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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 4UW7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245279**
2. STATE VENDOR OR MEDICAID NO. (L2) **138218700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - SPECIALTY CARE**
(L4) **3815 WEST BROADWAY**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **04/23/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12. Total Facility Beds **96** (L18)
13. Total Certified Beds **96** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Unit Supervisor 05/29/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 05/29/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE **04/06/2018** (L33)

DETERMINATION APPROVAL

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
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.

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.

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/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: 4UW7
Facility ID: 00890

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245279**
2. STATE VENDOR OR MEDICAID NO. (L2) **138218700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMU**
(L4) **3815 WEST BROADWAY**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)
6. DATE OF SURVEY **02/28/2018** (L34)
8. ACCREDITATION STATUS: __ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **12/31**

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

12.Total Facility Beds **96** (L18)
13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
An abbreviated standard survey was conducted to investigate case #H5279089.

17. SURVEYOR SIGNATURE Date :
Sandra Hick, HFE NE II 03/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Amy Johnson, Enforcement Specialist 04/05/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **04/01/1985** (L24)
23. LTC AGREEMENT BEGINNING DATE (L41)
24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

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.

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

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;

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

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
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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING ______ B. WING ______	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 2/25/18 through 2/28/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On 2/28/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose	F 561		4/15/18

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING ______ B. WING ______	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 561	Continued From page 1 activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate waking preferences for 1 of 1 resident (R77) reviewed for choices. Findings include: R77's diagnosis included left lower leg fracture obtained from the admission Minimum Data Set (MDS) dated 2/13/18. In addition, R77's Nursing Admit Re-Admit Data Collection dated 2/24/18, identified R77's usual waking time was 8:30 a.m. R77's care plan dated 2/13/18, indicated resident had an activities of daily living (ADL) deficit related to left ankle fracture due to fall as evidenced by pain, weakness, deconditioning and impaired balance/mobility. Care plan directed	F 561	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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	245279	A. BUILDING ______ B. WING ______	02/28/2018

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F 561	Continued From page 2 staff to provide extensive assistance of one staff. On 2/27/18, 7:15 a.m. the door to R77's room was observed wide open. R77 was on the phone leaving a message for her daughter, asking her to call her back immediately. R77 tone of voice suggested she was upset. When approached, R77 appeared upset, shaking and stated in a angry voice "She came here at 6:46 a.m. and woke me up and wanted me to go do therapy. I told her I did not sleep well at night because I had to use the toilet and had pain and she told me I had to go do the exercises. She left and went and told them I had refused. All I told her was I had not slept at night and needed to just stay in bed for a little more and she went and told lies that I had refused. I want to tell her that was not true." At 7:19 a.m. R77 stated she had been waiting for help to use the bathroom. She stated the therapy staff had told her she was going to find help for her. R77 stated she needed to go to the bathroom and asked surveyor to help her. Surveyor put the call light on and as surveyor walked out of the room R77 stated "I didn't sleep well and that was why I told her I would not come. She could have said I will come later. She did not need to be snotty." At 7:24 a.m. nursing assistant (NA)-B applied the transfer belt and transferred R77 to the wheelchair and in the bathroom transferred R77 to the toilet. At 7:30 a.m., after R77 had used the toilet NA-B transferred her to the wheel chair, pushed the chair to the bedside and then parked R77 by the bed. R77 asked NA-B who the therapist was and still sounding upset stated "I did not refuse. I told her I had not slept at night and just wanted to do it later." NA-B told R77 she would find out who the therapist was.	F 561	On 2/27/18 resident R77 was re-interviewed, she indicated her preferred wake time was between 6-7am, but does have some days that she likes to sleep later; her care plan was reviewed and amended. On 2/27/18 this information was shared with the Therapy Coordinator and schedules were adjusted accordingly. Preferred wake times for all residents on 1st floor will be reviewed and compared with therapy schedules to confirm accuracy. The Routine Practice Policy will be reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 561	Continued From page 3	F 561		

On 2/27/18, at 7:57 a.m. the occupational therapist (OT) stated she had been in R77's room at 6:45 a.m. and had introduced herself. The OT stated R77 was not ready to work with her. OT stated "she was not happy I was there and she was going to sleep." When asked if she knew R77's waking preference, OT stated she did not know as this was the first time she had worked with R77. OT also stated her visit schedule was pre-completed before she got to the facility and R77 was the first to be seen that morning.

On 02/27/18, at 8:46 a.m. R77 approached surveyor and asked if she had found the name of the therapy staff that had been in her room. Surveyor told resident she had and the resident was wondering if she was going to come back to work with her and surveyor stated "yes." When asked about bedtime and waking up when at home R77 stated stayed up late at night watching television at night and stated, "I try to get out of bed around seven or eight." When asked about toilet needs R77 stated when knew when she needed to go and would ask for assistance.

On 2/27/18, at 10:16 a.m. the director of nursing (DON) reviewed the Nursing Admit Re-Admit Data Collection form dated 2/24/18, and stated the assessment indicated R77's "usual waking time was 8:30 a.m." The DON stated therapy staff had access to the assessments. The DON further stated "we have talked about this they may have their schedule done however, they should adjust it with the resident preferred routine."

On 2/27/18, at 10:45 AM family member (FM)-C stated she thought R77 was afraid of going to sleep and was up at night even at home. FM-C

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F 561	Continued From page 4 stated R77 liked to sit up and doze off as she sat in her chair. When asked about R77's usual rising time, FM-C stated R77 would not be up before 7:00 a.m. FM-C stated she was having problems with the facility following up on instructions or requests regarding R77's cares and routine. She stated it was frustrating to the family. On 2/27/18, at 12:59 p.m. the director of therapy stated she completed the daily therapy schedules the previous day and sent the schedules to the staff. She stated she encouraged the therapists to ask the residents if they were early risers and stated if a resident declined therapy, staff were supposed to leave the room and let the resident know they would return at the preferred time. When asked if therapy staff had access to nursing assessment to access usual waking up time, she stated the department was developing a system to allow the therapy department access to the resident preferences.	F 561		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily	F 676		4/15/18

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F 676	Continued From page 5 living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide rehabilitation services for 1 of 2 residents (R285) reviewed for activities of daily living. Findings include: R285's admission record, dated 2/22/18, indicated current diagnoses of orthopedic aftercare, absence of right leg below knee and dermatitis. R285's care plan, dated 2/27/18, indicated R285 had limited physical mobility due to edema to right BKA (below the knee amputation). The care plan	F 676	R285s therapy documentation was reviewed and corrected on 3/22/2018. R285s MDS was modified to reflect accurate number of therapy minutes on 3/22/2018. All residents on PTA-A caseload that are currently in facility were interviewed on 3/22/2018 to verify that they received therapy services which were documented. All therapy staff will be re-educated regarding documentation accuracy.	

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F 676	Continued From page 6 directed staff to provide R285 stand by assistance with mobility, use of a wheelchair for transfers and weight bearing as tolerated. Physical Therapy Daily Treatment Note dated 2/24/18, indicated physical therapy assistant (PTA)-A provided therapeutic exercises to R285 for 31 minutes. PTA-A note dated 2/24/18, at 11:23 a.m., indicated "There Ex done to increase strength and endurance. Pt instructed and competed (sic) B (bilateral) LE (lower extremity) knee flex and ext, X15 reps, supine SLR, quad sets 12 reps X2. Cueing to perform correct motions. Rest breaks needed. During an interview on 2/25/18, at 4:03 p.m., R285 stated on 2/24/18 PTA-A stood at the door and instructed R285 to do the exercises that were done the day before and then left without having worked with the resident. During an interview on 2/28/18, at 9:31 a.m., director of rehab verified PTA-A worked with R285 per PTA-A documentation for 30 minute treatment and did therapeutic exercises for strengthening, endurance, used verbal cues to do exercises correctly. When told R285 stated PTA-A did not work with her, the director of rehab stated "I would say he did do the work per his documentation, but she is also cognizant and it's his word vs her word. There was no documented evidence that R285 was not compliant or was re-approached. During an interview on 2/28/18, at 1:20 p.m., PTA-A stated he went through exercises with R285 and that they had worked in her room. During a follow up call from PTA-A on 2/28/18, at 2:22 p.m., PTA-A stated he "didn't actually see her and was a documentation error." During an interview on 2/28/18, 2:45 p.m., the administrator when asked are facility staff	F 676	The Therapy Coordinator and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 676	Continued From page 7 suppose to document that they saw a resident when they did not see them stated she would not expect anyone to falsify documents. During an interview on 2/28/18, at 2:57 p.m., the director of rehab indicated if residents are not seen they are suppose to document resident was not seen and verified PTA-A was scheduled to see R285 on 2/24/18 and there were no documented refusals on that day. Director of rehab further indicated staff are provided with a schedule and are suppose to carry them out. SYNERTX rehabilitation Clinical Frequently Asked Questions revised date of February 2018, indicated "SYNERTX required a daily note which included daily documentation to support each CPT code billed as well as documenting the patient's response to treatment."	F 676		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide consistent activity programming for 3 of 3 residents (R3, R8, R46) who were dependent on staff to attend activity programs.	F 679	Activity Interest Data Collection and care plans for residents R3, R8 and R46 were reviewed on 3/28/2018. Activity Interest Data Collection and care plans will be reviewed for all residents on the affected	4/15/18

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F 679	Continued From page 8 Findings include: A review of the facility's activity calendars titled Boundary Waters Community, dated January and February 2018, identified the following scheduled activities: Sunday - game, unit ball toss, unit news/devotions, worship service in the chapel, unit music and unit movie Monday - unit story telling, unit jokes, unit ball toss, unit poems/snacks and unit visiting Tuesday - unit exercise, unit jokes, unit puzzle, bible study, unit trivia, unit fireside chats Wednesday - unit visiting, unit news/devotions, worship, unit ball toss, bingo, unit game and unit poems Thursday - unit trivia, unit new/devotions, unit jokes, ice cream social and unit puzzles Friday - unit poems, unit news/devotions, unit newspaper, bowling, unit ball toss, unit music Saturday - unit game, unit exercise, unit devotion, bingo, unit story telling/snacks and unit trivia. During random observations from 2/25/18 through 2/28/18, there was no evidence of scheduled activities occurring on the unit. R3's Activity Interest Data Collection Tool dated 8/26/17, indicated R3's interests included listening to music, television and movies, walking. theatre, animals and military service. R3's	F 679	unit, Boundary Waters. An interdisciplinary team will review the activity needs and develop a calendar with groups that are specific to these individuals. All applicable staff will be re-educated on the Activity Program and Routine Practice Policies. Activity Director and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 679	Continued From page 9 quarterly minimum data set (MDS) dated 11/16/18, indicated he was severely cognitively impaired and required extensive assistance for locomotion on the unit. R3's care plan dated 11/22/17, indicated he was dependent on staff for activities, cognitive stimulation and social interaction. The care plan identified preferences that included listening to music, watching television and spending time with family. The care plan directed staff to encourage family participation and offer pet visits. During an observation on 2/25/18, at 12:07 p.m. R3 was in his room in a wheel chair. He appeared to be asleep. On 2/27/18, at 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 R3 to the activity. At 10:29 a.m. R3 was lying in his bed. The television was on but R3 was not engaged in the program. An activity was scheduled on the unit but no activity occurred. On 2/28/18, at 8:17 a.m., R3 was in his room with the door closed. At 10:32 a.m. R3 was in his room with the door closed. A worship service was scheduled in the chapel however, no one invited R3 to attend. 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. R8's Activity Interest Data Collection Tool dated	F 679		

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F 679	Continued From page 10 9/26/17, indicated he enjoyed the following: rides, fishing, football, going to restaurants, cards, magazines, theatre, humor, worship service and traveling. R8's quarterly MDS dated 11/30/17, indicated he was severely cognitively impaired and required physical assist to move on the unit. R8's care plan dated 9/22/18, indicated he was dependent on staff for activities, cognitive stimulation and social interaction. The care plan identified preferred activities that included: chapel, music groups, ice cream social and games. The care plan directed staff to provide bed side visits and activities in room if R8 was unable to attend out of room events. During an observation on 2/26/18, at 9:45 a.m. R8 was seated at a table in the dining room by himself. He appeared to be asleep. There were no activities occurring on the unit, no music or staff engagement. The activity calendar indicated a game was scheduled for 9:30 a.m. and a ball toss scheduled for 10:30 a.m. At 10:40 a.m. R8 sat in front of a television on the unit. He appeared to be asleep. At 1:30 p.m. R8 was in his room. He could be heard calling out loud non-sensical noises. At 4:04 p.m. all of the residents on the unit were in their rooms or off the unit. The activity calendar identified unit poems and snacks but no activity occurred. During observation on 2/27/18, at 9:30 a.m. R8 sat alone at a table in the dining room. No activity was occurring on the unit even though the activity calendar indicated an exercise group at 9:30 a.m. 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 R8 to the activity. At 9:38 a.m. staff assisted R8 back to his room and	F 679		

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F 679	Continued From page 11 placed him in front of the television. At 10:22 a.m. the activity calendar indicated unit jokes would be occurring. No activities were offered on the unit. R8 remained in his room in his wheel chair and could be heard yelling out occasionally. Another resident was asleep at a table in the dining room. At 12:12 p.m., R8 could still be heard calling our from his room. R46's Activity Interest Data Collection Tool dated 11/1/17, identified interests that included listening to music, singing, playing an instrument, landscaping, television, cards, books and talking. The tool indicated R46 served in the military and had been a farmer and a machinist. R46's quarterly MDS dated 11/30/17, indicated he was severely cognitively impaired and required assistance on and off the unit. R46's care plan dated 12/21/17, indicated he was dependent on staff for activities, cognitive stimulation and social interaction. The care plan directed staff to provide 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	F 679		

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F 679	Continued From page 12 service was being held in the chapel but staff did not invite R46 to attend. 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 2/217/18, at 2:04 p.m. the director of therapeutic recreation (DTR) stated she assisted in developing the activity calendar. She stated the activities on the unit were mostly led by the floor staff. The DTR stated the activities staff was on the unit at least daily. She further stated they could not bring anyone from the unit over to the secured unit to join activities because they don't want extra residents on the secured unit. The DTR stated a lot of the residents on the unit liked to stay in their rooms and staff try to do individualized programming. She stated the facility had a music therapist who retired at the end of December and staff were trying to meet the need fro music within the department. She stated concerts had not been done in a while. She further stated she had a lot of residents asking her about music and stated there was no plan to replace the music therapist at this time.	F 679		

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	245279	A. BUILDING ______ B. WING ______	02/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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F 679	Continued From page 13 During an interview on 2/28/18, at 10:40 a.m. trained medication aided (TMA)-A stated R3 used to sit in the dining room and listen to a lot of music. TMA-A stated the staff on the unit were responsible for initiating most of the activities on the unit but stated the staff did not have enough time. During interview on 2/28/18, at 1:04 p.m. the director of nursing (DON) stated She was aware the activities were not being done on the units. A facility policy related to activity programming was requested but not received.	F 679		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to investigate bruising for 1 of 2 residents (R1) reviewed for non-pressure related skin concerns, failed to provide timely treatment for 1 of 1 residents (R285) reviewed with a rash, and failed to ensure staff followed the plan of care to promote safety for 1 of 1 residents (R8) reviewed with a non-weight bearing status. Findings include:	F 684	On 2/27/2018 a licensed nurse assessed resident R1□s bruise and an incident 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 be reviewed by Nurse Managers and/or their designees to ensure any non-pressure	4/15/18

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F 684	Continued From page 14 R1's diagnoses included rheumatoid arthritis and lupus anticoagulant sydrome obtained from the Admission Record dated 2/28/18. On 2/25/18, at 11:44 a.m. R1 was observed seated at the dining room area. When approached R1 was observed with two purple bruises on the right arm. On 2/26/18, at 8:51 a.m. R1 was observed with two purple bruise in the right arm. When asked how she got them stated she did not know about those but for the other bruises it was because of the sticks to get blood "sometimes they just come" as she touched her arm. R1's care plan dated 2/20/18, indicated R1 had potential/actual impairment to skin related to acute knee pain as evidenced by inflammation on knee and yeast infection under breast. The care plan directed licensed nurse to observe skin weekly. The care plan lacked documentation for staff to monitor for bruising as a side effect of medications R1 received. During review of R1's Skin Observation- V2 dated 2/25/18, it was revealed nurse had indicated there was no skin conditions observed. During review of the physician orders it was revealed R1 had an order dated 2/26/17, for Coumadin 2 mg every Monday, Tuesday, Wednesday, Thursday for lupus anticoagulant syndrome until 3/1/18 and Prednisone 10 mg once daily order dated 2/24/18, for rheumatoid arthritis. On 2/27/18, at 9:39 a.m. nursing assistant (NA)-A	F 684	related skin issues have been appropriately assessed and documented. All licensed staff will be reeducated on and GSS Procedure for Skin Assessment, Pressure Ulcer Prevention and Documentation Requirements by the Director of Nursing Services and/or designee. All nursing staff will be reeducated on daily skin observation and reporting procedures by the Director of Nursing Services and/or designee. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations. Resident R285 received her ordered medications on 2/25/2018. Resident R285 discharged from facility on 3/4/2018. There were no further documented complaints of itching during the rest of her stay. All licensed nursing staff will be re-educated on GSS Policy Physician/Practitioner Orders and the procedure for processing orders. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 684	Continued From page 15 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. On 2/27/18, at 10:04 a.m. the director of nursing (DON) and registered nurse (RN)-A went to R1's room. When DON asked R1 if she knew how she got the bruises, R1 stated she did not know how the bruises happened. -At 10:07 a.m. the DON and RN-A we interviewed, DON stated she would expect the staff to report the bruises and was going to review the medical record to verify if this bruising had been identified from admission. -At 10:11 a.m. the DON and RN-A verified the medical record lacked documentation of the bruises and DON stated R1's care plan of was supposed to address the bruising as a side effects of the medications R1 took "we did not get that in." R285's Admission Record, dated 2/22/18, indicated current diagnoses of orthopedic aftercare, absence of right leg below knee and dermatitis. A Progress Note dated 2/23/18, late entry 3:45 p.m., indicated registered nurse (RN)-E received an order from R285's out of facility doctor for Triamcinolone cream 240 grams, four times daily to rash (itching), Hydroxyzine 10 milligrams (mg) at bedtime for itching), allegra 180 mg 1 tab in am for itching, RN-E indicated orders were faxed to TCP (Twin Cities Physicians) at 3:40 p.m. and passed it to on coming nurse. Progress Note dated 2/24/18, at 10:44 p.m., RN-F indicated "Patient c/o (complaint of) rash on the abdominal fold, groin area, back, neck, face,	F 684	Resident R8 care plan was reviewed and amended on 2/27/2018. TMA-C was re-educated on resident R8□s plan of care on 2/27/2018. All residents in the facility that use a mechanical lift will be observed and/or interviewed to verify that staff are following lift procedures and applicable care plans. All applicable staff will be re-educated regarding on the Mechanical Lift Procedure and the Care Plan Policy. The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.	

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F 684	Continued From page 16	F 684		

bilateral antecubital area and itching. Writer paged the on call care provider, spoke with NP (nurse practitioner) who said to put in the orders given by dermatologist. Orders faxed to pharmacy, Triamcinolone needs to be clarified before transcribing."
R285's medications were ordered on 2/23/18 at 3:45 p.m., but R285 did not received first dose of any of the ordered medications until 2/25/18.
Review of R285's Medication Administration Record indicated the following:
- 2/25/18, at 8:00 a.m., for allegra allergy tablet 180 mg give 1 tablet by mouth one time a day for itching R285 received first dose on 2/25/18 at 8:00 a.m.
- 2/25/18, at 8:00 p.m., for hydrOXYyzine HCL tablet give 81 mg by mouth one time a day for itching R285 received first dose on 2/25/18 at 8:00 p.m.
- 2/25/18, at 8:00 p.m., for Triamcinolone Acetonide Cream 0.1% apply to rash topically four times a day for rash R285 received first dose on 2/25/18 at 8:00 p.m.
R285's care plan was updated 2/27/18, and indicated R285 had rashes on abdominal fold, groin area, back, neck, face, antecubital, legs and foot. Care plan directed staff to "monitor skin rashes for increased spread or signs of infection. Avoid scratching and keep hands and body parts from excessive moisture."
During an interview on 2/27/18, at 1:42 p.m., R285 stated "the original ointment for the rash was not working and the rash was spreading and it was everywhere but the bottom of my foot." R285 indicated her dermatologist instructed her to use the original ointment on her face, the new ointment on the body and ordered a pill for the itching in the morning and a pill for something at night. When asked from a scale of 1-10 to rate

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F 684	Continued From page 17 her itching R285 stated "without the pill and ointment it was like a 100." R285 further indicates she was "desperate for the cream and by Saturday it (the rash) was pretty much every where." During an interview on 2/28/18, at 10:45 a.m., the director of nursing (DON), indicated expectations for facility staff when an order was received from an outside physicians included: the facility nurse would receive the order, notify the primary provider that was taking care of the resident, then the primary would either approve or give other orders. When asked when would the medications should be available to the resident, the DON indicated "if you call it in that day they should get the medication that day or the next morning depending on the time and if they (pharmacy) have the medication." Facility policy titled Physician/Practitioner Orders revised date of 11/2016 indicated "The nursing services and health information management (HIM) departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner. Teamwork and communication between the two departments is essential." R8's significant change minimum data set dated 2/8/18, indicated he was severely cognitively impaired and required extensive assistance for transfers. R8's care plan dated 2/7/18, directed staff to transfer using mechanical lift and indicated he was non-weight bearing. The care plan further identified a fracture of his right ankle related to a fall. During an observation on 2/27/18, at 1:24 p.m. R8 was sitting in his room in his wheel chair. At approximately 1:35 p.m. trained medication aide	F 684		

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F 684	Continued From page 18 (TMA)-C entered the room alone and left a few minutes later. At 1:38 p.m. R8 was observed lying in bed. There was no mechanical lift in or near R8's room. TMA-C was interviewed and stated she had transferred him alone, without the use of the mechanical lift. She stated she should have used the lift. During an interview on 2/28/18, at 9:54 a.m. the director of therapy stated R8 had sustained an ankle fracture and was non-weight bearing as a result. She stated the therapy staff recommended a mechanical lift for transfers because R8 was unable to follow directions of non-weight bearing and was incapable of transferring without putting his right foot down. She further stated transferring him without the lift could cause prolonged healing time. During interview on 2/28/18, at 1:20 p.m. the director of nursing (DON) stated R8 sustained a fall in the facility resulting in a fracture of his ankle. The DON stated staff should be using a mechanical lift for transfers.	F 684		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 689	Resident R7□s care plan was amended	4/15/18

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F 689	Continued From page 19	F 689		

review, the facility failed to promote safety with transfers and ambulation for 1 of 2 residents (R7) reviewed for accidents

Findings include:

R7's diagnoses included Alzheimer, dementia, blindness of one eye, glaucoma and obesity obtained from the the quarterly Minimum Data Set (MDS) dated 2/15/18. In addition, the MDS indicated resident had moderately impaired cognition. R7's care plan dated 12/20/17, identified R7 had limited physical mobility related to lower extremity pain and deconditioning as evidenced by need to use walker to ambulate. Care plan indicated R7 required staff encouragement with mobility placing equipment nearby and use of a Rollator type wheeled walker for ambulation.

During an observation on 2/28/18, at 7:19 a.m. trained medication aide (TMA)-A entered R7's room. TMA-A approached R7 and stated she was going to get him ready for the day. At 7:22 a.m. TMA-A cued R7 to come into the bathroom. R7 sat at the edge of the bed then stood up and ambulated into the bathroom. R7 ambulated without socks or shoes, was observed with an unsteady gait and stated "My pants are falling off" as he held onto the incontinent brief and sat down. At 7:26 a.m. TMA-A cued R7 to stand so she would provide pericare. As R7 stood he indicated he was unsteady. TMA-A then asked R7 to walked over to the toilet. R7 took five steps to the toilet and TMA-A cued him to hold the grab bars as she completed pericare and applied a clean incontinent pad. R7 walked from the bathroom to a chair on the other side of the bed. As R7 walked across the room he was observed

to include the preference of not wearing shoes until he gets dressed. On 2/28/2018 TMA-A was re-educated on offering shoes or gripper socks prior to ambulation. On 2/28/2018 RN-B was re-educated on the proper usage of Nova Rolling Walkers.

All residents who use rolling walkers will be observed and assessed to ensure they□re being used properly.

All appropriate staff will be re-educated on the proper use of rolling walkers and regarding offering shoes or gripper socks prior to ambulation.

The Director of Nursing Services and/or designee will be responsible to ensure compliance through routine audits conducted weekly x4, monthly x3. Audit results will be taken to the QAPI committee for further recommendations.

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F 689	Continued From page 20	F 689		

to be unsteady and without socks or shoes. R7 pulled the incontinent pad up with his right hand as he bumped into the foot of bed. At 7:35 a.m. TMA-A assisted R7 to put on socks and and shoes.

On 2/28/18, at 8:14 a.m. TMA-A escorted R7 into a room with a scale. R7 ambulated with his walker. At 8:17 a.m. R7 was ambulating towards the nursing station when TMA-A re-directed R7 to go back to his room. R7's room was located across the unit from the nurses station. R7 appeared agitated, raised his voice and began swearing and registered nurse (RN)-B approached R7 who stated he wanted to sit down. RN-B cued R7 to sit on the seat of his walker. From 8:18 a.m. to 8:25 a.m. R7 sat on the walker seat as he dozed on and off. At 8:26 a.m. RN-B approached R7 and asked if he wanted to remain where he was or sit at a table in the dining room. R7 stated he wanted to sit at the table. RN-B then stated "do you want me to push you there" as he sat on the walker seat. At 8:27 a.m. RN-B pushed R7's walker as R7 sat on it from the dining room to the room which was approximately 50 feet distance.

During interview on 2/28/18, at 10:57 a.m. TMA-A acknowledged she had not offered R7 shoes prior to ambulation in his room. TMA-A stated R7 had a behaviors that included not wanting his shoes on until he got dressed and would have yelled if staff applied the shoes before that. When asked if she had reported this to the nurse she stated she had not.
-At 11:00 a.m. RN-B stated she had wheeled R7 on the walker because he had complained about his legs and felt it was better to wheel him. When asked if she was familiar with the manufacturer

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F 689	Continued From page 21 instruction for pushing someone when seated on the walker she stated she did not know. When asked if she would have expected TMA-A to have offered the shoes when resident was ambulating in the room, RN-B stated "yes." RN-B further stated R7 was a fall risk and had an unsteady gait. On 2/28/18, at 12:10 p.m. RN-C stated staff were not supposed to push R7 while seated on his walker. RN-C further stated she would educate staff to offer R7 the shoes even though R7 refused them until he was dressed. A review of Nova Rolling Walker User Guide Safety Warning instructions directed the user "Do not use as a wheelchair or to transport someone. Do not self propel or scoot around while seated..." Failure to follow these instructions can lead to serious injury.	F 689		

F5279028

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **02 - MAIN BLDG** B. WING ______	**03/01/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	**3815 WEST BROADWAY** **ROBBINSDALE, MN 55422**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on March 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.	K 000		

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

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

Electronically delivered
March 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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

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

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

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

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

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

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

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: ____ B. WING ____	02/28/2018

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

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2 000	Continued From page 1	2 000		

Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health.

On 2/25/18 through 2/28/18, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote safety with transfers and ambulation for 1 of 2 residents (R7) reviewed for accidents and failed to investigate bruising for 1 of 2 residents (R1) reviewed for non-pressure related skin concerns, failed to provide timely treatment for 1 of 1 residents (R285) reviewed with a rash, and failed to ensure staff followed the plan of care to promote safety for 1 of 1 residents (R8) reviewed with a non-weight bearing status. Findings include:	2 830	Corrected, no POC required	4/15/18

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2 830	Continued From page 3	2 830		

R7's diagnoses included Alzheimer, dementia, blindness of one eye, glaucoma and obesity obtained from the the quarterly Minimum Data Set (MDS) dated 2/15/18. In addition, the MDS indicated resident had moderately impaired cognition. R7's care plan dated 12/20/17, identified R7 had limited physical mobility related to lower extremity pain and deconditioning as evidenced by need to use walker to ambulate. Care plan indicated R7 required staff encouragement with mobility placing equipment nearby and use of a Rollator type wheeled walker for ambulation.

During an observation on 2/28/18, at 7:19 a.m. trained medication aide (TMA)-A entered R7's room. TMA-A approached R7 and stated she was going to get him ready for the day. At 7:22 a.m. TMA-A cued R7 to come into the bathroom. R7 sat at the edge of the bed then stood up and ambulated into the bathroom. R7 ambulated without socks or shoes. While TMA-A looked on, R7 was observed with an unsteady gait and stated "My pants are falling off" as he held onto the incontinent brief, then sat down. At 7:26 a.m. TMA-A cued R7 to stand so she would provide pericare. As R7 stood he indicated he was unsteady. TMA-A then asked R7 to walked over to the toilet. R7 took five steps to the toilet and TMA-A cued him to hold the grab bars as she completed pericare and applied a clean incontinent pad. R7 walked from the bathroom to a chair on the other side of the bed. As R7 walked across the room he was observed to be unsteady and without socks or shoes. R7 pulled the incontinent pad up with his right hand as he bumped into the foot of bed. At 7:35 a.m. TMA-A assisted R7 to put on socks and and shoes.

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2 830	Continued From page 4 On 2/28/18, at 8:14 a.m. TMA-A escorted R7 into a room with a scale. R7 ambulated with his walker. At 8:17 a.m. R7 was ambulating towards the nursing station when TMA-A re-directed R7 to go back to his room. R7's room was located across the unit from the nurses station. R7 appeared agitated, raised his voice and began swearing and registered nurse (RN)-B approached R7 who stated he wanted to sit down. RN-B cued R7 to sit on the seat of is walker. From 8:18 a.m. to 8:25 a.m. R7 sat on the walker seat as he dozed on and off. At 8:26 a.m. RN-B approached R7 and asked if he wanted to remain where he was or sit at a table in the dining room. R7 stated he wanted to sit at the table. RN-B then stated "do you want me to push you there" as he sat on the walker seat. At 8:27 a.m. RN-B pushed R7's walker as R7 sat on it from the dining room to the room which was approximately 50 feet distance. During interview on 2/28/18, at 10:57 a.m. TMA-A acknowledged she had not offered R7 shoes prior to ambulation in his room. TMA-A stated R7 had a behaviors that included not wanting his shoes on until he got dressed and would have yelled if staff applied the shoes before that. When asked if she had reported this to the nurse she stated she had not. -At 11:00 a.m. RN-B stated she had wheeled R7 on the walker because he had complained about his legs and felt it was better to wheel him. When asked if she was familiar with the manufacturer instruction for pushing someone when seated on the walker she stated she did not know. When asked if she would have expected TMA-A to have offered the shoes when resident was ambulating in the room, RN-B stated "yes." RN-B further stated R7 was a fall risk and had an unsteady gait.	2 830		

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2 830	Continued From page 5	2 830		

On 2/28/18, at 12:10 p.m. RN-C stated staff was not supposed to push R7 while seated on his walker. RN-C further stated she would educate staff to offer R7 the shoes still even though R7 refused them until he was dressed.

A review of Nova Rolling Walker User Guide Safety Warning instructions directed the user "Do not use as a wheelchair or to transport someone. Do not self propel or scoot around while seated..." Failure to follow these instructions can lead to serious injury.

R1's diagnoses included rheumatoid arthritis and lupus anticoagulant syndrome obtained from the Admission Record dated 2/28/18.

On 2/25/18, at 11:44 a.m. R1 was observed seated at the dining room area. When approached R1 was observed with two purple bruises on the right arm.

On 2/26/18, at 8:51 a.m. R1 was observed with two purple bruise in the right arm. When asked how she got them stated she did not know about those but for the other bruises it was because of the sticks to get blood "sometimes they just come" as she touched her arm.

R1's care plan dated 2/20/18, indicated R1 had potential/actual impairment to skin related to acute knee pain as evidenced by inflammation on knee and yeast infection under breast. The care plan directed licensed nurse to observe skin weekly. The care plan lacked documentation for staff to monitor for bruising as a side effect of medications R1 received.

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2 830	Continued From page 6	2 830		

During review of R1's Skin Observation- V2 dated 2/25/18, it was revealed nurse had indicated there was no skin conditions observed.

During review of the physician orders it was revealed R1 had an order dated 2/26/17, for Coumadin 2 mg every Monday, Tuesday, Wednesday, Thursday for lupus anticoagulant syndrome until 3/1/18 and Prednisone 10 mg once daily order dated 2/24/18, for rheumatoid arthritis.

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.

On 2/27/18, at 10:04 a.m. the director of nursing (DON) and registered nurse (RN)-A went to R1's room. When DON asked R1 if she knew how she got the bruises, R1 stated she did not know how the bruises happened.
-At 10:07 a.m. the DON and RN-A we interviewed, DON stated she would expect the staff to report the bruises and was going to review the medical record to verify if this bruising had been identified from admission.
-At 10:11 a.m. the DON and RN-A verified the medical record lacked documentation of the bruises and DON stated R1's care plan of was supposed to address the bruising as a side effects of the medications R1 took "we did not get that in."

R285's Admission Record, dated 2/22/18, indicated current diagnoses of orthopedic aftercare, absence of right leg below knee and dermatitis.
A Progress Note dated 2/23/18, late entry 3:45

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2 830	Continued From page 7	2 830		

p.m., indicated registered nurse (RN)-E received an order from R285's out of facility doctor for Triamcinolone cream 240 grams, four times daily to rash (itching), Hydroxyzine 10 milligrams (mg) at bedtime for itching), allegra 180 mg 1 tab in am for itching, RN-E indicated orders were faxed to TCP (Twin Cities Physicians) at 3:40 p.m. and passed it to on coming nurse.
Progress Note dated 2/24/18, at 10:44 p.m., RN-F indicated "Patient c/o (complaint of) rash on the abdominal fold, groin area, back, neck, face, bilateral antecubital area and itching. Writer paged the on call care provider, spoke with NP (nurse practitioner) who said to put in the orders given by dermatologist. Orders faxed to pharmacy, Triamcinolone needs to be clarified before transcribing."
R285's medications were ordered on 2/23/18 at 3:45 p.m., but R285 did not received first dose of any of the ordered medications until 2/25/18.
Review of R285's Medication Administration Record indicated the following:
- 2/25/18, at 8:00 a.m., for allegra allergy tablet 180 mg give 1 tablet by mouth one time a day for itching R285 received first dose on 2/25/18 at 8:00 a.m.
- 2/25/18, at 8:00 p.m., for hydrOXYyzine HCL tablet give 81 mg by mouth one time a day for itching R285 received first dose on 2/25/18 at 8:00 p.m.
- 2/25/18, at 8:00 p.m., for Triamcinolone Acetonide Cream 0.1% apply to rash topically four times a day for rash R285 received first dose on 2/25/18 at 8:00 p.m.
R285's care plan was updated 2/27/18, and indicated R285 had rashes on abdominal fold, groin area, back, neck, face, antecubital, legs and foot. Care plan directed staff to "monitor skin rashes for increased spread or signs of infection. Avoid scratching and keep hands and body parts

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2 830	Continued From page 8	2 830		

from excessive moisture."
During an interview on 2/27/18, at 1:42 p.m., R285 stated "the original ointment for the rash was not working and the rash was spreading and it was everywhere but the bottom of my foot." R285 indicated her dermatologist instructed her to use the original ointment on her face, the new ointment on the body and ordered a pill for the itching in the morning and a pill for something at night. When asked from a scale of 1-10 to rate her itching R285 stated "without the pill and ointment it was like a 100." R285 further indicates she was "desperate for the cream and by Saturday it (the rash) was pretty much every where."
During an interview on 2/28/18, at 10:45 a.m., the director of nursing (DON), indicated expectations for facility staff when an order was received from an outside physicians included: the facility nurse would receive the order, notify the primary provider that was taking care of the resident, then the primary would either approve or give other orders. When asked when would the medications should be available to the resident, the DON indicated "if you call it in that day they should get the medication that day or the next morning depending on the time and if they (pharmacy) have the medication."
Facility policy titled Physician/Practitioner Orders revised date of 11/2016 indicated "The nursing services and health information management (HIM) departments each have responsibilities for processing physician/practitioner orders in a timely and accurate manner. Teamwork and communication between the two departments is essential."

R8's significant change minimum data set dated 2/8/18, indicated he was severely cognitively impaired and required extensive assistance for

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2 830	Continued From page 9	2 830		

transfers. R8's care plan dated 2/7/18, directed staff to transfer using mechanical lift and indicated he was non-weight bearing. The care plan further identified a fracture of his right ankle related to a fall.

During an observation on 2/27/18, at 1:24 p.m. R8 was sitting in his room in his wheel chair. At approximately 1:35 p.m. trained medication aide (TMA)-C entered the room alone and left a few minutes later. At 1:38 p.m. R8 was observed lying in bed. There was no mechanical lift in or near R8's room. TMA-C was interviewed and stated she had transferred him alone, without the use of the mechanical lift. She stated she should have used the lift.

During an interview on 2/28/18, at 9:54 a.m. the director of therapy stated R8 had sustained an ankle fracture and was non-weight bearing as a result. She stated the therapy staff recommended a mechanical lift for transfers because R8 was unable to follow directions of non-weight bearing and was incapable of transferring without putting his right foot down. She further stated transferring him without the lift could cause prolonged healing time.

During interview on 2/28/18, at 1:20 p.m. the director of nursing (DON) stated R8 sustained a fall in the facility resulting in a fracture of his ankle. The DON stated staff should be using a mechanical lift for transfers.

SUGGESTED METHOD OF CORRECTION:
The director of nursing or designee, could review all residents at risk for bruising to assure they are receiving the necessary treatment/services for prevention. The director of nursing or designee, could conduct random audits of the delivery of

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2 830	Continued From page 10 care; to ensure appropriate care and services are implemented; to reduce of the development of bruises. The director of nursing or designee could educate staff regarding medication transcription and timeliness of medication procurement and administration. The director of nursing could conduct random audits to ensure timely response to medication orders. In addition, the director of nursing or designee, could review all residents at risk for accidents to assure they are receiving the necessary treatment/services for prevention. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other	2 915		4/15/18

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2 915	Continued From page 11 functional communication systems; and This MN Requirement is not met as evidenced by: 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. Findings include: R285's admission record, dated 2/22/18, indicated current diagnoses of orthopedic aftercare, absence of right leg below knee and dermatitis. R285's care plan, dated 2/27/18, indicated R285 had limited physical mobility due to edema to right BKA (below the knee amputation). The care plan directed staff to provide R285 stand by assistance with mobility, use of a wheelchair for transfers and weight bearing as tolerated. Physical Therapy Daily Treatment Note dated 2/24/18, indicated physical therapy assistant (PTA)-A provided therapeutic exercises to R285 for 31 minutes. PTA-A note dated 2/24/18, at 11:23 a.m., indicated "There Ex done to increase strength and endurance. Pt instructed and competed (sic) B (bilateral) LE (lower extremity) knee flex and ext, X15 reps, supine SLR, quad sets 12 reps X2. Cueing to perform correct motions. Rest breaks needed. During an interview on 2/25/18, at 4:03 p.m., R285 stated on 2/24/18 PTA-A stood at the door and instructed R285 to do the exercises that were done the day before and then left without having	2 915	Corrected, no POC required	

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2 915	Continued From page 12 worked with the resident. During an interview on 2/28/18, at 9:31 a.m., director of rehab verified PTA-A worked with R285 per PTA-A documentation for 30 minute treatment and did therapeutic exercises for strengthening, endurance, used verbal cues to do exercises correctly. When told R285 stated PTA-A did not work with her, the director of rehab stated "I would say he did do the work per his documentation, but she is also cognizant and it's his word vs her word. There was no documented evidence that R285 was not compliant or was re-approached. During an interview on 2/28/18, at 1:20 p.m., PTA-A stated he went through exercises with R285 and that they had worked in her room. During a follow up call from PTA-A on 2/28/18, at 2:22 p.m., PTA-A stated he "didn't actually see her and was a documentation error." During an interview on 2/28/18, 2:45 p.m., the administrator when asked are facility staff suppose to document that they saw a resident when they did not see them stated she would not expect anyone to falsify documents. During an interview on 2/28/18, at 2:57 p.m., the director of rehab indicated if residents are not seen they are suppose to document resident was not seen and verified PTA-A was scheduled to see R285 on 2/24/18 and there were no documented refusals on that day. Director of rehab further indicated staff are provided with a schedule and are suppose to carry them out. SYNERTX rehabilitation Clinical Frequently Asked Questions revised date of February 2018, indicated "SYNERTX required a daily note which included daily documentation to support each CPT code billed as well as documenting the patient's response to treatment." SUGGESTED METHOD OF CORRECTION:	2 915		

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2 915	Continued From page 13 The director of rehab and/or designee could educate responsible staff to provide care to residents' receiving skilled therapies. The director of rehab or designee could conduct audits of skilled treatments to ensure their needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 915		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the	21426	Corrected, no POC required	4/15/18

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agency failed to ensure 4 of 5 residents (R77, R56, R131, R1) and 1 of 5 employees (E-1) Tuberculin Skin Test (TST) results were documented appropriately per State regulation.

Findings include:

R77 was admitted to the facility on 2/7/18. The medical record indicated R77 was administered a first and second step TST on 2/8/18, at 2:12 p.m. and 2/15/18, at 11:27 a.m. respectively however, the medical record revealed the TST had not been read within 48-72 hours as directed by the State regulation.

R56 was admitted to the facility on 1/2/18. The medical record indicated R56 was administered a first and second step TST on 1/3/18, at 9:49 p.m. and 1/110/18, at 2:34 p.m. respectively however, the medical record revealed the TST had not been read within 48-72 hours as directed by the State regulation.

R131 was admitted to the facility on 2/21/18. The medical record indicated R131 was administered a first step TST on 2/22/18, at 3:33 p.m. and was read on 2/24/18, at 2:08 p.m. however, the medical record revealed the TST had not been read within 48-72 hours as directed by the State regulation.

R1 was admitted to the facility on 2/15/18. The medical record indicated R1 was administered a first step TST on 2/15/18, at 2:10 p.m. and was read on 2/17/18, at 12:04 p.m. however, the medical record revealed the TST had not been read within 48-72 hours as directed by the State regulation.

On 2/27/18, at 1:34 p.m. registered nurse (RN)-A

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21426	Continued From page 15 verified and stated the staff was supposed to document results within the time frame per the TB regulation. E-1's personnel file identified a hire date of 12/29/17. Review of the file indicated E-1 had a second TST administered on 1/10/18 and was read 1/13/18, at 2:30 p.m. with results identified as 0 millimeter (mm) and negative however, the results revealed the TST lacked documentation of the time given and read as directed by the State regulation. On 2/28/18, at 12:06 p.m. RN-D verified E-1's second step TST lacked time given and read. -At 12:07 p.m. the director of nursing stated she had been informed the TST's were being read two hours before 48 hours and would have expected the nurses to follow the State regulation of 48-72 hours. SUGGESTED METHOD OF CORRECTION: The Director of nursing and/or designee could review and revise policies and procedures, train staff and monitor to assure Tuberculin Skin Tests (TST) are read, results documented; and assure that employees are screened for tuberculosis (TB) using a symptom screen, and by either a single step IGRA (Interferon Gamma Release Assay blood test) or a two-step TST and documented appropriately per State regulation. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General	21435		4/15/18

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Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review, the facility failed to provide consistent activity programming for 3 of 3 residents (R3, R8, R46) who were dependent on staff to attend activity programs.

Corrected, no POC required

Findings include:

A review of the facility's activity calendars titled Boundary Waters Community, dated January and February 2018, identified the following scheduled activities:

Sunday - game, unit ball toss, unit news/devotions, worship service in the chapel, unit music and unit movie

Monday - unit story telling, unit jokes, unit ball toss, unit poems/snacks and unit visiting

Tuesday - unit exercise, unit jokes, unit puzzle, bible study, unit trivia, unit fireside chats

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Wednesday - unit visiting, unit news/devotions, worship, unit ball toss, bingo, unit game and unit poems

Thursday - unit trivia, unit new/devotions, unit jokes, ice cream social and unit puzzles

Friday - unit poems, unit news/devotions, unit newspaper, bowling, unit ball toss, unit music

Saturday - unit game, unit exercise, unit devotion, bingo, unit story telling/snacks and unit trivia.

During random observations from 2/25/18 through 2/28/18, there was no evidence of scheduled activities occurring on the unit.

R3's Activity Interest Data Collection Tool dated 8/26/17, indicated R3's interests included listening to music, television and movies, walking. theatre, animals and military service. R3's quarterly minimum data set (MDS) dated 11/16/18, indicated he was severely cognitively impaired and required extensive assistance for locomotion on the unit. R3's care plan dated 11/22/17, indicated he was dependent on staff for activities, cognitive stimulation and social interaction. The care plan identified preferences that included listening to music, watching television and spending time with family. The care plan directed staff to encourage family participation and offer pet visits.

During an observation on 2/25/18, at 12:07 p.m. R3 was in his room in a wheel chair. He appeared to be asleep.

On 2/27/18, at 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 R3 to

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the activity. At 10:29 a.m. R3 was lying in his bed. The television was on but R3 was not engaged in the program. An activity was scheduled on the unit but no activity occurred.

On 2/28/18, at 8:17 a.m., R3 was in his room with the door closed. At 10:32 a.m. R3 was in his room with the door closed. A worship service was scheduled in the chapel however, no one invited R3 to attend.

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.

R8's Activity Interest Data Collection Tool dated 9/26/17, indicated he enjoyed the following: rides, fishing, football, going to restaurants, cards, magazines, theatre, humor, worship service and traveling.
R8's quarterly MDS dated 11/30/17, indicated he was severely cognitively impaired and required physical assist to move on the unit. R8's care plan dated 9/22/18, indicated he was dependent on staff for activities, cognitive stimulation and social interaction. The care plan identified preferred activities that included: chapel, music groups, ice cream social and games. The care plan directed staff to provide bed side visits and activities in room if R8 was unable to attend out of room events.

During an observation on 2/26/18, at 9:45 a.m. R8 was seated at a table in the dining room by himself. He appeared to be asleep. There were no activities occurring on the unit, no music or

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staff engagement. The activity calendar indicated a game was scheduled for 9:30 a.m. and a ball toss scheduled for 10:30 a.m. At 10:40 a.m. R8 sat in front of a television on the unit. He appeared to be asleep. At 1:30 p.m. R8 was in his room. He could be heard calling out loud non-sensical noises. At 4:04 p.m. all of the residents on the unit were in their rooms or off the unit. The activity calendar identified unit poems and snacks but no activity occurred.

During observation on 2/27/18, at 9:30 a.m. R8 sat alone at a table in the dining room. No activity was occurring on the unit even though the activity calendar indicated an exercise group at 9:30 a.m. 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 R8 to the activity. At 9:38 a.m. staff assisted R8 back to his room and placed him in front of the television. At 10:22 a.m. the activity calendar indicated unit jokes would be occurring. No activities were offered on the unit. R8 remained in his room in his wheel chair and could be heard yelling out occasionally. Another resident was asleep at a table in the dining room. At 12:12 p.m., R8 could still be heard calling our from his room.

R46's Activity Interest Data Collection Tool dated 11/1/17, identified interests that included listening to music, singing, playing an instrument, landscaping, television, cards, books and talking. The tool indicated R46 served in the military and had been a farmer and a machinist. R46's quarterly MDS dated 11/30/17, indicated he was severely cognitively impaired and required assistance on and off the unit. R46's care plan dated 12/21/17, indicated he was dependent on staff for activities, cognitive stimulation and social interaction. The care plan directed staff to provide

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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 not invite R46 to attend. 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. She stated the activities on the unit were mostly	21435		

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led by the floor staff. The DTR stated the activities staff was on the unit at least daily. She further stated they could not bring anyone from the unit over to the secured unit to join activities because they don't want extra residents on the secured unit. The DTR stated a lot of the residents on the unit liked to stay in their rooms and staff try to do individualized programming. She stated the facility had a music therapist who retired at the end of December and staff were trying to meet the need fro music within the department. She stated concerts had not been done in a while. She further stated she had a lot of residents asking her about music and stated there was no plan to replace the music therapist at this time.

During an interview on 2/28/18, at 10:40 a.m. trained medication aided (TMA)-A stated R3 used to sit in the dining room and listen to a lot of music. TMA-A stated the staff on the unit were responsible for initiating most of the activities on the unit but stated the staff did not have enough time.

During interview on 2/28/18, at 1:04 p.m. the director of nursing (DON) stated She was aware the activities were not being done on the units.

A facility policy related to activity programming was requested but not received.

SUGGESTED METHOD FOR CORRECTION: The activity director or designee could develop systems of ensuring activity programming for cognitively impaired residents. The Activity Director could educate all appropriate staff and develop monitoring systems to ensure ongoing compliance.

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21435	Continued From page 22 TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21435		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences. (b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has	21830		4/15/18

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executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:
(1) examining the personal effects of the resident;
(2) examining the medical records of the resident in the possession of the facility;
(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and
(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights.
(c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21830	Continued From page 24 county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to accommodate preferences for rising for 1 of 1 resident (R77) reviewed for choices. Findings include: R77's diagnosis included left lower leg fracture obtained from the admission Minimum Data Set (MDS) dated 2/13/18. In addition, R77's Nursing Admit Re-Admit Data Collection dated 2/24/18, identified R77's usual waking time was 8:30 a.m. R77's care plan dated 2/13/18, indicated resident had an activities of daily living (ADL) deficit related to left ankle fracture due to fall as evidenced by pain, weakness, deconditioning and impaired balance/mobility. Care plan directed staff to provide extensive assistance of one staff. On 2/27/18, 7:15 a.m. the door to R77's room was observed wide open. R77 was on the phone leaving a message for her daughter, asking her to call her back immediately. R77 tone of voice suggested she was upset. When approached,	21830	Corrected, no POC required	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING: ______ B. WING ______	02/28/2018

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21830	Continued From page 25	21830		

R77 appeared upset, shaking and stated in a angry voice "She came here at 6:46 a.m. and woke me up and wanted me to go do therapy. I told her I did not sleep well at night because I had to use the toilet and had pain and she told me I had to go do the exercises. She left and went and told them I had refused. All I told her was I had not slept at night and needed to just stay in bed for a little more and she went and told lies that I had refused. I want to tell her that was not true." At 7:19 a.m. R77 stated she had been waiting for help to use the bathroom. She stated the therapy staff had told her she was going to find help for her. R77 stated she needed to go to the bathroom and asked surveyor to help her. Surveyor put the call light and as surveyor walked out of the room R77 stated "I didn't sleep well and that was why I told her I would not come. She could have said I will come later. She did not need to be snotty." At 7:24 a.m. nursing assistant (NA)-B applied the transfer belt and transferred R77 to the wheelchair and in the bathroom transferred R77 to the toilet. At 7:30 a.m., after R77 had used the toilet NA-B transferred her to the wheel chair, pushed the chair to the bedside and then parked R77 by the bed. R77 asked NA-B who the therapist was and still sounding upset stated "I did not refuse. I told her I had not slept at night and just wanted to do it later." NA-B told R77 she would find out who the therapist was.

On 2/27/18, at 7:57 a.m. the occupational therapist (OT) stated she had been in R77's room at 6:45 a.m. and had introduced herself. The OT stated R77 was not ready to work with her. OT stated "she was not happy I was there and she was going to sleep." When asked if she knew R77's waking preference, OT stated she did not know as this was the first time she had worked

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21830	Continued From page 26	21830		

with R77. OT also stated her visit schedule was pre-completed before she got to the facility and R77 was the first to be seen that morning.

On 02/27/18, at 8:46 a.m. R77 approached surveyor and asked if she had found the name of the therapy staff that had been in her room. Surveyor told resident she had and the resident was wondering if she was going to come back to work with her and surveyor stated "yes." When asked about bedtime and waking up when at home R77 stated stayed up late at night watching television at night and stated, "I try to get out of bed around seven or eight." When asked about toilet needs R77 stated when knew when she needed to go and would ask for assistance.

On 2/27/18, at 10:16 a.m. the director of nursing (DON) reviewed the Nursing Admit Re-Admit Data Collection form dated 2/24/18, and stated the assessment indicated R77's "usual waking time was 8:30 a.m." The DON stated therapy staff had access to the assessments. The DON further stated "we have talked about this they may have their schedule done however, they should adjust it with the resident preferred routine."

On 2/27/18, at 10:45 AM family member (FM)-C stated she thought R77 was afraid of going to sleep and was up at night even at home. FM-C stated R77 liked to sit up and doze off as she sat in her chair. When asked about R77's usual rising time, FM-C stated R77 would not be up before 7:00 a.m. FM-C stated she was having problems with the facility following up on instructions or requests regarding R77's cares and routine. She stated it was frustrating to the family.

On 2/27/18, at 12:59 p.m. the director of therapy

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21830	Continued From page 27 stated she completed the daily therapy schedules the previous day and sent the schedules to the staff. She stated she encouraged the therapists to ask the residents if they were early risers and stated if a resident declined therapy, staff were supposed to leave the room and let the resident know they would return at the preferred time. When asked if therapy staff had access to nursing assessment to access usual waking up time, she stated the department was developing a system to allow the therapy department access to the resident preferences. SUGGESTED METHOD OF CORRECTION: Social Service and/or their designee could develop /revise policies for resident choices and educate all facility staff on those policies. The DON and/or designee could conduct resident interviews to ensure resident choices are being honored, reviewed then aduit to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21830		