.m. activity aide (AA-A) A-A invited three residents to not. AA-A did not invite R3 to 9 a.m. R3 was lying in his bed. On but R3 was not engaged in thirty was scheduled on the occurred. If a.m., R3 was in his room with the 10:32 a.m. R3 was in his closed. A worship service he chapel however, no one did ams. She stated there had not orgrams recently due to the loss or. FM-A stated R3 was limited below and stated she wished				

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	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, C 3815 WEST BROAD ROBBINSDALE, I	TY, STATE, ZIP CODE NAY IN 55422 R'S PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH COR	RECTIVE ACTION SHOUL RENCED TO THE APPROI	D BE	(X5) COMPLETION DATE
F 679	rides, fishing, footh magazines, theatre traveling. R8's quarterly MDS was severely cogn physical assist to replan dated 9/22/18 on staff for activities social interaction. preferred activities groups, ice cream plan directed staff activities in room if room events. During an observa R8 was seated at a himself. He appears no activities occurring staff engagement. a game was scheduled for sat in front of a tele appeared to be as his room. He could non-sensical noise residents on the ununit. The activity cand snacks but no During observation sat alone at a table was occurring on to calendar indicated At 9:37 a.m. activities AA-A did not in the country of the	he enjoyed the following: ball, going to restaurants, cards, a, humor, worship service and a dated 11/30/17, indicated he itively impaired and required nove on the unit. R8's care, indicated he was dependent as, cognitive stimulation and the care plan identified that included: chapel, music social and games. The care to provide bed side visits and R8 was unable to attend out of tion on 2/26/18, at 9:45 a.m. a table in the dining room by red to be asleep. There were ing on the unit, no music or The activity calendar indicated fulled for 9:30 a.m. and a ball 10:30 a.m. At 10:40 a.m. R8 evision on the unit. He eep. At 1:30 p.m. R8 was in I be heard calling out loud s. At 4:04 p.m. all of the alendar identified unit poems	F6	79			

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F 679	a.m. the activity cal would be occurring the unit. R8 remain chair and could be Another resident wadining room. At 12: heard calling our from R46's Activity Interest 11/1/17, identified in to music, singing, plandscaping, televis The tool indicated Finance and the tool indicated Finance on and dated 12/21/17, indicated for activities, conteraction. The carone to one bedside out of room. The carone to anot invite R46 to the was in his room. Not unit. At 1:18 p.m. Red. The activity carone was scheduled but p.m. R46 remained occurred and staff of engage R46 in any	endar indicated unit jokes. No activities were offered on ed in his room in his wheel heard yelling out occasionally. as asleep at a table in the 12 p.m., R8 could still be om his room. Lest Data Collection Tool dated interests that included listening laying an instrument, sion, cards, books and talking. R46 served in the military and and a machinist. R46's ind 11/30/17, indicated he was impaired and required off the unit. R46's care plan icated he was dependent on ognitive stimulation and social re plan directed staff to provide activities if unable to attend are plan identified music, and as his preferred activities. On 2/27/18, at 9:37 a.m. entered the unit. AA-A invited in activity off the unit. AA-A did activity. At 10:28 a.m., R46 activities occurred on the 46 was in his room laying in activity occurred. At 1:46 in his room alone. No activity did not enter the room to way.	F 6	79			
		2 a.m., R46 again was bed in his room. A worship					

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F 679	service was being hot invite R46 to attract the staff on the most of the activities stated the trained mode the activities and "challenge" since	on 2/27/18, at 2:55 p.m. AA-A he unit were responsible for s occurring on the unit. AA-A nedication aides (TMA)'s don't distated it had been a	F6	579		

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F 679	trained medication to sit in the dining remusic. TMA-A state responsible for initia the unit but stated t time.	on 2/28/18, at 10:40 a.m. aided (TMA)-A stated R3 used from and listen to a lot of ed the staff on the unit were ating most of the activities on the staff did not have enough	F 679			
F 684 SS=D	director of nursing (the activities were r	2/28/18, at 1:04 p.m. the (DON) stated She was aware not being done on the units. ted to activity programming not received.	F 684			4/15/18
	applies to all treatm facility residents. Be assessment of a re that residents received accordance with pro- practice, the compressed plan, and the real plan, and the real plan, and the real plan observation of 2 residents (R1 related skin concernation treatment for 1 of 1 with a rash, and fail plan of care to prome	fundamental principle that tent and care provided to ased on the comprehensive sident, the facility must ensure we treatment and care in ofessional standards of ehensive person-centered		On 2/27/2018 a licensed nurse ass resident R1 s bruise and an incide report was created; care plan was amended. Skin observations continued weekly per policy until resident R1 discharged on 3/20/2018. Documentation for all residents will reviewed by Nurse Managers and/odesignees to ensure any non-press	ent nued be or their	

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	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	, :	STREET ADDRESS, CITY, STATE, ZIP CODE 8815 WEST BROADWAY ROBBINSDALE, MN 55422	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 684	lupus anticoagulan Admission Record On 2/25/18, at 11:4 seated at the dining approached R1 was bruises on the right. On 2/26/18, at 8:51 two purple bruise in how she got them at those but for the ottes ticks to get blocome" as she touch R1's care plan date potential/actual impacute knee pain as knee and yeast infeplan directed licens weekly. The care postaff to monitor for medications R1 recommedications R1 recommedicati	cluded rheumatoid arthritis and t sydrome obtained from the dated 2/28/18. 44 a.m. R1 was observed groom area. When as observed with two purple t arm. 1 a.m. R1 was observed with the right arm. When asked stated she did not know about ther bruises it was because of cod "sometimes they just hed her arm. 2 d 2/20/18, indicated R1 had be pairment to skin related to be evidenced by inflammation on ection under breast. The care sed nurse to observe skin clan lacked documentation for bruising as a side effect of ceived. 1's Skin Observation- V2 dated ealed nurse had indicated there	F 684	related skin issues have been appropriately assessed and docu All licensed staff will be reeducate and GSS Procedure for Skin Asse Pressure Ulcer Prevention and Documentation Requirements by Director of Nursing Services and/designee. All nursing staff will be reeducated on daily skin observar reporting procedures by the Direct Nursing Services and/or designee. The Director of Nursing Services designee will be responsible to encompliance through routine audits conducted weekly x4, monthly x3 results will be taken to the QAPI committee for further recommend. Resident R285 received her order medications on 2/25/2018. Resident R285 discharged from facility on There were no further documente complaints of itching during the restay. All licensed nursing staff will be re-educated on GSS Policy Physician/Practitioner Orders and procedure for processing orders. The Director of Nursing Services designee will be responsible to encompliance through routine audits conducted weekly x4, monthly x3 results will be taken to the QAPI committee for further recommend	ed on essment, the for tion and etor of e. and/or issure is and/2018. Ed est of her and/or issure is and/or	

	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		E SURVEY IPLETED
		245279	B. WING		02/	28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	, :	STREET ADDRESS, CITY, STATE, ZIP CO 8815 WEST BROADWAY ROBBINSDALE, MN 55422		
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F 684	and NA-B stated the when a resident reference medications, had a abnormal skin color on 2/27/18, at 10:0 (DON) and register room. When DON got the bruises, R1 the bruises happer -At 10:07 a.m. the interviewed, DON staff to report the best the medical record been identified from -At 10:11 a.m. the I medical record lack bruises and DON supposed to address	ney would report to the nurse fused cares, wanted a change in behavior and or. O4 a.m. the director of nursing red nurse (RN)-A went to R1's asked R1 if she knew how she stated she did not know how ned. DON and RN-A we stated she would expect the oruises and was going to review to verify if this bruising had	F 684	Resident R8 care plan was reamended on 2/27/2018. TM/re-educated on resident R8 care on 2/27/2018. All residents in the facility that mechanical lift will be observed interviewed to verify that staff following lift procedures and a care plans. All applicable staff will be re-educated and the Care Plans. The Director of Nursing Servit designee will be responsible to compliance through routine a conducted weekly x4, monthly results will be taken to the QA committee for further recommits.	A-C was s plan of t use a ed and/or are applicable educated Lift policy. Ices and/or to ensure audits y x3. Audit API	
	indicated current di aftercare, absence dermatitis. A Progress Note da p.m., indicated regi an order from R28! Triamcinolone crea to rash (itching), Hy at bedtime for itchin for itching, RN-E in TCP (Twin Cities P passed it to on con Progress Note date RN-F indicated "Pa	Record, dated 2/22/18, iagnoses of orthopedic of right leg below knee and ated 2/23/18, late entry 3:45 istered nurse (RN)-E received 5's out of facility doctor for am 240 grams, four times daily ydroxyzine 10 milligrams (mg) ng), allegra 180 mg 1 tab in am dicated orders were faxed to hysicians) at 3:40 p.m. and ning nurse. ed 2/24/18, at 10:44 p.m., atient c/o (complaint of) rash on a groin area, back, neck, face.				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	NG		MPLETED
		245279	B. WING		0;	2/28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	bilateral antecubital paged the on call conurse practitioner) given by dermatolopharmacy, Triamcir before transcribing. R285's medications 3:45 p.m., but R285 any of the ordered Review of R285's Mecord indicated the 2/25/18, at 8:00 and 180 mg give 1 table itching R285 receiv 8:00 a.m 2/25/18, at 8:00 p.m 2/25/18, at 8:00 p.m 2/25/18, at 8:00 p.m 2/25/18 at 8:00 p.m 2/25/1	area and itching. Writer are provider, spoke with NP who said to put in the orders gist. Orders faxed to nolone needs to be clarified were ordered on 2/23/18 at 6 did not received first dose of medications until 2/25/18. Medication Administration e following: a.m., for allegra allergy tablet by mouth one time a day for ed first dose on 2/25/18 at a.m., for hydrOXYyzine HCL y mouth one time a day for ed first dose on 2/25/18 at a.m., for Triamcinolone and first dose on 2/25/18 at a.m., for Triamcinolone and first dose on 2/25/18, and arashes on abdominal fold, eck, face, antecubital, legs and cted staff to "monitor skin d spread or signs of infection. In the deep hands and body parts	F6	84		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245279	B. WING		02	/28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422		, 20, 2010
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 684	her itching R285 st. ointment it was like indicates she was "by Saturday it (the where." During an interview director of nursing for facility staff whe an outside physicia would receive the oprovider that was to the primary would enders. When aske should be available indicated "if you can the medication that depending on the tinave the medication Facility policy titled revised date of 11/2 services and health (HIM) departments processing physicia timely and accurate communication bet essential." R8's significant chan 2/8/18, indicated he impaired and required and required transfers. R8's care staff to transfer usin indicated he was no plan further identifier related to a fall. During an observat R8 was sitting in his	ated "without the pill and a 100." R285 further desperate for the cream and rash) was pretty much every on 2/28/18, at 10:45 a.m., the (DON), indicated expectations on an order was received from an included: the facility nurse order, notify the primary aking care of the resident, then either approve or give other d when would the medications to the resident, the DON at it in that day they should get a day or the next morning me and if they (pharmacy)	F 6	i84		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED
		245279	B. WING _		02/28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETION
F 684 F 689 SS=D	minutes later. At 1:: in bed. There was r R8's room. TMA-C she had transferred the mechanical lift. During an interview director of therapy s ankle fracture and v result. She stated th a mechanical lift for unable to follow dire and was incapable his right foot down. him without the lift of time. During interview on director of nursing (fall in the facility res ankle. The DON sta mechanical lift for to Free of Accident Ha CFR(s): 483.25(d)(see room alone and left a few 38 p.m. R8 was observed lying no mechanical lift in or near was interviewed and stated I him alone, without the use of She stated she should have on 2/28/18, at 9:54 a.m. the stated R8 had sustained an was non-weight bearing as a ne therapy staff recommended transfers because R8 was ections of non-weight bearing of transferring without putting She further stated transferring could cause prolonged healing 2/28/18, at 1:20 p.m. the EDON) stated R8 sustained a sulting in a fracture of his ated staff should be using a ransfers. azards/Supervision/Devices 1)(2)	F 68	34	4/15/18
	supervision and ass accidents. This REQUIREMEN by:	resident receives adequate sistance devices to prevent NT is not met as evidenced sion, interview and document		Resident R7□s care plan was am	ended

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	FIPLE CONSTRUCTION NG		` '	SURVEY PLETED
		245279	B. WING _			02/2	28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD E IE APPROPR	BE	(X5) COMPLETION DATE
F 689	transfers and ambureviewed for accided. Findings include: R7's diagnoses include blindness of one eyobtained from the tlength of the Set (MDS) dated 2/indicated resident house consistent of the set (MDS) dated 2/indicated resident house extremity providenced by need Care plan indicated encouragement with nearby and use of a for ambulation. During an observation trained medication room. TMA-A appropriate of the modern of the without socks or should be set of the without socks or should provide provide provided indicated he was undicated he was	ailed to promote safety with lation for 1 of 2 residents (R7) ints uded Alzheimer, dementia, e, glaucoma and obesity he quarterly Minimum Data 15/18. In addition, the MDS ad moderately impaired e plan dated 12/20/17, nited physical mobility related ain and deconditioning as to use walker to ambulate.	F 6	to include the preference of shoes until he gets dresse 2/28/2018 TMA-A was rese offering shoes or gripper sambulation. On 2/28/2018 re-educated on the proper Rolling Walkers. All residents who use rolling be observed and assessed they re being used proper. All appropriate staff will be the proper use of rolling waregarding offering shoes of prior to ambulation. The Director of Nursing Sedesignee will be responsible compliance through routing conducted weekly x4, mor results will be taken to the committee for further recommittee further recommit	ed. On educated of socks prior B RN-B was a usage of a usage	on r to as Nova s will re ated on d socks ad/or are	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	28/2018
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 689	Continued From page 20		F 689)		
	pulled the incontine as he bumped into TMA-A assisted R7 shoes. On 2/28/18, at 8:14	without socks or shoes. R7 ent pad up with his right hand the foot of bed. At 7:35 a.m. 7 to put on socks and and				
	walker. At 8:17 a.m the nursing station go back to his roon across the unit fron appeared agitated,	e. R7 ambulated with his n. R7 was ambulating towards when TMA-A re-directed R7 to n. R7's room was located n the nurses station. R7 raised his voice and began tered nurse (RN)-B				
	approached R7 wh down. RN-B cued I walker. From 8:18 walker seat as he o RN-B approached remain where he w room. R7 stated he	o stated he wanted to sit R7 to sit on the seat of his a.m. to 8:25 a.m. R7 sat on the dozed on and off. At 8:26 a.m. R7 and asked if he wanted to vas or sit at a table in the dining wanted to sit at the table. do you want me to push you				
	there" as he sat on RN-B pushed R7's	the walker seat. At 8:27 a.m. walker as R7 sat on it from the room which was approximately				
	acknowledged she to ambulation in his a behaviors that into on until he got dresstaff applied the she had reported thad not.	n 2/28/18, at 10:57 a.m. TMA-A had not offered R7 shoes prior s room. TMA-A stated R7 had cluded not wanting his shoes sed and would have yelled if loes before that. When asked if his to the nurse she stated she				
	on the walker beca his legs and felt it v	B stated she had wheeled R7 use he had complained about was better to wheel him. When amiliar with the manufacturer				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	28/2018	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY				STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION S	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 689	the walker she state asked if she would offered the shoes win the room, RN-B stated R7 was a fall gait. On 2/28/18, at 12:1 not supposed to puwalker. RN-C further staff to offer R7 the refused them until her A review of Nova R Safety Warning instruction of use as a wheeled Do not self propel of	ing someone when seated on ed she did not know. When have expected TMA-A to have when resident was ambulating stated "yes." RN-B further I risk and had an unsteady 0 p.m. RN-C stated staff were sh R7 while seated on his er stated she would educate shoes even though R7	F 6	,			

(X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES

F6279028

(X2) MULTIPLE CONSTRUCTION

Printed: 03/07/2018 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING 02 - MAIN BLDG COMPLETED 245279 03/01/2018 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3815 WEST BROADWAY GOOD SAMARITAN SOCIETY - SPECIALTY CA ROBBINSDALE, MN 55422** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY PREFIX (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX CROSS-REFERENCED TO THE APPROPRIATE TAG OR LSC IDENTIFYING INFORMATION) TAG DEFICIENCY) K 000 INITIAL COMMENTS K 000 **FIRE SAFETY** An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 01, 2018. At the time of this survey, Good Samaritan Society - Specialty Care Community was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR. Subpart 483.70(a). Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. Good Samaritan Society - Specialty Care Community is a 3-story building with a basement that was built in 2012 and determined to be Type II (111) construction. The facility is fully protected throughout by an automatic fire sprinkler system and has a fire alarms system with complete smoke detection that is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 88 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET. (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered March 15, 2018

Ms. Nicole Mattson, Administrator Good Samaritan Society - Specialty Care Community 3815 West Broadway Robbinsdale, MN 55422

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5279028

Dear Ms. Mattson:

The above facility was surveyed on February 25, 2018 through February 28, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

Good Samaritan Society - Specialty Care Community March 15, 2018 Page 2

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 contact Susanne Reuss, Unit Supervisor at (561) 201-3793 or at susanne.reuss@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Licensing and Certification Program Minnesota Department of Health

Kumalu Fiske Downing

P.O. Box 64900

St. Paul, MN 55164-0900

Telephone: (651) 201-4112 Fax: (651) 215-9697

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

cc: Licensing and Certification File

(X6) DATE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00890	B. WING		02/28/2018	8
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA 3815 WE	DDRESS, CITY, S ST BROADW SDALE, MN		•	
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2 000	Initial Comments		2 000			
	****ATTEI	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this correct pursuant to a surver found that the deficiency form of the many survers of the Minnesota Department of the Minnesota Department of the Minnesota Performance of the mumber and MN Russian survey.	nether a violation has been compliance with all rule provided at the tag ule number indicated below.				
	comply with any of lack of compliance. re-inspection with a result in the assess	ns several items, failure to the items will be considered Lack of compliance upon my item of multi-part rule will ment of a fine even if the item uring the initial inspection was				
	that may result from orders provided tha the Department with	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
	receipt of State lice the Minnesota Depa Informational Bullet http://www.health.si	participate in the electronic nsure orders consistent with artment of Health in 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/24/18 **Electronically Signed**

TITLE

STATE FORM 6899 4UW711 If continuation sheet 1 of 28

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	28/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
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2 000	Department of Heal you electronically. Is necessary for State enter the word "corn text. You must then State licensure proceed completion date, the corrected prior to el Minnesota Department's staff of the following correct Please indicate in your and identify the date Minnesota Department's the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned to Minnesota Department the State Licensing federal software. The assigned tag in column entitled "ID statute/rule number the state statute/rule in the "Summary Statute after the state as evidenced by." findings are the Sugand the Time Period	Althorders being subralthough no plan of oute Statutes/Rules, prected" in the box avaindicate in the electronicate in the electronicate your orders we ectronically submitting the end of Health. 2/28/18, surveyors ovisited the above protion orders are issued our electronic plan on have reviewed these when they will be contracted by the electronic plan of the electr	correction lease ailable for ronic ding ill be ng to the of this ovider and ed. of e orders, completed. umenting using en ules for e far left ate ing text of is listed cies" ortion of includes e state e not met cors correction	2 000			
	FOURTH COLUMN "PROVIDER'S PLA		N." THIS				

Minnesota Department of Health

STATE FORM 6899 4UW711 If continuation sheet 2 of 28

	TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/28/2018		
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	T BROADW DALE, MN 🤄				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 000	Continued From pa	ge 2	2 000				
	THIS WILL APPEA	R ON EACH PAGE.					
	PLAN OF CORREC	QUIREMENT TO SUBMIT A OTION FOR VIOLATIONS OF E STATUTES/RULES.					
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			4/15/18	
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident is bed.					
	by: Based on observation review, the facility for transfers and ambureviewed for accide bruising for 1 of 2 mon-pressure related provide timely treat (R285) reviewed with staff followed the plane.	ent is not met as evidenced on, interview and document ailed to promote safety with alation for 1 of 2 residents (R7) ents and failed to investigate esidents (R1) reviewed for ed skin concerns, failed to ment for 1 of 1 residents th a rash, and failed to ensure an of care to promote safety (R8) reviewed with a status.		Corrected, no POC required			

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00890		B. WING		02/2	28/2018
-	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S BT BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
2 830	R7's diagnoses incl blindness of one ey obtained from the th Set (MDS) dated 2/indicated resident had cognition. R7's care identified R7 had ling to lower extremity providenced by need Care plan indicated encouragement with nearby and use of a for ambulation. During an observation trained medication aroom. TMA-A approaching to get him read trained medication aroom. TMA-A cued R7 to sat at the edge of the ambulated into the without socks or sh R7 was observed we stated "My pants are the incontinent brief TMA-A cued R7 to spericare. As R7 stounsteady. TMA-A the to the toilet. R7 too TMA-A cued him to completed pericare incontinent pad. R7 a chair on the other walked across the runsteady and without the incontinent pad bumped into the food into the food bumped into the food bum	uded Alzheimer, der e, glaucoma and ob ne quarterly Minimur 15/18. In addition, th ad moderately impa e plan dated 12/20/1° nited physical mobili ain and decondition to use walker to am	esity m Data le MDS ired 7, ty related lng as bulate. uipment led walker 19 a.m. d R7's d she was 22 a.m. loom. R7 lated looked on, and leld onto 7:26 a.m. lorovide vas ked over lilet and las she throom to R7 led to be R7 led	2 830			

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890		B. WING		02/2	8/2018
NAME OF	PROVIDER OR SUPPLIER			, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		T BROADW DALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	On 2/28/18, at 8:14 a room with a scale walker. At 8:17 a.m the nursing station go back to his room across the unit from appeared agitated, swearing and regis approached R7 wh down. RN-B cued f walker. From 8:18 walker seat as he of RN-B approached remain where he wroom. R7 stated he RN-B then stated there" as he sat on RN-B pushed R7's dining room to the 50 feet distance. During interview on acknowledged she to ambulation in his a behaviors that incon until he got dress staff applied the sh she had reported the shead reported the shad not. -At 11:00 a.m. RN-on the walker becahis legs and felt it wasked if she was fainstruction for push the walker she stat asked if she would offered the shoes win the room, RN-B in the ro	age 4 I a.m. TMA-A escorte I. R7 ambulated with I. R7 was ambulating when TMA-A re-direct In. R7's room was loca In the nurses station. It raised his voice and tered nurse (RN)-B III o stated he wanted to R7 to sit on the seat of a.m. to 8:25 a.m. R7 III dozed on and off. At 8 R7 and asked if he w III as or sit at a table in III wanted to sit at the to III do you want me to put the walker seat. At 8 III walker as R7 sat on III room. TMA-A stated cluded not wanting his is sed and would have III ose before that. When III is to the nurse she s III stated she had when III was better to wheel his III was better to wheel his III was and had an uns III risk and had an uns III risk and had an uns	his towards towards sted R7 to ated R7 began of sit of is sat on the size a.m. anted to the dining table. It is is sat on the coximately on. TMA-A hoes prior I R7 had as shoes yelled if the asked if tated she seeled R7 ed about m. When acturer eated on When A to have abulating rther	2 830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/2	28/2018
	ROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
	not supposed to puswalker. RN-C further staff to offer R7 the refused them until her A review of Nova Rosafety Warning instructure as a wheeled Do not self propel of Failure to follow the serious injury. R1's diagnoses inclupus anticoagulant Admission Record of Con 2/25/18, at 11:44 seated at the dining approached R1 was bruises on the right Con 2/26/18, at 8:51 two purple bruise in how she got them so those but for the other the sticks to get blocome" as she touch R1's care plan date potential/actual improacute knee pain as knee and yeast infe plan directed licens weekly. The care plan was the care plan date weekly. The care plan was the care plan directed licens weekly. The care plan was the care plan date weekly. The care plan was the care plan directed licens weekly. The care plan was the care plan directed licens weekly. The care plan was the care plan was the care plan directed licens weekly. The care plan was	o p.m. RN-C stated as R7 while seated or stated she would enshoes still even thouse was dressed. colling Walker User Corructions directed the chair or to transport as a scoot around while se instructions can be used in the chair of the ch	on his educate augh R7 duide auser "Do someone. a seated" ead to hritis and from the asked ow about cause of just R1 had ed to mation on The care skin ation for	2 830			

6899

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/2	8/2018
NAME OF F	PROVIDER OR SUPPLIER		I.	STATE, ZIP CODE	, JE/E	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	T BROADW			
OVA) ID	CHMMADV CTA	TEMENT OF DEFICIENCIES	DALE, MN	PROVIDER'S PLAN OF CORRECTION	N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 6	2 830			
		's Skin Observation- V2 dated aled nurse had indicated there ons observed.				
	revealed R1 had an Coumadin 2 mg eve Wednesday, Thurs syndrome until 3/1/	e physician orders it was n order dated 2/26/17, for ery Monday, Tuesday, day for lupus anticoagulant 18 and Prednisone 10 mg ted 2/24/18, for rheumatoid				
	On 2/27/18, at 9:39 a.m. nursing assistant (NA)-A and NA-B stated they would report to the nurse when a resident refused cares, wanted medications, had a change in behavior and abnormal skin color.					
	(DON) and register room. When DON a got the bruises, R1 the bruises happen-At 10:07 a.m. the I interviewed, DON s staff to report the bithe medical record been identified from At 10:11 a.m. the I medical record lack bruises and DON s supposed to address	OON and RN-A we tated she would expect the ruises and was going to review to verify if this bruising had				
	indicated current dia aftercare, absence dermatitis.	Record, dated 2/22/18, agnoses of orthopedic of right leg below knee and uted 2/23/18, late entry 3:45				

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	<u>ITA DEPARTMENT OF HE</u> IT OF DEFICIENCIES	(X1) PROVIDER/SUPPL	IER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION N	UMBER:	A. BUILDING:		COMP	LETED
		00890		B. WING		02/2	8/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- CDECIALTY CA	3815 WES	ST BROADW	AY		
GOOD 3	AWARITAN SOCIETY	- SPECIALIT CA	ROBBINS	DALE, MN 5	55422		
(X4) ID PREFIX		TEMENT OF DEFICIENCI MUST BE PRECEDED B	-	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORM		TAG	CROSS-REFERENCED TO THE APPRO		DATE
					DEFICIENCY)		
2 830	Continued From pa	ge 7		2 830			
	p.m., indicated regi	stered nurse (RN)-E	Ereceived				
	an order from R285						
	Triamcinolone crea						
	to rash (itching), Hy at bedtime for itchir						
	for itching, RN-E inc						
	TCP (Twin Cities Pl						
	passed it to on com						
	Progress Note date						
	RN-F indicated "Pa	` .	,				
	the abdominal fold, bilateral antecubital						
	paged the on call ca						
	(nurse practitioner)						
	given by dermatolog						
	pharmacy, Triamcir		clarified				
	before transcribing.		/00/10 ot				
	R285's medications 3:45 p.m., but R285						
	any of the ordered						
	Review of R285's M						
	Record indicated th						
		a.m., for allegra alle					
	180 mg give 1 table itching R285 receiv						
	8:00 a.m.	ed ilist dose on 2/2	5/10 at				
		o.m., for hydrOXYyz	zine HCL				
	tablet give 81 mg b						
	itching R285 receiv	ed first dose on 2/2	5/18 at				
	8:00 p.m.	fou Tuious sin ala					
	- 2/25/18, at 8:00 p Acetonide Cream 0	.m., for Triamcinolo					
	four times a day for						
	on 2/25/18 at 8:00 p		5. 5000				
	R285's care plan w	as updated 2/27/18					
	indicated R285 had		,				
	groin area, back, ne						
	foot. Care plan dire						
	rashes for increase Avoid scratching ar						

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/2	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	BT BROADW			
(V4) ID	SLIMMARY STA	TEMENT OF DEFICIENCIES	DALE, MN S	PROVIDER'S PLAN OF CORRECTION)N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
2 830	Continued From pa	ge 8	2 830			
	from excessive mo					
		on 2/27/18, at 1:42 p.m., riginal ointment for the rash				
		d the rash was spreading and				
	it was everywhere b	out the bottom of my foot."				
		dermatologist instructed her				
		ointment on her face, the new ody and ordered a pill for the				
	itching in the morni	ng and a pill for something at				
		from a scale of 1-10 to rate				
		ated "without the pill and a 100." R285 further				
		desperate for the cream and				
		rash) was pretty much every				
	where."	on 2/28/18, at 10:45 a.m., the				
		(DON), indicated expectations				
	for facility staff whe	n an order was received from				
		ns included: the facility nurse order, notify the primary				
		aking care of the resident, then				
	the primary would e	either approve or give other				
		d when would the medications				
		to the resident, the DON If it in that day they should get				
		day or the next morning				
	depending on the ti	me and if they (pharmacy)				
	have the medicatio	n." Physician/Practitioner Orders				
		2016 indicated "The nursing				
	services and health	information management				
		each have responsibilities for				
		an/practitioner orders in a employment manner. Teamwork and				
		ween the two departments is				
	essential."	·				
	R8's significant cha	inge minimum data set dated				
	2/8/18, indicated he	e was severely cognitively red extensive assistance for				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		* *	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00890		B. WING		02/2	28/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	transfers. R8's care staff to transfer using indicated he was not plan further identified related to a fall. During an observat R8 was sitting in his approximately 1:35 (TMA)-C entered the minutes later. At 1: in bed. There was not R8's room. TMA-C she had transferred the mechanical lift. During an interview director of therapy ankle fracture and result. She stated to a mechanical lift for unable to follow director of the lift of th	e plan dated 2/7/18, dang mechanical lift and on-weight bearing. The da fracture of his right ion on 2/27/18, at 1:2 is room in his wheel of p.m. trained medicate room alone and lef 38 p.m. R8 was obseased mechanical lift in of was interviewed and him alone, without the She stated she should he therapy staff record transfers because Frections of non-weight of transferring without She further stated she	de care ght ankle 24 p.m. hair. At tion aide it a few erved lying or near distated he use of ld have a.m. the ned an ing as a mmended as was a bearing at putting ansferring ed healing the tained a finis listing a	2 830			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION (X3) DAT A. BUILDING:			
		00890	B. WING		02/	28/2018
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815	ET ADDRESS, CITY, WEST BROADV BINSDALE, MN	VAY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 830	implemented; to red bruises. The director of nurs staff regarding med timeliness of medic administration. The conduct random au to medication order. In addition, the directory could review all result assure they are rectreatment/services nursing or designed audits of the delive appropriate care and TIME PERIOD FOR (21) days.	ropriate care and services duce of the development of sing or designee could edulication transcription and ation procurement and director of nursing could dits to ensure timely respo	nse e, to or of			4/15/18
	Subp. 6. Activities comprehensive res home must ensure A. a resident is treatments and ser abilities in activities deterioration is a not the resident's condipart, activities of da resident's ability to: (1) bathe, dres (2) transfer an (3) use the toil (4) eat; and	of daily living. Based on the ident assessment, a nursing that: given the appropriate vices to maintain or improve of daily living unless ormal or characteristic partation. For purposes of this ily living includes the as, and groom; dambulate;	e ng e			4, 10, 10

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00890	B. WING		02/2	8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW			
(VA) ID	CLIMMA DV CTA	ATEMENT OF DEFICIENCIES	DALE, MN	PROVIDER'S PLAN OF CORRECTION	ON	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	age 11	2 915			
	functional commun	ication systems; and				
	by:	ent is not met as evidenced		Corrected, no POC required		
	Based on interview and document review, the facility failed to provide rehabilitation services for 1 of 2 residents (R285) reviewed for activities of daily living.			Odirected, no r Od required		
	Findings include:					
	indicated current di aftercare, absence dermatitis. R285's care plan, chad limited physica BKA (below the knedirected staff to proassistance with motransfers and weigh Physical Therapy D2/24/18, indicated p(PTA)-A provided the for 31 minutes. PTA-A note dated 2 indicated "There Exand endurance. Pt B (bilateral) LE (low ext, X15 reps, supin Cueing to perform needed. During an interview	record, dated 2/22/18, lagnoses of orthopedic of right leg below knee and dated 2/27/18, indicated R285 all mobility due to edema to right lee amputation). The care plan ovide R285 stand by ability, use of a wheelchair for not bearing as tolerated. Daily Treatment Note dated onlysical therapy assistant therapeutic exercises to R285 all contents and competed (sic) were extremity) knee flex and the SLR, quad sets 12 reps X2. correct motions. Rest breaks and the SLR, at 4:03 p.m.,				
	and instructed R28	4/18 PTA-A stood at the door 5 to do the exercises that were e and then left without having				

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Millinesc	ita Department of He	eaith				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMP	LETED
			D WING			
		00890	B. WING		02/2	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AF	DRESS CITY S	STATE, ZIP CODE		
10.00	THO VIDEN ON OOM LIEN					
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 915	Continued From pa	age 12	2 915			
	worked with the rest During an interview director of rehab ver R285 per PTA-A dot treatment and did to strengthening, endre exercises correctly. PTA-A did not work stated "I would say documentation, but his word vs her work evidence that R285 re-approached. During an interview PTA-A stated he were R285 and that they During a follow up to 2:22 p.m., PTA-A stated he were and was a document of the puring an interview administrator when suppose to docume when they did not seen they are suppose to the puring an interview director of rehab incompose to the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview director of rehab incompose to document of the puring an interview and puring an intervie	sident. y on 2/28/18, at 9:31 a.m., erified PTA-A worked with ocumentation for 30 minute herapeutic exercises for urance, used verbal cues to do. When told R285 stated with her, the director of rehabilities he did do the work per his as he is also cognizant and it's rd. There was no documented was not compliant or was a con 2/28/18, at 1:20 p.m., ent through exercises with had worked in her room. It call from PTA-A on 2/28/18, at tated he "didn't actually see umentation error." y on 2/28/18, 2:45 p.m., the asked are facility staff ent that they saw a resident see them stated she would not alsify documents. y on 2/28/18, at 2:57 p.m., the dicated if residents are not see the document resident was ed PTA-A was scheduled to 18 and there were no als on that day. Director of ated staff are provided with a uppose to carry them out. Station Clinical Frequently evised date of February 2018, TX required a daily note which mentation to support each well as documenting the				

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SUGGESTED METHOD OF CORRECTION:

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_	TEMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00890		B. WING	····	02/2	28/2018
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S T BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 915	The director of reha educate responsible residents' receiving of rehab or designe skilled treatments to consistently.	ge 13 ab and/or designee coule staff to provide care skilled therapies. The ecould conduct audits of ensure their ineeds and CORRECTION: Twe	to director s of are met	2 915			
21426	(a) A nursing home maintain a compreh infection control procurrent tuberculosis issued by the United Control and Preven Tuberculosis Elimin Morbidity and Morta This program must infection control pla unpaid employees, residents, and volumed the shall provide regarding implements.	e provider must establishensive tuberculosis ogram according to the sinfection control guided States Centers for Dition (CDC), Division of lation, as published in lality Weekly Report (Minclude a tuberculosis in that covers all paid a contractors, students, neers. The Department of the guideline lance with this subdivision accounts that covers are technical assistance of the guideline lance with this subdivision accounts to the subdivision accoun	sh and most elines isease CDC's MWR). and nt of	21426			4/15/18
	by:	ent is not met as evide and document review,			Corrected, no POC required		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/2	28/2018
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
21426	agency failed to ene R56, R131, R1) and Tuberculin Skin Ted documented appropriate appropriate and 2/15/18, at 11:2 the medical record indifirst and second stand 2/15/18, at 11:2 the medical record been read within 48 State regulation. R56 was admitted to medical record indifirst and second stand 1/110/18, at 2:3 the medical record indifirst and second stand 1/110/18, at 2:3 the medical record been read within 48 State regulation. R131 was admitted medical record indifirst step TST on read on 2/24/18, at medical record reversed within 48-72 h regulation. R1 was admitted to medical record indifirst step TST on 2/read on 2/17/18, at medical record reversed within 48-72 h regulation.	sure 4 of 5 residents (d 1 of 5 employees (Est (TST) results were priately per State regulated R77 was administed TST on 2/8/18, at 227 a.m. respectively have alled the TST had 3-72 hours as directed to the facility on 1/2/18 cated R56 was administed TST on 1/3/18, at 934 p.m. respectively have alled the TST had 3-72 hours as directed R5-72 hours as directed by the state of the facility on 2/15/18 cated R1 was administration as directed by the state of the facility on 2/15/18 cated R1 was administration as directed by the state of the TST had not ours as directed by the state of the TST had not our	Jalation. 3. The sistered a 2:12 p.m. owever, in not is by the 3. The sistered a 2:49 p.m. owever, is not is by the inistered and was ne is been see State 3. The stered a nd was the is been see State is state is state in the state is state in the state is state is state in the state in the state is state in the state in the state is state in the state in th	21426			

Minnesota Department of Health

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Minnesota Department of Health
STATEMENT OF DEFICIENCIES (X1)

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
7.1.12 . 27.1.1	G. GG2GG		A. BUILDING:		00	
		00890	B. WING		02/2	8/2018
NAME OF F	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALLY CA	ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21426	Continued From pa	ge 15	21426			
		the staff was supposed to vithin the time frame per the				
	12/29/17. Review o second TST admin read 1/13/18, at 2:3 as 0 millimeter (mm results revealed the	identified a hire date of f the file indicated E-1 had a istered on 1/10/18 and was 80 p.m. with results identified a) and negative however, the e TST lacked documentation of read as directed by the State				
	second step TST la -At 12:07 p.m. the c had been informed two hours before 48	16 p.m. RN-D verified E-1's acked time given and read. director of nursing stated she the TST's were being read B hours and would have s to follow the State regulation				
	The Director of nurse review and revise p staff and monitor to (TST) are read, rest that employees are (TB) using a symptosingle step IGRA (In Assay blood test) or	THOD OF CORRECTION: sing and/or designee could colicies and procedures, train assure Tuberculin Skin Tests cults documented; and assure screened for tuberculosis om screen, and by either a interferon Gamma Release r a two-step TST and priately per State regulation.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-One				
21435	MN Rule 4658.0900 Recreation Program	0 Subp. 1 Activity and n; General	21435			4/15/18

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00890	B. WING		02/2	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Subpart 1. General home must provide recreation program based on each indivistrengths, and need meet the physical, right well-being of each right comprehensive rescomprehensive plate 4658.0400 and 465 provided opportunities planning and develor recreation program. This MN Requirement by: Based on observation review, the facility fractivity programming R46) who were depactivity programs. Findings include: A review of the facil Boundary Waters Constructivities: Sunday - game, unities and unities music and unities and unities with the programs of the solution of the solution of the facil Boundary waters of the facil	al requirements. A nursing an organized activity and an organized activity and The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and not care required in parts 58.0405. Residents must be ries to participate in the opment of the activity and the ident is not met as evidenced from interview and document ailed to provide consistenting for 3 of 3 residents (R3, R8, bendent on staff to attend dominity, dated January and intified the following scheduled it ball toss, unit orship service in the chapel,	21435	Corrected, no POC required		

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/2	8/2018
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA 3815 WES	DRESS, CITY, S ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	worship, unit ball to poems Thursday - unit trivi jokes, ice cream so Friday - unit poems newspaper, bowling Saturday - unit gambingo, unit story tell During random obsthrough 2/28/18, the scheduled activities R3's Activity Interes 8/26/17, indicated Flistening to music, theatre, animals an quarterly minimum 11/16/18, indicated impaired and required locomotion on the unit/22/17, indicated activities, cognitive interaction. The carthat included listenitelevision and spen plan directed staff the participation and of During an observat R3 was in his room to be asleep. On 2/27/18, at At 9:	risiting, unit news/devotions, ss, bingo, unit game and unit a, unit new/devotions, unit picial and unit puzzles , unit news/devotions, unit gr, unit ball toss, unit music are, unit exercise, unit devotion, ling/snacks and unit trivia. ervations from 2/25/18 are was no evidence of a occurring on the unit. At Data Collection Tool dated are are was no evidence of a levision and movies, walking, and military service. R3's data set (MDS) dated he was severely cognitively and are plan identified preferences and to music, watching ding time with family. The care of encourage family fer pet visits. Sign on 2/25/18, at 12:07 p.m. in a wheel chair. He appeared are and and and and and a social are plan identified preferences and the was dependent on staff for stimulation and social are plan identified preferences and the was dependent on staff for stimulation and social are plan identified preferences and the was dependent on staff for stimulation and social are plan identified preferences and the plan identified preferences are plan identified preferences and the preferences are plan identified preferences are plan identified preferences and the preferences are plan identified preferences are pla	21435			
		A-A invited three residents to nit. AA-A did not invite R3 to				

Minnesota Department of Health

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/2	8/2018	
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	T BROADW DALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21435	Continued From pa	ge 18	21435				
	The television was the program. An acunit but no activity of	9 a.m. R3 was lying in his bed. on but R3 was not engaged in tivity was scheduled on the occurred. a.m., R3 was in his room with					
	the door closed. At room with the door	10:32 a.m. R3 was in his closed. A worship service ne chapel however, no one					
	During an interview on 2/25/18, at 1:09 p.m. family member (FM)-A stated the facility had some activity programs. She stated there had not been any music programs recently due to the loss of the music director. FM-A stated R3 was limited in what he could enjoy and stated she wished there was more music.						
	9/26/17, indicated hardes, fishing, footb magazines, theatre traveling. R8's quarterly MDS was severely cogniphysical assist to magazine plan dated 9/22/18, on staff for activities social interaction. The preferred activities groups, ice creams plan directed staff that activities in room if room events.	at Data Collection Tool dated the enjoyed the following: all, going to restaurants, cards, humor, worship service and dated 11/30/17, indicated he tively impaired and required nove on the unit. R8's care indicated he was dependent s, cognitive stimulation and the care plan identified that included: chapel, music social and games. The care o provide bed side visits and R8 was unable to attend out of					
	R8 was seated at a himself. He appear	ion on 2/26/18, at 9:45 a.m. table in the dining room by ed to be asleep. There were					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00890		B. WING		02/:	28/2018
	PROVIDER OR SUPPLIER	- SPECIALTY CA	8815 WES	DRESS, CITY, S T BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
21435	staff engagement. a game was scheduled for sat in front of a tele appeared to be asked his room. He could non-sensical noises residents on the ununit. The activity cale and snacks but no set alone at a table was occurring on the calendar indicated at 9:37 a.m. activity AA-A invited three runit. AA-A did not in a.m. staff assisted placed him in front a.m. the activity cal would be occurring the unit. R8 remain chair and could be Another resident was dining room. At 12: heard calling our from the calendar indicated Figure 11/1/17, identified in to music, singing, plandscaping, televis The tool indicated Finad been a farmer quarterly MDS dates severely cognitively assistance on and could atted 12/21/17, indicatef for activities, compared to the staff for activities, compared to the staff for activities, compared to the safe for activities.	The activity calendar in uled for 9:30 a.m. and a 10:30 a.m. At 10:40 a. vision on the unit. He eep. At 1:30 p.m. R8 w be heard calling out los. At 4:04 p.m. all of the it were in their rooms of lendar identified unit poactivity occurred. on 2/27/18, at 9:30 a.m. in the dining room. No is unit even though the an exercise group at 9:27 aide (AA-A) entered the esidents to an activity exite R8 to the activity. R8 back to his room are of the television. At 10 endar indicated unit jok. No activities were offed in his room in his wheard yelling out occase as asleep at a table in the 12 p.m., R8 could still the	a ball .m. R8 as in ud e or off the oems n. R8 activity activity 30 a.m. he unit. off the At 9:38 hd b:22 ces ered on heel sionally. the oe I dated istening talking. ary and she was if e plan ent on d social	21435			

Minnesota Department of Health

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		STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CA 3815 WEST BROADWAY ROBBINSDALE, MN 55422 (X4) ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21435 Continued From page 20 one to one bedside activities if unable to attend out of room. The care plan identified music, polka, news and cards as his preferred activities. During observation on 2/27/18, at 9:37 a.m. activity aide (AA-A) entered the unit. AA-A did not invite R46 to the activity. At 10:28 a.m., R46 was in his room. No activities occurred on the unit. At 1:18 p.m. R46 was in his room laying in bed. The activity calendar indicated a unit puzzle was scheduled but no activity occurred. At 1:46 p.m. R46 remained in his room alone. No activity occurred and staff did not enter the room to engage R46 in any way. On 2/28/17, at 10:32 a.m., R46 again was observed laying in bed in his room. A worship service was being held in the chapel but staff did			00890		B. WING		02/	28/2018
(X4) ID PREFIX TAG (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH DEFICIENCY) (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) 21435 Continued From page 20 one to one bedside activities if unable to attend out of room. The care plan identified music, polka, news and cards as his preferred activities. During observation on 2/27/18, at 9:37 a.m. activity aide (AA-A) entered the unit. AA-A invited three residents to an activity off the unit. AA-A did not invite R46 to the activity. At 10:28 a.m., R46 was in his room. No activities occurred on the unit. At 1:18 p.m. R46 was in his room laying in bed. The activity calendar indicated a unit puzzle was scheduled but no activity occurred. At 1:46 p.m. R46 remained in his room alone. No activity occurred and staff did not enter the room to engage R46 in any way. On 2/28/17, at 10:32 a.m., R46 again was observed laying in bed in his room. A worship service was being held in the chapel but staff did	NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE DATE DEFICIENCY)	GOOD S	AMARITAN SOCIETY	- SPECIALTY CA					
one to one bedside activities if unable to attend out of room. The care plan identified music, polka, news and cards as his preferred activities. During observation on 2/27/18, at 9:37 a.m. activity aide (AA-A) entered the unit. AA-A invited three residents to an activity off the unit. AA-A did not invite R46 to the activity. At 10:28 a.m., R46 was in his room. No activities occurred on the unit. At 1:18 p.m. R46 was in his room laying in bed. The activity calendar indicated a unit puzzle was scheduled but no activity occurred. At 1:46 p.m. R46 remained in his room alone. No activity occurred and staff did not enter the room to engage R46 in any way. On 2/28/17, at 10:32 a.m., R46 again was observed laying in bed in his room. A worship service was being held in the chapel but staff did	PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY I	S FULL	ID PREFIX	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
During an interview on 2/27/18, at 2:55 p.m. AA-A stated the staff on the unit were responsible for most of the activities occurring on the unit. AA-A stated the trained medication aides (TMA)'s don't do the activities and stated it had been a "challenge" since she started. During an interview on 2/27/18, at 1:37 p.m. TMA-C stated most of the activities are done by the staff on the floor. TMA-C stated there was a schedule but stated the schedule did not work and stated they do activities when they have a chance. TMA-A stated R8 does not do much except bingo. During an interview on 2/27/18, at 2:04 p.m. the director of therapeutic recreation (DTR) stated she assisted in developing the activity calendar.	21435	one to one bedside out of room. The capolka, news and capolka, new	activities if unable to are plan identified must rds as his preferred at on 2/27/18, at 9:37 at entered the unit. AAn activity off the unit. activity. At 10:28 a.r. activities occurred of 46 was in his room la lendar indicated a union activity occurred. In his room alone. Notice in his room alone. Notice in his room. A woneld in the chapel but end. on 2/27/18, at 2:55 phe unit were response occurring on the unit were response occurring on the unit attended in his room. A woneld in the chapel but end. on 2/27/18, at 2:55 phe unit were response occurring on the unit attended in his room. A woneld in the chapel but end. on 2/27/18, at 2:55 phe unit were response occurring on the unit activities are of the activities are of the activities are of the activities when they have activities wh	sic, activities. a.m. A invited AA-A did m., R46 on the aying in lit puzzle At 1:46 o activity in to as literated as a literate at work literate at work literate a literate at	21435			

Minnesota Department of Health

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890		B. WING		02/2	8/2018
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN 5			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		ID ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
21435	Continued From pa	nge 21		21435			
	led by the floor staff activities staff was further stated they the unit over to the because they don't secured unit. The Eresidents on the unand staff try to do in She stated the facil retired at the end o trying to meet the n department. She st done in a while. Sh of residents asking	f. The DTR stated the on the unit at least da could not bring anyon secured unit to join a want extra residents DTR stated a lot of the lit liked to stay in their ndividualized program lity had a music thera f December and staff need fro music within rated concerts had not a further stated she her about music and to replace the music to	aily. She the from the ctivities on the trooms ming. pist who were the to been the dad a lot stated				
	trained medication to sit in the dining r music. TMA-A state responsible for initia	on 2/28/18, at 10:40 aided (TMA)-A stated oom and listen to a low the staff on the unitating most of the activate staff did not have	I R3 used of of were vities on				
	director of nursing	n 2/28/18, at 1:04 p.m (DON) stated She wa not being done on the	s aware				
	A facility policy relawas requested but	ted to activity prograr not received.	nming				
	The activity director systems of ensuring cognitively impaired Director could educe	THOD FOR CORRECT or designee could do go activity programming residents. The Activities all appropriate staystems to ensure o	evelop ig for ity aff and				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					SURVEY LETED
			A. BOILDING.			
		00890	B. WING	· · · · · · · · · · · · · · · · · · ·	02/2	8/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALLY CA	ST BROADW SDALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21435	Continued From pa	age 22	21435			
	TIME PERIOD FOR Twenty-One (21) da					
21830	MN St. Statute 144 Residents of HC Fa	.651 Subd. 10 Patients & ac.Bill of Rights	21830			4/15/18
	Subd. 10. Particip notification of family	pation in planning treatment; y members.				
	in the planning of the includes the opport alternatives with incopportunity to require care conferences, a family member or oboth. In the event to present, a family member or conferences.	Il have the right to participate neir health care. This right tunity to discuss treatment and dividual caregivers, the est and participate in formal and the right to include a other chosen representative or that the resident cannot be ember or other representative dent may be included in such				
	unconscious or cor communicate, the f efforts as required either a family men writing by the reside	who enters a facility is matose or is unable to facility shall make reasonable under paragraph (c) to notify mber or a person designated in ent as the person to contact in				
	admitted to the faci family member to p planning, unless the to believe the resid directive to the con-	the resident has been ility. The facility shall allow the participate in treatment e facility knows or has reason ent has an effective advance trary or knows the resident has				
	member included in notifying a family m family member to p planning, the facility efforts, consistent v	that they do not want a family in treatment planning. After member but prior to allowing a participate in treatment by must make reasonable with reasonable medical ine if the resident has				
	practice, to determi	ine ii the resident has				

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		00890	B. WING		02/	28/2018
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815 W	ADDRESS, CITY, SEST BROADW	'AY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21830	executed an advance sident's health car this paragraph, "rea (1) examining the resident; (2) examining the resident in the poss (3) inquiring of ar family member con whether the resider directive and wheth physician to whom care; and (4) inquiring of the resident normally gwhether the resider directive. If a facilit designated emerge member to participa accordance with thi liable to resident for the notification of the mergency contact family member was patient's privacy rig (c) In making rea family member or directive the facility shall attembers or a design examining the persand the medical reconsession of the facility a family memergency contact admission, the facil social service agen agency that the resthe facility has been	ce directive relative to the e decisions. For purposes of asonable efforts" include: e personal effects of the ession of the facility; my emergency contact or tacted under this section at has executed an advance er the resident has a the resident normally goes for e physician to whom the poes for care, if known, at has executed an advance y notifies a family member of ncy contact or allows a family ate in treatment planning in s paragraph, the facility is not a damages on the grounds the family member or or the participation of the improper or violated the	or Y t at			

6899

		(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBI	:D. `	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00890	В. V	WING		02/2	8/2018	
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CA 3815 WEST BROADWAY ROBBINSDALE, MN 55422							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21830	county social service enforcement agency identifying and notify designated emerge service agency or lethat assists a facility subdivision is not liad damages on the grothe family member participation of the or violated the patient or violated the patient of the facility for the	te agency and local law y shall assist the facility ying a family member oncy contact. A county socal law enforcement agy in implementing this able to the resident for bunds that the notification emergency contact of family member was imports privacy rights. The privacy rights are to accommodate on, interview and docuralled to accommodate on for 1 of 1 resident (Resident contact).	ture a Set ursing 4/18, 0 a.m. esident ed	1830	Corrected, no POC required			

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Minnesota Department of Health							
		(X1) PROVIDER/SUPPLIE		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUI	MBER:	A. BUILDING:		COMPLETED	
			ļ				
		00890		B. WING		02/2	8/2018
		00000				<i>VL</i>	0/2010
NAME OF F	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		T BROADW			
	AMAIIIAN OOOLL	OI LOIALI I GA	ROBBINS	DALE, MN 5	55422		
(X4) ID		ATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		Y MUST BE PRECEDED BY .SC IDENTIFYING INFORMA		PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
TAG		OU IDENTIFICATION OF THE	(TION)	TAG	DEFICIENCY)	THALL	2
21830	Continued From pa	ıge 25		21830			
	R77 appeared upse	et, shaking and stated	d in a				
		ame here at 6:46 a.m					
	woke me up and wa	anted me to go do the	erapy. I				
		eep well at night beca					
		d had pain and she to					
		ercises. She left and					
		used. All I told her wa					
		nd needed to just stay					
		she went and told lie					
		to tell her that was n					
		tated she had been w					
		nroom. She stated the					
		he was going to find h				l	
		e needed to go to the				l	
		ed surveyor to help he all light and as survey					
		an light and as survey 7 stated "I didn't sleep					
		her I would not come	•				
		rill come later. She did					
		At 7:24 a.m. nursing					
		transfer belt and tran					
		air and in the bathroo					
		the toilet. At 7:30 a.m					
		oilet NA-B transferred					
		shed the chair to the					
		77 by the bed. R77 as					
	NA-B who the thera	apist was and still sou	unding				
	upset stated "I did r	not refuse. I told her I	had not				
	slept at night and ju	ust wanted to do it late	er." NA-B				
	told R77 she would	I find out who the ther	rapist				
	was.						
		a.m. the occupation					
		ed she had been in R					
		ad introduced herself.					
		t ready to work with h					
		t happy I was there a					
		"When asked if she					
		erence, OT stated she					
ļ	Know as this was th	ne first time she had v	worked			ļ	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED			
		00890	B. WING		02/	28/2018		
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CA 3815 WEST BROADWAY ROBBINSDALE, MN 55422							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
21830	with R77. OT also spre-completed befor R77 was the first to On 02/27/18, at 8:4 surveyor and asked the therapy staff that Surveyor told reside was wondering if sh work with her and sasked about bedtim home R77 stated si watching television get out of bed arour asked about toilet in when she needed to assistance. On 2/27/18, at 10:1 (DON) reviewed the Data Collection form the assessment inditime was 8:30 a.m. had access to the astated "we have tall their schedule done it with the resident process of the stated she thought sleep and was up a stated R77 liked to in her chair. When stime, FM-C stated F7:00 a.m. FM-C stated F7:00 a.m. FM-C stated with the facility follor requests regarding stated it was frustrated.	stated her visit schedule was are she got to the facility and be seen that morning. 6 a.m. R77 approached if she had found the name at had been in her room. It she had and the resider he was going to come back urveyor stated "yes." When he and waking up when at tayed up late at night at night and stated, "I try to not seven or eight." When he are and would ask for the Nursing Admit Re-Admit on dated 2/24/18, and stated in dated 2/24/18, and stated in dated 2/24/18, and stated in dated 2/24/18, and stated it are about this they may have however, they should adjust oreferred routine." 5 AM family member (FM) R77 was afraid of going to the night even at home. FM-C sit up and doze off as she saked about R77's usual rise and routine or R77's cares and routine. Sit of R77's cares and routine.	of of ot to of ot to other versit of other versit of other o					

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STATEMENT OF DEFICIENCIES (X1)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
00890		B. WING 02/			8/2018				
NAME OF	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
GOOD SAMARITAN SOCIETY - SPECIALTY CA ROBBINSDALE, MN 55422									
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE			
21830	stated she complete schedules the previous chedules to the state encouraged the the they were early rise declined therapy, state room and let the return at the preferritherapy staff had act to access usual was department was destherapy department preferences. SUGGESTED MET Social Service and/develop /revise polieducate all facility significant properties to ensure honored, reviewed compliance.	ted the daily therapy ious day and sent the	21830						

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