Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
November 3, 2023

Administrator
Good Samaritan Society - St. James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: August 31, 2023

Dear Administrator:

On October 31, 2023, the Minnesota Department(s) of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

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Electronically delivered

November 3, 2023

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: Reinspection Results
Event ID: 532E12

Dear Administrator:

On October 31, 2023, survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on August 31, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
Orville L. Freeman Building
HRD 3A 3rd Floor
PO Box 64900, 625 Robert St. N.
St. Paul, MN 55155
Phone: 651-201-4384
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September 20, 2023

Administrator
Good Samaritan Society - St. James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: August 31, 2023

Dear Administrator:

On August 31, 2023, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by December 1, 2023 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by March 1, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us
Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 20, 2023

Administrator
Good Samaritan Society - St. James
1000 South Second Street
St James, MN 56081

Re: State Nursing Home Licensing Orders
Event ID: 532E11

Dear Administrator:

The above facility was surveyed on August 29, 2023 through August 31, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 feel free to call me with any questions.

Holly Zahler, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4384
Email: holly.zahler@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	C 08/31/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/29/23-8/31/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained.	E 000		
E 037 SS=C	EP Training Program CFR(s): 483.73(d)(1) §403.748(d)(1), §416.54(d)(1), §418.113(d)(1), §441.184(d)(1), §460.84(d)(1), §482.15(d)(1), §483.73(d)(1), §483.475(d)(1), §484.102(d)(1), §485.68(d)(1), §485.542(d)(1), §485.625(d)(1), §485.727(d)(1), §485.920(d)(1), §486.360(d)(1), §491.12(d)(1). *[For RNCHIs at §403.748, ASCs at §416.54, Hospitals at §482.15, ICF/IIDs at §483.475, HHAs at §484.102, REHs at §485.542, "Organizations" under §485.727, OPOs at §486.360, RHC/FQHCs at §491.12:] (1) Training program. The [facility] must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing	E 037		9/29/23

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

Electronically Signed | 09/29/2023

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

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E 037	Continued From page 1 staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the [facility] must conduct training on the updated policies and procedures. *[For Hospices at §418.113(d):] (1) Training. The hospice must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing hospice employees, and individuals providing services under arrangement, consistent with their expected roles. (ii) Demonstrate staff knowledge of emergency procedures. (iii) Provide emergency preparedness training at least every 2 years. (iv) Periodically review and rehearse its emergency preparedness plan with hospice employees (including nonemployee staff), with special emphasis placed on carrying out the procedures necessary to protect patients and others. (v) Maintain documentation of all emergency preparedness training. (vi) If the emergency preparedness policies and procedures are significantly updated, the hospice must conduct training on the updated policies and procedures.	E 037		

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E 037	Continued From page 2 *[For PRTFs at §441.184(d):] (1) Training program. The PRTF must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) After initial training, provide emergency preparedness training every 2 years. (iii) Demonstrate staff knowledge of emergency procedures. (iv) Maintain documentation of all emergency preparedness training. (v) If the emergency preparedness policies and procedures are significantly updated, the PRTF must conduct training on the updated policies and procedures. *[For PACE at §460.84(d):] (1) The PACE organization must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing on-site services under arrangement, contractors, participants, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Demonstrate staff knowledge of emergency procedures, including informing participants of what to do, where to go, and whom to contact in case of an emergency. (iv) Maintain documentation of all training. (v) If the emergency preparedness policies and procedures are significantly updated, the PACE must conduct training on the updated policies and procedures. *[For LTC Facilities at §483.73(d):] (1) Training	E 037		

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E 037	Continued From page 3 Program. The LTC facility must do all of the following: (i) Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected role. (ii) Provide emergency preparedness training at least annually. (iii) Maintain documentation of all emergency preparedness training. (iv) Demonstrate staff knowledge of emergency procedures. *[For CORFs at §485.68(d):](1) Training. The CORF must do all of the following: (i) Provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. All new personnel must be oriented and assigned specific responsibilities regarding the CORF's emergency plan within 2 weeks of their first workday. The training program must include instruction in the location and use of alarm systems and signals and firefighting equipment. (v) If the emergency preparedness policies and procedures are significantly updated, the CORF must conduct training on the updated policies and procedures. *[For CAHs at §485.625(d):] (1) Training program.	E 037		

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E 037	Continued From page 4 The CAH must do all of the following: (i) Initial training in emergency preparedness policies and procedures, including prompt reporting and extinguishing of fires, protection, and where necessary, evacuation of patients, personnel, and guests, fire prevention, and cooperation with firefighting and disaster authorities, to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles. (ii) Provide emergency preparedness training at least every 2 years. (iii) Maintain documentation of the training. (iv) Demonstrate staff knowledge of emergency procedures. (v) If the emergency preparedness policies and procedures are significantly updated, the CAH must conduct training on the updated policies and procedures. *[For CMHCs at §485.920(d):] (1) Training. The CMHC must provide initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, and maintain documentation of the training. The CMHC must demonstrate staff knowledge of emergency procedures. Thereafter, the CMHC must provide emergency preparedness training at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 5 of 5 new employees reviewed for emergency preparedness (EP) training had received initial training on the EP plan. Further, the facility failed to ensure all	E 037	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	

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E 037	Continued From page 5 employees received annual EP training in 2022. This deficient practice had the potential to affect all 25 residents residing in the facility. Findings include: Documentation of initial EP training was requested for the following employees hired in 2023 and it was not provided: --Trained medication aide (TMA)-A, hired 1/10/23 --Nursing assistant (NA)-B, hired 3/28/23 --Registered nurse (RN)-A, hired 4/19/23 --(TMA)-C, hired 6/13/23 --(RN)-B, hired 7/10/23 Documentation was requested for annual EP training for all employees in 2022 and it was not provided. During an interview on 8/31/23 at 5:15 p.m., the interim administrator verified no EP training had been conducted for all employees in 2022 nor for new employees hired in 2023. A policy on EP training for new employees and annual training for all employees was requested; the administrator stated there was no policy on this.	E 037	statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. All five staff members noted received the required EP training by 9/27. Administrator reviewed the onboarding process for all new employees and ensured all current staff have received the EP training for our facility by 9/29/23. And the annual EP training for 2023 occurred for all staff May 17th, 2023. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. All current employees have received the proper EP training of our facility, everyone received the annual EP training in 2023 and the process is in place to ensure all new staff receive this training in their onboarding as well as all staff receive the	

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E 037	Continued From page 6	E 037	required annual training in 2024. Will have an emergency preparedness section to review in QAPI and will review our annual required trainings each month to ensure compliance. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization's Emergency Management Plan policy has been reviewed and is current. Environmental Services Employee, Human Resources Employee, DNS and Administrator have all been educated on the policy. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Administrator or designee will audit all new hires weekly for the next four weeks to ensure they received their EP training as part of their onboarding and then audit will continue monthly. Findings will be reported to the QAPI committee monthly until committee determine substantial compliance. 5)The date of compliance is September 29, 2023.	
E 039 SS=C	EP Testing Requirements CFR(s): 483.73(d)(2)	E 039		9/29/23

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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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E 039	Continued From page 7 §416.54(d)(2), §418.113(d)(2), §441.184(d)(2), §460.84(d)(2), §482.15(d)(2), §483.73(d)(2), §483.475(d)(2), §484.102(d)(2), §485.68(d)(2), §485.542(d)(2), §485.625(d)(2), §485.727(d)(2), §485.920(d)(2), §491.12(d)(2), §494.62(d)(2). *[For ASCs at §416.54, CORFs at §485.68, REHs at §485.542, OPO, "Organizations" under §485.727, CMHCs at §485.920, RHCs/FQHCs at §491.12, and ESRD Facilities at §494.62]: (2) Testing. The [facility] must conduct exercises to test the emergency plan annually. The [facility] must do all of the following: (i) Participate in a full-scale exercise that is community-based every 2 years; or (A) When a community-based exercise is not accessible, conduct a facility-based functional exercise every 2 years; or (B) If the [facility] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required community-based or individual, facility-based functional exercise following the onset of the actual event. (ii) Conduct an additional exercise at least every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using	E 039		

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	245593	A. BUILDING _____ B. WING _____	C 08/31/2023

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E 039	Continued From page 8 a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [facility's] emergency plan, as needed. *[For Hospices at 418.113(d):] (2) Testing for hospices that provide care in the patient's home. The hospice must conduct exercises to test the emergency plan at least annually. The hospice must do the following: (i) Participate in a full-scale exercise that is community based every 2 years; or (A) When a community based exercise is not accessible, conduct an individual facility based functional exercise every 2 years; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospital is exempt from engaging in its next required full scale community-based exercise or individual facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion using a narrated, clinically-relevant emergency	E 039		

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E 039	Continued From page 9 scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (3) Testing for hospices that provide inpatient care directly. The hospice must conduct exercises to test the emergency plan twice per year. The hospice must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual facility-based functional exercise; or (B) If the hospice experiences a natural or man-made emergency that requires activation of the emergency plan, the hospice is exempt from engaging in its next required full-scale community based or facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop led by a facilitator that includes a group discussion using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the hospice's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the hospice's emergency plan, as needed. *[For PRFTs at §441.184(d), Hospitals at	E 039		

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E 039	Continued From page 10 §482.15(d), CAHs at §485.625(d):] (2) Testing. The [PRTF, Hospital, CAH] must conduct exercises to test the emergency plan twice per year. The [PRTF, Hospital, CAH] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the [PRTF, Hospital, CAH] experiences an actual natural or man-made emergency that requires activation of the emergency plan, the [facility] is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an [additional] annual exercise or and that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [facility's] response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the [facility's] emergency plan, as needed. *[For PACE at §460.84(d):] (2) Testing. The PACE organization must conduct	E 039		

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E 039	Continued From page 11 exercises to test the emergency plan at least annually. The PACE organization must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or (B) If the PACE experiences an actual natural or man-made emergency that requires activation of the emergency plan, the PACE is exempt from engaging in its next required full-scale community based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or individual, a facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the PACE's response to and maintain documentation of all drills, tabletop exercises, and emergency events and revise the PACE's emergency plan, as needed. *[For LTC Facilities at §483.73(d):] (2) The [LTC facility] must conduct exercises to test the emergency plan at least twice per year,	E 039		

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E 039	Continued From page 12 including unannounced staff drills using the emergency procedures. The [LTC facility, ICF/IID] must do the following: (i) Participate in an annual full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise. (B) If the [LTC facility] facility experiences an actual natural or man-made emergency that requires activation of the emergency plan, the LTC facility is exempt from engaging its next required a full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the [LTC facility] facility's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the [LTC facility] facility's emergency plan, as needed. *[For ICF/IIDs at §483.475(d)]: (2) Testing. The ICF/IID must conduct exercises to test the emergency plan at least twice per year. The ICF/IID must do the following: (i) Participate in an annual full-scale exercise that is community-based; or	E 039		

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E 039	Continued From page 13 (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise; or. (B) If the ICF/IID experiences an actual natural or man-made emergency that requires activation of the emergency plan, the ICF/IID is exempt from engaging in its next required full-scale community-based or individual, facility-based functional exercise following the onset of the emergency event. (ii) Conduct an additional annual exercise that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the ICF/IID's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the ICF/IID's emergency plan, as needed. *[For HHAs at §484.102] (d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following: (i) Participate in a full-scale exercise that is community-based; or (A) When a community-based exercise is not accessible, conduct an annual individual, facility-based functional exercise every 2 years; or. (B) If the HHA experiences an actual natural	E 039		

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E 039	Continued From page 14 or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in its next required full-scale community-based or individual, facility based functional exercise following the onset of the emergency event. (ii) Conduct an additional exercise every 2 years, opposite the year the full-scale or functional exercise under paragraph (d)(2)(i) of this section is conducted, that may include, but is not limited to the following: (A) A second full-scale exercise that is community-based or an individual, facility-based functional exercise; or (B) A mock disaster drill; or (C) A tabletop exercise or workshop that is led by a facilitator and includes a group discussion, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (iii) Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed. *[For OPOs at §486.360] (d)(2) Testing. The OPO must conduct exercises to test the emergency plan. The OPO must do the following: (i) Conduct a paper-based, tabletop exercise or workshop at least annually. A tabletop exercise is led by a facilitator and includes a group discussion, using a narrated, clinically relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency	E 039		

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E 039	Continued From page 15 plan. If the OPO experiences an actual natural or man-made emergency that requires activation of the emergency plan, the OPO is exempt from engaging in its next required testing exercise following the onset of the emergency event. (ii) Analyze the OPO's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the [RNHCI's and OPO's] emergency plan, as needed. *[RNCHIs at §403.748]: (d)(2) Testing. The RNHCI must conduct exercises to test the emergency plan. The RNHCI must do the following: (i) Conduct a paper-based, tabletop exercise at least annually. A tabletop exercise is a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan. (ii) Analyze the RNHCI's response to and maintain documentation of all tabletop exercises, and emergency events, and revise the RNHCI's emergency plan, as needed. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure two emergency preparedness (EP) exercises, including two full-scale community based exercises, or one community based exercise and a table top exercise, or had activated their plan as a result of a actual event, were completed annually to test their EP program. This had the potential to affect all 25 residents residing at the facility. Findings include:	E 039	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility had to activate the emergency plan by implementing a fire watch for two days due to the loss of communication from our fire panel on 8/28/23 to correct the deficient practice. And the annual EP training for 2023 occurred for all staff May 17th, 2023.	

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E 039	Continued From page 16 During an interview on 8/31/23 at 5:15 p.m., the interim administrator stated there had been no documentation of training exercises conducted at the facility in 2022. A policy on EP exercises had been requested; the administrator stated there was no policy on this.	E 039	2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to be affected by this deficient practice. The emergency plan that was activated was reviewed and found to have been followed correctly and efficiently to ensure all resident and staff remained safe from a possible fire. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization's Emergency Management Plan policy has been reviewed and is current. All staff were educated on this policy 9/27/23. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Administrator or designee will audit twice a year for the next year to ensure the proper training is completed by the facility in 2024, or the facility has correctly implemented another emergency plan in an actual event. Will review the findings at QAPI to ensure compliance. 5)The date of compliance is September	

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E 039	Continued From page 17	E 039	29, 2023.	
F 000	INITIAL COMMENTS On 8/29/23-8/31/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with NO deficiencies cited: H55934717C (MN00095578) H55934718C (MN00093255) H55934720C (MN00095577) H55934764C (MN00091614) H55934765C (MN00093820) H55934766C (MN00091898) H55934787C (MN00091864) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status.	F 641		9/29/23

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F 641	Continued From page 18 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the current status and needs for 1 of 1 resident (R21) reviewed for accuracy of the MDS assessment. Findings include: R21's quarterly Minimum Data Set (MDS) assessment dated 5/25/23, indicated R21 was admitted on 2/20/23, had intact cognition, no behaviors, required two-person physical assist with bed mobility, transfers; two-person physical assist with dressing, toilet use and personal hygiene; utilized a wheelchair, diagnoses included: bipolar disorder, psychotic disorder, PTSD, chronic pain syndrome, musical weakness, difficulty in walking. R21's admission MDS dated 2/26/23, lacked indication R21 and a serious mental illness and/or intellectual disability or a related condition. On 8/30/23 at 1:17 p.m., registered nurse (RN)-B and interim director of nursing (DON), stated section A of the MDS was completed by offsite staff. RN-A stated she recently been hired at the facility as the MDS nurse, and another unknown nurse had completed the admission MDS prior to her start date at the facility. The interim DON confirmed R21's admission MDS assessment had not been accurately coded and lacked documentation of serious mental illness. On 8//30/23 at 3:30 p.m., the interim administrator verified R21's admission MDS had been coded inaccurately, and should had	F 641	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R21 MDS dated 2/26/23 has been modified to correct the coding for the PASRR at A1500 completed on 9/27/23. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. Social Services was educated on PASRR coding on the MDS on 9/27/23. And an audit of PASRR for all current residents will be completed by Social Services by 9/28/23. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. The organization□s policy Pre-Admission Screening and Resident Review (PASARR) □ Rehab/Skilled has been reviewed and is current. Social Services will complete coding A1500 on all future Admission MDS assessments. All admissions going forward will be accurately coded based on outcome of the PASRR notice at time of admission. 4)How the corrective actions(s) will be	

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F 641	Continued From page 19 indicated R21's preadmission screening and resident review to have a serious mental illness. The interim administrator stated the facility had recently hired a new MDS nurse and R21's MDS was not completed by on site facility staff. The facility MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) policy dated 6/13/23, indicated: 2. During the observation period each team member will review the EMR to determine if there is accurate documentation to support coding for the MDS. Each location will need to review state-specific documentation requirements and Medicare requirements to determine the MDS payment items. If supportive documentation does not exist, then prior to the assessment reference date the team member responsible for coding that item will write a supportive documentation note in the PN - MDS. If while reviewing the medical record the team member finds conflicting information, then a clarifying note will be written in the PN - MDS as part of the supportive documentation note. 10.Validation verification must be completed after each discipline has coded and signed their section. Any errors or warnings must be reviewed and acknowledged. 11.The MDS coordinator will complete a validation verification of the entire MDS. Any errors or warnings must be reviewed and acknowledged. 12.The RN MDS coordinator/ RN Designee will sign and date the MDS signifying it as complete at Z0500. This date cannot be prior to the assessment reference date. 13.For comprehensive MDSs: a. After the MDS is completed by each discipline, each discipline will electronically complete the	F 641	monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Director of nursing or designee will review all admission MDS completed for the next 4 weeks for accuracy then will review 1 admission a month x 3 months for accurate coding of A1500 on the MDS against the PASRR report. Audit results will be brought to the monthly QAPI committee for input on the need to increase, decrease or discontinue audits. 5)The date of compliance is September 29, 2023.	

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	245593	A. BUILDING _____ B. WING _____	C 08/31/2023

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F 641	Continued From page 20 appropriate CAA documentation and CAA Summary. b. The RN MDS coordinator/ RN Designee will electronically sign V0200B1 and date V0200B2 signifying completion of the RAI process. c. Care Plan Review - PN must be completed by each discipline after each MDS is signed as completed. The care plan is reviewed with each MDS completion, with the exception of the 5-day and 14-day if the initial care plan has not been completed yet. d. The care plan coordinator will electronically sign V0200C1 and date V0200C2 signifying completion of the care plan process. The facility Pre-Admission Screening and Resident Review (PASARR) policy dated 12/21/22, indicated: Purpose To determine admission criteria for residents with mental illness and/or mental retardation To ensure that individuals retardation serious mental disorder or intellectual disability receive the care and services they need and the most appropriate setting. Before Admission: 5. The level II PASARR screening is conducted by the agency designated by the state. The screening will determine whether the prospective resident requires the level of services provided by the location weather the individual requires specialized services	F 641		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review	F 644		9/29/23

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F 644	Continued From page 21 (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to incorporate the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and comprehensive care for 1 of 3 residents (R21) reviewed. Findings Include: R21's quarterly Minimum Data Set (MDS) assessment dated 5/25/23, indicated R21 was admitted on 2/20/23, had intact cognition, no behaviors, required two-person physical assist with bed mobility, transfers; two-person physical assist with dressing, toilet use and personal hygiene; utilized a wheelchair, diagnoses included: bipolar disorder, psychotic disorder, post traumatic stress disorder (PTSD), chronic pain syndrome, musical weakness, difficulty in walking.	F 644	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R21 has been offered to go out for mental health services, had also contacted R21□s guardian to setup an appointment but resident has declined to leave the facility for an appointment. Also a psychiatrist has been contacted to contract with the facility to see the resident/s onsite in person. Facility has also contacted Meditelecare to contract with our facility so R21, along with all residents, would also have the option to meet via telehealth. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what	

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F 644	Continued From page 22 R21's admission MDS dated 2/26/23, indicated R21 was not currently considered by the state level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. However, a Level II Preadmission Screening (PAS) for persons with mental illness initial assessment dated 2/15/23, was completed for R21 and indicated R21 continued psychiatric medication management and should receive mental health services while at the nursing facility and facility documentation revealed resident had refusal of cares and delusions. R21's care plan dated 8/31/23, indicated R21 used psychopharmacological medications r/t (related to) delusional disorder and PTSD and interventions included: consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate, discuss with health care provider, family regarding ongoing need for use of medication, educate resident/family about risks, benefits and the side effects and/or toxic symptoms of medication, monitor resident condition based on clinical practice guidelines or clinical standards of practice r/t use of olanzapine. Review of R21's record indicated no psychiatry appointments, mental health treatments, support services, or individualized nursing interventions related to PTSD. R21's physician visit notes were reviewed and the visit notes did not specifically identify, address and/or mention R21's PTSD, effectiveness of any treatments, or ongoing plan for treatment.	F 644	corrective action will be taken. All residents have the potential to be affected by this deficient practice. 9/28 review of PASRR was completed and no other residents are at risk. Facility has contacted mental health providers (Sanford Psychology and Meditelecare) to start providing mental health services for all residents in need. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization□s policies Behavioral Health Services Rehab/Skilled and Pre-Admission Screening and Resident Review (PASARR) □ Rehab/Skilled has been reviewed and is current. Education provided to all nursing staff responsible for resident assessments and social services. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The Director of Nursing or designee will audit all admission PASRRs and initial MDS assessments weekly for the next four weeks then monthly for three months to ensure the PASRR recommendations have been incorporated into the resident□s care plan. Findings will be brought to the QAPI committee to	

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F 644	Continued From page 23 On 8/30/23 at 11:43 a.m., R21 was observed in bed, the doors to room closed, and the lights off. R21 was wearing a hospital gown, appearance was of being sad, with flat affect. R21 stated she stayed in her room usually, and had not been offered any mental health services. R21 said she did not have anyone in the facility to talk with on a consistent basis, and was not aware she had a medical provider or doctor who took care of her medical concerns. R21 stated she infrequently attended activities due to not liking to leave her room due to pain and her low immune system. R21 stated she was unaware of any interventions to address her mental health. On 8/30/23 at 1:17 p.m.,social services (SS)-A stated the MDS assessments were completed by staff off site and was not aware the PASARR level II had not identified R21 to have a serious mental illness. SS-A stated the PASARR level II was not incorporated into R21's assessment, care plan, or comprehensive assessments. On 8/31/23 at 8:07 a.m.,during a telephone interview R21's guardian stated R21 had a mental illness and PTSD, and expected R21's care would include psychiatry. R21's guardian stated she was not aware if R21 had seen psychiatry since admission to the facility. On 8/31/23 at 10:12 a.m., nurse practitioner (NP)-D confirmed R21 had not seen psychiatry since she had admitted to the facility, and stated currently there was not a psychiatrist that came to the facility. NP-D confirmed she saw R21 on rounds and addressed R21's medications and determined necessary care and services. NP-D stated she would expect the facility to follow the	F 644	determine compliance. 5)The date of compliance is September 29, 2023.	

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F 644	Continued From page 24 hospital discharge orders as indicated. On 8/31/23 at 2:42 p.m., SS-A and the interim director of nursing (DON) stated they were unaware R21 had a PASARR level II completed. SS-A and the interim DON verified PASARR level II was not utilized during the MDS assessment. The interim DON agreed mental health services should have been provided for oversight of R21's mental health diagnoses. The interim DON and SS-A confirmed R21, had no other notes or documentation to ensure mental health services had been provided timely and with the recommendations of the PASARR level II. The facility Pre-Admission Screening and Resident Review (PASARR) policy dated 12/21/22, indicated: Purpose To determine admission criteria for residents with mental illness and/or mental retardation To ensure that individuals retardation serious mental disorder or intellectual disability receive the care and services they need and the most appropriate setting. Before Admission: 5. The level II PASARR screening is conducted by the agency designated by the state. The screening will determine whether the prospective resident requires the level of services provided by the location weather the individual requires specialized services.	F 644		
F 726 SS=F	Competent Nursing Staff CFR(s): 483.35(a)(3)(4)(c) §483.35 Nursing Services	F 726		9/29/23

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F 726	Continued From page 25 The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. §483.35(a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. §483.35(c) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure agency nursing assistants (NA's) received appropriate orientation and training prior to starting their first shift caring for residents. This had the potential to affect all 25 residents residing in the facility. Findings include:	F 726	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The facility currently is not utilizing any agency staff. For all potential future agency staff, the facility has put together a	

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F 726	Continued From page 26 On 8/29/23 at 2:36 p.m., agency nursing assistant (NA)-A stated the facility used a lot of agency nursing staff including NA's. NA-A stated agency staff came one hour prior to their scheduled shift and received an hour of orientation before caring for residents on their own. NA-A stated one hour was not enough time to show and explain everything. NA-A stated when she arrived one hour prior to her first shift, she was provided sheet of paper that included resident's names and room numbers. NA-A stated the facility did not provide a tour of the facility, resident specific information, transfer status of the resident's, or training on facility equipment, and was unable to log into the electronic medical record (EMR) equipment. Further, NA-A stated the staff who trained her was another agency staff who was not familiar with the facility and stated, "I have just been winging it". NA-A stated the facility did not use an orientation check sheet. NA-A stated she asked facility staff how residents transferred and wrote the ambulation status on the resident sheet. NA-A stated each resident room had a white board on the wall with information written on it such as ambulation status. NA-A stated she referred to the white board as well to determine cares for residents. On 8/30/23 at 1:55 p.m., NA-B stated she was facility staff and had worked at the facility for six months. NA-B stated agency staff did not receive facility specific training and were not familiar with the facility mechanical lifts, and stated she had observed agency NA's not sure how to use the shower chair lifts or the slings for the mechanical lifts, and would intervene when observed to assist agency staff.	F 726	training program with a competency check list to ensure that agency staff meet competency requirements for resident care before starting to work. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All the residents at the facility have the potential to be affected by the deficient practice. For any agency staff contracted the DNS/designee will ensure the training program with competency check list has been completed to ensure the agency staff meet the training requirements. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization□s policy on Orientation of Contingent Labor Responsibilities as well as the GSS Contingent Labor CNA & Other Contingent Staff Orientation Checklist has been reviewed and is current. The facility leadership have been trained on the policy to ensure all staff get trained and are competent to care for residents according to the policy and procedure. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice.	

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F 726	Continued From page 27 On 8/31/23 at 8:39 a.m., the interim director of nursing (DON) stated the staff scheduler was responsible for orientation for agency NA's. The interim DON stated agency NA's came one hour before the start of their shift, and were given a facility tour and shadowed another NA during that hour. The interim DON stated the one-hour orientation was expected from facility staff and not another agency staff member. The interim DON stated skilled nursing staff came in two hours prior to their shift for orientation. The interim DON stated agency staff were expected to be trained on facility specific information that included equipment, and would use the EMR to know a resident's ambulation status and resident specific information. The interim DON stated the facility used an orientation checklist for agency staff and new facility staff. On 8/31/23 at 8:55 a.m., trained medication aide (TMA)-A stated the EMR was used by staff and indicated a resident's ambulation status and resident specific information. TMA-A stated agency staff were not always provided EMR access or their EMR log in information did not work. On 8/31/23 10:59 a.m., the scheduling coordinator, stated she started her position in July and was responsible for agency staffing, and stated agency NA orientation time was scheduled for one hour prior to the NA's shift. The scheduling coordinator stated she was not aware of a checklist for agency staff orientation, and stated the orientation was a tour of the building, a cheat sheet for resident transfers, and safety risks for the residents. The scheduling coordinator confirmed occasions when agency staff were not able to access the EMR during	F 726	Facility will conduct random audits weekly for any new agency staff contracted to ensure they were trained. Findings will be reported to the QAPI committee monthly until the committee determines substantial compliance. 5)The date of compliance is September 29, 2023.	

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F 726	Continued From page 28 their shift. On 8/31/23 at 11:20 a.m., during a follow up interview the interim DON confirmed the facility had not provided agency NA's or nursing staff the orientation checklist for agency staff as expected. The interim DON stated it was her expectation that agency NA's were competent in NA duties, had a certain skill set and were familiar with transfer equipment. The interim DON confirmed the facility utilized a significant number of agency staff. The interim DON stated sometimes agency staff were the only staff who were assigned to the facility to provide resident care. The interim DON stated that was not preferred, but sometimes they were the only nurses and NA's available. On 8/31/23 at 11:29 a.m., the interim administrator stated agency staff were expected to utilize the orientation check list. However, the interim administrator confirmed the facility current practice did not include the agency check list at this time, and stated going forward would re-implement the orientation check list. The facility assessment dated 8/22/23, indicated contacted workers will not use facility equipment or provide certain services unless competencies are completed, ex (example) using lift equipment and whirlpool spa. Checklist will be utilized per policy/procedure. The staffing agreement with staffing agency-F signed 10/12/18, indicated one hour of orientation time prior to all first shift. Assignments and Orientation will include, but will not be limited to: state and federal regulations, including HIPAA training Employee Right to Know,	F 726		

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F 726	Continued From page 29 OSHA resident rights, a written test which qualifies workers for the duties they will perform, legal liabilities of charting, vulnerable adult laws, basic disaster policies, safety in resident care, infection control, the agency will provide the Society with orientation materials upon request. Document title GSS Contingent Labor CNA & other contingent staff orientation check list dated 9/21, indicated: -Please return the attached orientation check list within 48 hours of your traveler starting their assignment with Good Samaritan Society. It is very important this document is complete, as this is required compliance item. Purpose: the intent of this orientation is to provide an accelerated experience for contingent labor Audience: Good Samaritan Society long term care contingent labor CNA and other contingent staff Scope: the contingent labor can perform tasks unsupervised only after competency validation is completed. Agency training (completed prior to start): intro to organization, identification, incident/accident reporting, basic safety and OSHA standards, corporate compliance, documentation, abuse, neglect and exploitation elder Justice Act reporting, HIPPA, hazard communication, resident rights, infection control, BBP, TB, dementia management, advanced directives, preventing unnecessary hospitalization. Roles and responsibilities: review how to log on using Quick Badge shift routines, assignments, responsibility and resident care plans breaks/phone policies real times, feeding, nourishment, hydration reporting to nurse and/or supervisor	F 726		

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F 726	Continued From page 30 oxygen safety restraints with return demonstration of quick release snap if applicable to location call light, incontinence products supplies nursing assistant documentation PPE donning and doffing complete hand hygiene and hand washing checklist complete safe and building equipment competency validation checklist facility/unit tour I'm in unit with preceptor	F 726		
F 727 SS=C	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: The facility's request for a waiver was accepted and and approved by the State Agency following following the survey exited 2/27/23. The tag was re-issued at PAST NON-COMPLIANCE; therefore NO plan of correction is required. This will remain in effect until such time as the registered nurse (RN) coverage can be filled and the facility	F 727	POC is not required.	9/29/23

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F 727	Continued From page 31 achieves compliance. F727: CFR 483.35 (b)(1), RN coverage 8 consecutive hours a day, 7 days a week. Findings include: Review of nursing schedule in the last 30 days identified no registered nurse (RN) had been scheduled on 8/9/23, 8/8/23, 8/7/23, 8/3/23, 8/1/23. On 8/31/23 at 11:26 a.m., the interim administrator stated the facility had obtained a waiver for RN coverage and the facility was currently working on filling the positions. The interim administrator stated the facility had hired an additional RN to fill the eight hour weekend shifts and was currently working on a plan to stagger the RN care coordinators hours with another RN and will have RN's rotate weekend shifts to provide better RN coverage on the weekends. During the interview the interim administrator stated the facility had recently hired more RN's and were in the process of orientation. Review of the upcoming schedule identified RN's were in training and orientation and identified the facility was actively attempting RN coverage to meet the requirement.	F 727		
F 740 SS=D	Behavioral Health Services CFR(s): 483.40 §483.40 Behavioral health services. Each resident must receive and the facility must provide the necessary behavioral health care and services to attain or maintain the highest practicable physical, mental, and psychosocial	F 740		9/29/23

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F 740	Continued From page 32 well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders. This REQUIREMENT is not met as evidenced by: Based on interview, observation, and document review, the facility failed to offer mental health services to increase and/or support the mental well-being of 1 of 1 resident (R21) diagnosed with post-traumatic stress disorder (PTSD). Findings include: R21's quarterly Minimum Data Set (MDS) assessment dated 5/25/23, indicated R21 was admitted on 2/20/23, had intact cognition, no behaviors, required two-person physical assist with bed mobility, transfers; two-person physical assist with dressing, toilet use and personal hygiene; utilized a wheelchair, diagnoses included: bipolar disorder, psychotic disorder, PTSD, chronic pain syndrome, musical weakness, difficulty in walking. R21's care plan dated 8/31/23, indicated R21 used psychopharmacological medications r/t (related to) delusional disorder and PTSD and interventions included: consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate, discuss with health care provider, family regarding ongoing need for use of medication, educate resident/family about risks, benefits and the side effects and/or toxic symptoms of medication, monitor resident condition based on clinical practice guidelines or clinical standards of	F 740	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R21 has been offered to go out for mental health services but she declined. So, facility had also contacted R21□s guardian to setup an appointment but resident declined again. Social Worker met with resident individually 9/7 and 9/25 and had her care conference with the guardian 9/13 to discuss her care and remind her of extra services available. And a psychiatrist has been contacted to contract with the facility to see the resident/s onsite. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. 9/28 review of PASARR was completed and no other residents are at risk. All current resident□s diagnoses were reviewed by the social worker on 9/28 and all residents with a mental health diagnosis will be rescreened with the PASARR II. Facility	

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F 740	Continued From page 33 practice r/t use of olanzapine (antipyschoitc medication). Trauma Assessment dated 2/27/23, indicated R21 had indicated no experienced trauma. Level II Preadmission Screening (PAS) for persons with mental illness initial assessment dated 2/15/23, indicated R21 continued psychiatric medication management and should receive mental health services while at the nursing facility. Hospital provider notes dated 9/13/22, indicated R21's guardian was in agreement with psychiatry to meet with patient for medication assessment and for outpatient psychiatry follow up, social work will coordinate with the health unit coordinator and place an order for follow up psychiatry to be scheduled prior to patients discharge. R21's after visit summary dated 2/20/23, indicated consult and follow up appointment to be scheduled included psychiatry and psychology general consult, indication: medication assessment and clinical question: delusional disorder, schedulers have made the appointment for you (R21) to follow up at Psychiatry Clinic, March 17th. R21's provider orders dated 8/31/23, indicated olanzapine for management of mental health. Progress note on 3/8/2023, social services (SS)-A indicated a care conference included R21's guardian, staff, and R21 did not wish to come and had no concerns, nursing reported R21 was taking her meds without issues, SS-A went over	F 740	has contacted mental health providers (Sanford Psychology and Meditelecare) to start providing mental health services for all residents in need on site. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization□s policy Behavioral Health Services Rehab/Skilled has been reviewed and is current. Director of nursing, Administrator and Social Worker have been educated on this policy. Facility has contacted mental health providers (Sanford Psychology and Meditelecare) to start providing mental health services for all residents in need on site. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. The DNS or designee will audit all admission PASRRs and initial MDS assessments weekly for the next four weeks then monthly. Findings will be reported to the QAPI committee monthly until committee determine substantial compliance 5)The date of compliance is September 29, 2023.	

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F 740	Continued From page 34 the assessments, team and guardians talked about her delusions and stories she would tell, it is hard to know what is true or delusion, team was informed that R21 liked to refuse bathing, guardians will look into an appointment with the psychiatric doctor. Review of R21's record, indicated no psychiatry appointments, mental health treatments, support services, or individualized nursing interventions related to PTSD was completed. R21's physician visit notes were reviewed, the visit notes did not specifically identify, address and/or mention R21's PTSD, effectiveness of any treatments, or ongoing plan for treatment. On 8/30/23 at 11:43 a.m., R21 was observed in bed, the doors to room closed, and the lights off. R21 was wearing a hospital gown, appearance was of being sad, with flat affect. R21 stated she stayed in her room usually, and had not been offered any mental health services. R21 said she did not have anyone in the facility to talk with on a consistent basis, and was not aware she had a medical provider or doctor who took care of her medical concerns. R21 stated she infrequently attended activities due to not liking to leave her room due to pain and her low immune system. R21 stated she was unaware of any interventions to address her mental health. On 8/30/23 at 11:32 a.m., trained medication aide (TMA)-A stated R21 did not get out of bed or leave room because R21 was embarrassed about her past trauma. On 8/30/23 at 1:17 p.m., SS-A stated R21 had a trauma assessment completed on admission and	F 740		

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F 740	Continued From page 35 R21 indicated at that time she had no previous trauma. SS-A verified R21's diagnosis included PTSD however this had not been discussed with R21, due to her stating on admission she had no previous trauma. SS-A stated R21 frequently stayed in her room and in bed because R21 feared germs, does not like crowds, and stated she does not like to around be people. SS-A further indicated R21 had an opioid addiction, and an appointed guardian. On 8/31/23 at 8:07 a.m., during a telephone interview R21's guardian stated R21 had a mental illness and PTSD. R21's guardian stated she expected R21's care would include psychiatry and was not aware if R21 was seeing psychiatry. On 8/31/23 at 10:12 a.m., nurse practitioner (NP)-D confirmed R21 had not seen psychiatry since R21 had admitted to the facility, and stated currently there was not a psychiatrist that came to the facility. NP-D confirmed she saw R21 on rounds and addressed R21's medications and determined necessary care and services. NP-D stated she would expect the facility to follow the hospital discharge ordered as indicated. On 8/31/23 at 12:44 p.m., R21 was observed in bed, the doors to the room closed, and the lights off. R21 was wearing a hospital gown and watching television and stated she did not have a history of trauma. On 8/31/23 at 2:42 p.m., SS-A and interim DON stated R21 had a scheduled psychiatry appointment on 3/17/23, and the appointment was canceled on due to scheduling error. SS-A and the interim DON confirmed the psychiatry appointment had not been rescheduled. The	F 740		

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F 740	Continued From page 36 interim DON and SS-A stated the facility was responsible to reschedule R21's psychiatric appointment. The interim DON and SS-A confirmed R21 had no other behavioral health services at this time and expected the hospital discharge orders followed. The interim DON agreed mental health services should have been provided for oversight of R21's mental health diagnoses. The interim DON and SS-A confirmed R21, had no other notes or documentation to ensure mental health services had been provided timely. The facility Trauma Informed Care policy dated 10/26/22, indicated. Purpose: To provide trauma informed care and avoid re traumatizing residents. Policy: staff will ensure that residents would experience trauma received culturally competent trauma informed care accordance with professional standards of practice and accounting for resident's experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization. each employee will have training and caring for residents with mental and psychosocial disorders as well as residents with the history of trauma in their post-traumatic stress disorder. Procedure: 2. the drama assessments completed by social services while interviewing the resident/representative 3. while conducting the focus on understanding the residents experience rather than trying to correct the behavior 4. document how trauma is currently affecting rest determine appropriate progress note	F 740		

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F 740	Continued From page 37 5. individualized care plan interventions to avoid re traumatization; focus number 2 psychosocial well-being deficit for actual or potential to relieve trauma. 6. when indicated refer to a clinical/mental health professional.	F 740		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		9/29/23

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F 756	Continued From page 38 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 4 of 5 residents (R10, R13, R15, and R18) reviewed for unnecessary medications. Findings include: R13's quarterly MDS assessment dated 7/21/23, indicated R13 was cognitively intact, required, one-person physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene, utilized a wheelchair, diagnoses included malnutrition and depression, and medications indicated scheduled pain medication, insulin injections, antianxiety, antidepressant, diuretic, and opioid. R13's physician orders dated 8/31/23, included multiple scheduled medications which included an antidepressant, diabetic medications, and opioid pain medication. R13's care plan dated 8/31/23, indicated R13 was on medications with FDA boxed warning or warnings of adverse consequences r/t (related to): pain management, diuretic use, antidepressant therapy and HTN (hypertension) treatment; interventions included: consult with	F 756	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. R10, R13, R15 and R18 recommendations have been addressed per consulting pharmacist recommendations. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents had the potential to be affected deficient practice. All residents□ pharmacy recommendations for the month of September 2023 have been reviewed by 9/28/23. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization□s policy Medication: Drug Regimen Review has	

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F 756	Continued From page 39 pharmacy, healthcare provider, etc. to consider dosage reduction with clinically appropriate. R13's review of consultant pharmacist progress notes in the EMR indicated the following repeat requests to provider: --8/29/23, No response to previous recommendations yet, will resend again. --7/25/23, resending clarification of orders. --6/20/23, resending last month's note to new DON. --4/14/23, no response to duplicate antidepressant note from last month yet. R15's quarterly MDS assessment dated 7/21/23, indicated R15 had a severe cognitive impairment, required, one-person physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene, utilized a wheelchair, diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, depression, and psychotic disorder, and medications indicated R15 received antipsychotic, antidepressant medications. R15's physician orders dated 8/31/23, included multiple scheduled medications which included an antidepressant, pain medications, and an antipsychotic medication. R15's care plan dated 8/31/23, indicated R15 used antidepressant medication r/t depression and interventions included: consult with pharmacy, healthcare provider, etc. to consider dosage reduction with clinically appropriate; psychopharmacological medications r/t psychotic disorder e/b (evidenced by) taking an antipsychotic medication and interventions included discuss with health care provider, re	F 756	been reviewed and is current. The consulting pharmacist will send GDR report at the end of every month to director of nursing and designee. Facility staff gives the original copy to the NP to review on the next scheduled facility visit. Then once NP reviews, a copy signed by the NP is placed in a binder and one signed copy is uploaded to EHR-OnBase so everyone can see this. Agenda will be added to the QAPI meeting to review these. Education has been completed on this process for IP Nurse Manager and Director of Nursing. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Director of Nursing or designee will audit the GDR and ensure the NP has been given the report and has reviewed the recommendations timely, monthly for 3 months. Findings will be reported to QAPI to ensure compliance. 5)The date of compliance is September 29, 2023.	

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F 756	Continued From page 40 ongoing for use of medication, monitor resident condition based on clinical practice guidelines clinical standards of use r/t of anti-psychotic. R15's review of consultant pharmacist progress notes in the EMR indicated the following repeat requests to provider: --6/20/23, No response to GDR yet, there has been a change in DON's, will send last months to her resending last month's note to new DON. --5/18/23, resending GDR --4/14/23, no response to last month's GDR yet. --2/17/23, resending prn (as needed) lorazepam note. R10's facesheet printed on 8/31/23, included diagnoses of depression, dementia, and anxiety. R10's quarterly Minimum Data Set (MDS) assessment dated 8/4/23, indicated R10 had moderately impaired cognition and required extensive assistance of one staff for most activities of daily living (ADL's). R10's physician orders included multiple scheduled medications including an antidepressant, antipsychotic and a medication for anxiety. R10's care plan with revised date of 7/7/22, indicated R10 was on an antidepressant medication and to discuss with health care provider and family, ongoing need for use of medication; to consult with pharmacy and/or health care provider to consider dosage reduction when clinically appropriate. Review of consultant pharmacist progress notes in the electronic medical record (EMR), indicated the following repeat requests to provider:	F 756		

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F 756	Continued From page 41 --5/18/23: Recommendation: antidepressant gradual dose reduction (GDR) --6/20/23: GDR not responded to yet; will send to new DON. --7/25/23: Fluoxetine (antidepressant) GDR resent. --8/29/23: No response to previous antidepressant GDR yet - will resend. R18's facesheet printed on 8/31/23, included diagnoses of depression and paranoid personality disorder. R18's quarterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair. R18's physician orders included multiple scheduled medications including an antipsychotic and antidepressant. R18's care plan with revised date of 7/25/23, indicated R18 was on antipsychotic and antidepressant medications and to consult with pharmacy and health care provider to consider dosage reduction when clinically appropriate. Review of consultant pharmacist progress notes in the EMR, indicated the following repeat requests to provider: --5/18/23: Resending psych GDR from March. --6/20/23: No response to last months notes yet. --7/25/23: No response to May's notes yet - will resend. --8/29/23: Antipsychotic GDR. During an interview on 8/30/23 at 11:09 a.m., the interim director of nursing (DON) stated written	F 756		

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F 756	Continued From page 42 pharmacy consultant recommendations had not been routed to a provider for response since she started in June 2023. The DON who started an interim position in June, stated she recently realized there had been no discussions about resident GDR's, and subsequently contacted the consultant pharmacist (CP)-C for an update. According to the interim DON, the CP-C had informed her she had been emailing pharmacy consultant recommendations to her but they had not been acted upon. During an interview on 8/30/23 at 7:17 p.m., together with the interim DON, reviewed R10 and R18's pharmacy consultant recommendations in the progress notes in the EMR; noting the repeated pharmacist requests for GDR's. The interim DON agreed they should have been followed up on, but there had been no process in place to do so. During an interview on 8/31/23 at 10:29 a.m., nurse practitioner (NP)-D stated staff were supposed to give her pharmacy recommendation sheets for her to review and provide a response, but this had not occurred for several months. During a phone interview on 8/31/23 at 12:20 p.m., CP-C stated she had been emailing the DON (current and former) each month with pharmacy consult reports but had not seen provider follow up in the EMR for several months. CP-C stated when the DON started in June, CP-C spoke to her in person about the process for pharmacy consult reports and informed her she would email the DON the reports each month in order for the DON to obtain provider response. According to CP-C, the first email with pharmacy reports had been sent to the DON on 6/20/23.	F 756		

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F 756	Continued From page 43 During an interview on 8/31/23 at 2:48 p.m., the DON admitted when she had started the interim role, there were many competing priorities. The interim DON stated she had received many emails which may have included pharmacy consultant recommendations that she did not recognize. The facility policy Medication Drug Regimen Review dated 2/10/23, indicated: Purpose: -To prevent medication errors that could cause harm to a resident or result in resident hospitalization. - To identify the potential for adverse events. Monthly Drug Regimen Review: 3. The pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed the pharmacist will also complete the medication regimen review summary QAPI committee document. Both reports will be given to the director of nursing services upon completion of each monthly DRR (drug regimen review). The reports must be shared with the attending physician and the locations medical director and these reports must be acted upon. 6. Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. all location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented. 7. The consultant pharmacy report will be scanned into OnBase/EMR upon receipt, under	F 756		

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	245593	A. BUILDING _____ B. WING _____	C 08/31/2023

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F 756	Continued From page 44 document type pharmacy consultant report. 8. Regarding psychopharmacological medication the location will ensure that residents who have not used psychopharmacological medications and sedative hypnotics are not given these unless that therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record. In addition, those residents who do not use these types of medications will receive gradual dose reductions or behavioral interventions unless clinically contraindicated, in an effort to discontinue the drugs.	F 756		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/29/23

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F 880	Continued From page 45 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 46 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. This had the potential to affect all 25 residents residing in the facility. Findings include: During an interview on 8/31/23 at 11:07 a.m., with the interim director of nursing (DON), registered nurse (RN)-A who was also the current infection preventionist (IP) and (RN)-B who was the former IP. Each had recently started employment at the facility: --DON in June 2023 --RN-B in July 2023 --RN-A in August 2023 According to the interim DON and RN-B, the previous IP had left the facility in April 2023 and left no documentation of infection surveillance. The interim DON and RN-B verified no infection surveillance had been conducted since they started employment. RN-B stated she had recently received an online tracking tool from the facility corporation. RN-B displayed the tracking tool, titled Infection Log, on a computer monitor. RN-B stated the log pulled data from the facility electronic medical record (EMR), but neither she nor RN-A had time yet to work with it. RN-B stated the facility corporation was involved remotely but no one had been monitoring surveillance data.	F 880	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The RN hired for the Infection Prevention role completed her CDC Nursing Home Infection Preventionist Training Course 9/19/23. This Infection Prevention RN has since been trained on tracking surveillance to identify trends and patterns, and reporting findings to the weekly IDT clinical meeting and monthly QAPI to ensure compliance. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. The infection prevention RN completed her CDC Nursing Home Infection Preventionist Training Course 9/19/23. This Infection Prevention RN was trained to complete consistent and comprehensive monthly surveillance data to track trends and patterns to reduce the spread of illness and infection by 9/19/23 via The Good Samaritan Society infection prevention tracking tool along with continuously updated spreadsheets. 3)What measures will be put in place or	

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F 880	Continued From page 47 The facility Infection Prevention and Control Program policy dated 10/21/2022, indicated its purpose was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Each facility would maintain an infection prevention and control program. The program would attempt to meet federal and state regulations for infection control where applicable.	F 880	what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization□s policy Infection Preventionist has been reviewed and is current. The current Infection Prevention RN was reeducated on this policy and procedure on tracking to reduce the spread of illness and infection on 9/28. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Director of Nursing or designee will audit the monthly data to ensure it has been completed each month. Will audit monthly for 3 months and review at each QAPI meeting to ensure compliance. 5)The date of compliance is September 29, 2023.	
F 882 SS=F	Infection Preventionist Qualifications/Role CFR(s): 483.80(b)(1)-(4) §483.80(b) Infection preventionist The facility must designate one or more individual(s) as the infection preventionist(s) (IP) (s) who are responsible for the facility's IPCP. The IP must: §483.80(b)(1) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field;	F 882		9/29/23

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F 882	Continued From page 48 §483.80(b)(2) Be qualified by education, training, experience or certification; §483.80(b)(3) Work at least part-time at the facility; and §483.80(b)(4) Have completed specialized training in infection prevention and control. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the acting infection preventionist (IP) had completed specialized training in infection prevention and control. This had the potential to affect all 25 residents residing in the facility. Findings include: An interview was conducted on 8/31/23 at 11:07 a.m., with the interim director of nursing (DON), registered nurse (RN)-A who was also the current IP and (RN)-B who was the former IP. Each had recently started employment at the facility over the past three months. RN-A and RN-B stated neither had specialized training in infection prevention and control. Both had been taking courses but neither had completed them. The interim DON confirmed there were no other individuals specialized in infection prevention and control employed at the facility. The facility Infection Preventionist policy dated 10/2/22, indicated the facility must designate one or more individuals as the Infection Preventionist (IP).	F 882	1)What corrective actions(s) will be accomplished for those residents found to have been affected by the deficient practice. The infection prevention RN completed her CDC Nursing Home Infection Preventionist Training Course 9/19/23. 2)How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken. All residents have the potential to be affected by this deficient practice. The infection prevention RN completed her CDC Nursing Home Infection Preventionist Training Course 9/19/23. 3)What measures will be put in place or what systemic changes will you make to ensure that the deficient practice does not recur. To ensure systemic changes are sustained, the organization□s policy Infection Preventionist has been reviewed	

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F 882	Continued From page 49 --The IP must have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field and be qualified by education, training, experience, or certification. --The IP must be qualified by education, training, experience, or certification. --The IP must complete specialized training in infection prevention and control. --Specialized Training qualification may be obtained by completing the CDC course for LTC Infection Preventionist. --Other training courses at an equivalent or higher level are also allowed.	F 882	and is current. The facility will ensure the Infection Prevention RN will be certified by the CDC before employment. This education was provided to the RN training to become the facility□s IP RN and that RN became certified by the CDC 9/19/23. 4)How the corrective actions(s) will be monitored to ensure deficient practice will not recur, i.e., what quality assurance program will be put into practice. Facility will audit the certification of the Infection Prevention RN annually to ensure it remains up to date and therefore the facility remains in compliance. 5)The date of compliance is September 29, 2023.	

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 8/29/23-8/31/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure and the following correction orders are issued. Please indicate in your electronic plan of correction you have reviewed these orders and	2 000		

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2 000	Continued From page 1 identify the date when they will be completed. The following complaints were reviewed during the survey: H55934717C (MN00095578), H55934718C (MN00093255), H55934720C (MN00095577), H55934764C (MN00091614), H55934765C (MN00093820) H55934766C (MN00091898), H55934787C (MN00091864) and NO licensing orders were issued. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin <https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html> The State licensing orders are delineated on the attached Minnesota 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	2 000		

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2 000	Continued From page 2 Minnesota Department of Health. 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. http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota 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. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 300	MN Rule 4658.0105 Competency A nursing home must ensure that direct care staff are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through the comprehensive resident assessments and described in the	2 300		9/29/23

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2 300	Continued From page 3 comprehensive plan of care, and are able to perform their assigned duties. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure agency nursing assistants (NA's) received appropriate orientation and training prior to starting their first shift caring for residents. This had the potential to affect all 25 residents residing in the facility. Findings include: On 8/29/23 at 2:36 p.m., agency nursing assistant (NA)-A stated the facility used a lot of agency nursing staff including NA's. NA-A stated agency staff came one hour prior to their scheduled shift and received an hour of orientation before caring for residents on their own. NA-A stated one hour was not enough time to show and explain everything. NA-A stated when she arrived one hour prior to her first shift, she was provided sheet of paper that included resident's names and room numbers. NA-A stated the facility did not provide a tour of the facility, resident specific information, transfer status of the resident's, or training on facility equipment, and was unable to log into the electronic medical record (EMR) equipment. Further, NA-A stated the staff who trained her was another agency staff who was not familiar with the facility and stated, "I have just been winging it". NA-A stated the facility did not use an orientation check sheet. NA-A stated she asked facility staff how residents transferred and wrote the ambulation status on the resident sheet. NA-A stated each resident room had a white board on the wall with information written on it such as ambulation status. NA-A stated she referred to the white board as well to determine	2 300	Corrected.	

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2 300	Continued From page 4 cares for residents. On 8/30/23 at 1:55 p.m., NA-B stated she was facility staff and had worked at the facility for six months. NA-B stated agency staff did not receive facility specific training and were not familiar with the facility mechanical lifts, and stated she had observed agency NA's not sure how to use the shower chair lifts or the slings for the mechanical lifts, and would intervene when observed to assist agency staff. On 8/31/23 at 8:39 a.m., the interim director of nursing (DON) stated the staff scheduler was responsible for orientation for agency NA's. The interim DON stated agency NA's came one hour before the start of their shift, and were given a facility tour and shadowed another NA during that hour. The interim DON stated the one-hour orientation was expected from facility staff and not another agency staff member. The interim DON stated skilled nursing staff came in two hours prior to their shift for orientation. The interim DON stated agency staff were expected to be trained on facility specific information that included equipment, and would use the EMR to know a resident's ambulation status and resident specific information. The interim DON stated the facility used an orientation checklist for agency staff and new facility staff. On 8/31/23 at 8:55 a.m., trained medication aide (TMA)-A stated the EMR was used by staff and indicated a resident's ambulation status and resident specific information. TMA-A stated agency staff were not always provided EMR access or their EMR log in information did not work. On 8/31/23 10:59 a.m., the scheduling	2 300		

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2 300	Continued From page 5 coordinator, stated she started her position in July and was responsible for agency staffing, and stated agency NA orientation time was scheduled for one hour prior to the NA's shift. The scheduling coordinator stated she was not aware of a checklist for agency staff orientation, and stated the orientation was a tour of the building, a cheat sheet for resident transfers, and safety risks for the residents. The scheduling coordinator confirmed occasions when agency staff were not able to access the EMR during their shift. On 8/31/23 at 11:20 a.m., during a follow up interview the interim DON confirmed the facility had not provided agency NA's or nursing staff the orientation checklist for agency staff as expected. The interim DON stated it was her expectation that agency NA's were competent in NA duties, had a certain skill set and were familiar with transfer equipment. The interim DON confirmed the facility utilized a significant number of agency staff. The interim DON stated sometimes agency staff were the only staff who were assigned to the facility to provide resident care. The interim DON stated that was not preferred, but sometimes they were the only nurses and NA's available. On 8/31/23 at 11:29 a.m., the interim administrator stated agency staff were expected to utilize the orientation check list. However, the interim administrator confirmed the facility current practice did not include the agency check list at this time, and stated going forward would re-implement the orientation check list. The facility assessment dated 8/22/23, indicated contacted workers will not use facility equipment or provide certain services unless competencies	2 300		

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2 300	Continued From page 6 are completed, ex (example) using lift equipment and whirlpool spa. Checklist will be utilized per policy/procedure. The staffing agreement with staffing agency-F signed 10/12/18, indicated one hour of orientation time prior to all first shift. Assignments and Orientation will include, but will not be limited to: state and federal regulations, including HIPAA training Employee Right to Know, OSHA resident rights, a written test which qualifies workers for the duties they will perform, legal liabilities of charting, vulnerable adult laws, basic disaster policies, safety in resident care, infection control, the agency will provide the Society with orientation materials upon request. Document title GSS Contingent Labor CNA & other contingent staff orientation check list dated 9/21, indicated: -Please return the attached orientation check list within 48 hours of your traveler starting their assignment with Good Samaritan Society. It is very important this document is complete, as this is required compliance item. Purpose: the intent of this orientation is to provide an accelerated experience for contingent labor Audience: Good Samaritan Society long term care contingent labor CNA and other contingent staff Scope: the contingent labor can perform tasks unsupervised only after competency validation is completed. Agency training (completed prior to start): intro to organization, identification, incident/accident reporting, basic safety and OSHA standards, corporate compliance, documentation, abuse, neglect and exploitation elder Justice Act reporting, HIPPA, hazard communication, resident rights, infection control, BBP, TB,	2 300		

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2 300	Continued From page 7 dementia management, advanced directives, preventing unnecessary hospitalization. Roles and responsibilities: review how to log on using Quick Badge shift routines, assignments, responsibility and resident care plans breaks/phone policies real times, feeding, nourishment, hydration reporting to nurse and/or supervisor oxygen safety restraints with return demonstration of quick release snap if applicable to location call light, incontinence products supplies nursing assistant documentation PPE donning and doffing complete hand hygiene and hand washing checklist complete safe and building equipment competency validation checklist facility/unit tour I'm in unit with preceptor SUGGESTED METHOD OF CORRECTION: The administrator or designee could develop and/or revise and implement policies and procedures related to nursing oversight and implement a training program for newly hired or supplemental agency nursing staff. The administrator or designee should ensure oversight is provided to ensure appropriate competency and orientation is provided upon hire, yearly, and as needed. The director of nursing or designee, should re-educate staff on the policies and procedures and have a system for evaluating and monitoring consistent implementation of these policies, with results of those audits being brought to the facility's Quality Assurance Committee for review to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one	2 300		

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2 300	Continued From page 8 (21) days.	2 300		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment accurately reflected the current status and needs for 1 of 1 resident (R21) reviewed for accuracy of the MDS assessment. Findings include: R21's quarterly Minimum Data Set (MDS) assessment dated 5/25/23, indicated R21 was admitted on 2/20/23, had intact cognition, no behaviors, required two-person physical assist with bed mobility, transfers; two-person physical assist with dressing, toilet use and personal hygiene; utilized a wheelchair, diagnoses included: bipolar disorder, psychotic disorder, PTSD, chronic pain syndrome, musical weakness, difficulty in walking. R21's admission MDS dated 2/26/23, lacked indication R21 and a serious mental illness and/or intellectual disability or a related condition. On 8/30/23 at 1:17 p.m., registered nurse (RN)-B and interim director of nursing (DON), stated	2 550	Corrected.	9/29/23

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2 550	Continued From page 9 section A of the MDS was completed by offsite staff. RN-A stated she recently been hired at the facility as the MDS nurse, and another unknown nurse had completed the admission MDS prior to her start date at the facility. The interim DON confirmed R21's admission MDS assessment had not been accurately coded and lacked documentation of serious mental illness. On 8//30/23 at 3:30 p.m., the interim administrator verified R21's admission MDS had been coded inaccurately, and should had indicated R21's preadmission screening and resident review to have a serious mental illness. The interim administrator stated the facility had recently hired a new MDS nurse and R21's MDS was not completed by on site facility staff. The facility MDS 3.0 (Minimum Data Set) RAI (Resident Assessment Instrument) policy dated 6/13/23, indicated: 2. During the observation period each team member will review the EMR to determine if there is accurate documentation to support coding for the MDS. Each location will need to review state-specific documentation requirements and Medicare requirements to determine the MDS payment items. If supportive documentation does not exist, then prior to the assessment reference date the team member responsible for coding that item will write a supportive documentation note in the PN - MDS. If while reviewing the medical record the team member finds conflicting information, then a clarifying note will be written in the PN - MDS as part of the supportive documentation note. 10.Validation verification must be completed after each discipline has coded and signed their section. Any errors or warnings must be reviewed and acknowledged.	2 550		

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2 550	Continued From page 10 11.The MDS coordinator will complete a validation verification of the entire MDS. Any errors or warnings must be reviewed and acknowledged. 12.The RN MDS coordinator/ RN Designee will sign and date the MDS signifying it as complete at Z0500. This date cannot be prior to the assessment reference date. 13.For comprehensive MDSs: a. After the MDS is completed by each discipline, each discipline will electronically complete the appropriate CAA documentation and CAA Summary. b. The RN MDS coordinator/ RN Designee will electronically sign V0200B1 and date V0200B2 signifying completion of the RAI process. c. Care Plan Review - PN must be completed by each discipline after each MDS is signed as completed. The care plan is reviewed with each MDS completion, with the exception of the 5-day and 14-day if the initial care plan has not been completed yet. d. The care plan coordinator will electronically sign V0200C1 and date V0200C2 signifying completion of the care plan process. The facility Pre-Admission Screening and Resident Review (PASARR) policy dated 12/21/22, indicated: Purpose To determine admission criteria for residents with mental illness and/or mental retardation To ensure that individuals retardation serious mental disorder or intellectual disability receive the care and services they need and the most appropriate setting. Before Admission: 5. The level II PASARR screening is conducted by the agency designated by the state. The screening will determine whether the prospective	2 550		

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2 550	Continued From page 11 resident requires the level of services provided by the location weather the individual requires specialized services SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise policies and procedures related to performing Minimum Data Set (MDS) assessments and the collection of required information. The director of nursing or designee should educate staff to the policy or procedure changes and audit other residents medical records to determine accuracy of their assessments. Audits should be measurable and specific. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 550		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consistent and comprehensive monthly surveillance data was tracked to identify trends and patterns to reduce the spread of illness and infection. This had the potential to affect all 25 residents residing in the facility.	21375	Corrected.	9/29/23

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21375	Continued From page 12 Findings include: During an interview on 8/31/23 at 11:07 a.m., with the interim director of nursing (DON), registered nurse (RN)-A who was also the current infection preventionist (IP) and (RN)-B who was the former IP. Each had recently started employment at the facility: --DON in June 2023 --RN-B in July 2023 --RN-A in August 2023 According to the interim DON and RN-B, the previous IP had left the facility in April 2023 and left no documentation of infection surveillance. The interim DON and RN-B verified no infection surveillance had been conducted since they started employment. RN-B stated she had recently received an online tracking tool from the facility corporation. RN-B displayed the tracking tool, titled Infection Log, on a computer monitor. RN-B stated the log pulled data from the facility electronic medical record (EMR), but neither she nor RN-A had time yet to work with it. RN-B stated the facility corporation was involved remotely but no one had been monitoring surveillance data. The facility Infection Prevention and Control Program policy dated 10/21/2022, indicated its purpose was to establish and maintain an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. Each facility would maintain an infection prevention and control program. The program would attempt to meet federal and state regulations for infection control	21375		

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21375	Continued From page 13 where applicable. SUGGESTED METHOD OF CORRECTION: The DON (Director of Nursing) or designee should review/revise facility policies to ensure they contain all components of an infection control program to mitigate transmission of potential infections. The DON or designee could educate all staff on existing or revised policies and perform audits to ensure the policies are being followed. The results of those audits should be taken to Quality Assurance Performance Improvement committee to determine compliance and the need for further monitoring. Time Period for Correction: Twenty-one (21) days.	21375		
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.	21426		9/29/23

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21426	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 6 employees (TMA (trained medication aide)-A, TMA-C, housekeeping (HK)-A, and nursing assistant (NA)-B) were properly screened and/or tested for tuberculosis (TB). Findings include: TMA-A was hired 1/10/23, and record review lacked evidence a symptom screening or TB testing was completed. TMA-C was hired 6/13/23, and record review lacked evidence a symptom screening or TB testing was completed. HK-A was hired 3/1/23, and record review lacked evidence a symptom screening or TB testing was completed. NA-B was hired 3/28/23, and record review lacked evidence a symptom screening or TB testing was completed. On 8/31/23 at 11:36 a.m., the interim administrator verified employees TMA-A, TMA-C, HK-A, and NA-B had not completed the TB symptom screening or testing for TB. The facility's TB Risk assessment worksheet for Health Care Settings Licensed by MDH dated 7/30/23, indicated the facility performed the	21426	Corrected.	

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21426	Continued From page 15 required TB screening and testing of all personnel at the time of hire. The facility Tuberculosis Control Plan and Screening for Employees policy dated 10/21/22, indicated: Purpose: To provide early identification of employees infected with Mycobacterium tuberculosis (TB) to prevent the spread of TB through appropriate screening and treatment of employees with TB or exposure to TB. Policy: New employees will have a baseline TB screening and post-exposure screening according to current CDC recommendations and guidelines. Procedure Baseline Screening for TB Prior to or upon hire, all employees will be screened for TB risk and for signs or symptoms of active TB disease: persistent cough (greater than three weeks duration), especially in the presence of other symptoms or signs compatible with TB, such as complaints of bloody sputum, night sweats, weight loss, anorexia or fever Prior to or upon hire, all employees will receive a baseline tuberculin skin test (TST) or single TB blood test. New employees with verified results not more than 30 days old will not be retested. If using TST, a two-step Mantoux method should be used for testing. This involves administering the initial test upon hire, which is read within 48 to 72 hours by a nursing professional or a physician/practitioner. If the first TST is negative, the second test should be placed one to three weeks after the placement of the first test or per state regulations. The second test is read 48 to 72 hours after administration.	21426		

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21426	Continued From page 16 IGRA testing is an acceptable form of TB testing. Two IGRAs have been approved for testing: QuantiFERON-TB Gold In-Tube test (QFT) T-Spot TB Test (T-spot) SUGGESTED METHOD OF CORRECTION: The infection control nurse (ICN), director of nursing (DON) and/or designee could review policies and procedures related to the screening and testing for tuberculosis for employees. Facility staff could be educated on the TB regulations, symptom screening, and the two-step Mantoux process. The ICN, DON and/or designee could audit new hires screening and testing for tuberculosis. The ICN, DON and/or designee could take those findings/education to the Quality Assurance Performance Improvement (QAPI) committee for a determined amount of time until the QAPI committee determines successful compliance or the need for ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty one-(21) days.	21426		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any	21530		9/29/23

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21530	Continued From page 17 irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consulting pharmacist recommendations were addressed or acted upon for 4 of 5 residents (R10, R13, R15, and R18) reviewed for unnecessary medications. Findings include: R13's quarterly MDS assessment dated 7/21/23, indicated R13 was cognitively intact, required, one-person physical assistance with bed mobility,	21530	Corrected.	

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21530	Continued From page 18 transfers, dressing, toilet use, and personal hygiene, utilized a wheelchair, diagnoses included malnutrition and depression, and medications indicated scheduled pain medication, insulin injections, antianxiety, antidepressant, diuretic, and opioid. R13's physician orders dated 8/31/23, included multiple scheduled medications which included an antidepressant, diabetic medications, and opioid pain medication. R13's care plan dated 8/31/23, indicated R13 was on medications with FDA boxed warning or warnings of adverse consequences r/t (related to): pain management, diuretic use, antidepressant therapy and HTN (hypertension) treatment; interventions included: consult with pharmacy, healthcare provider, etc. to consider dosage reduction with clinically appropriate. R13's review of consultant pharmacist progress notes in the EMR indicated the following repeat requests to provider: --8/29/23, No response to previous recommendations yet, will resend again. --7/25/23, resending clarification of orders. --6/20/23, resending last month's note to new DON. --4/14/23, no response to duplicate antidepressant note from last month yet. R15's quarterly MDS assessment dated 7/21/23, indicated R15 had a severe cognitive impairment, required, one-person physical assistance with bed mobility, transfers, dressing, toilet use, and personal hygiene, utilized a wheelchair, diagnoses included non-traumatic brain dysfunction, non-Alzheimer's dementia, depression, and psychotic disorder, and	21530		

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21530	Continued From page 19 medications indicated R15 received antipsychotic, antidepressant medications. R15's physician orders dated 8/31/23, included multiple scheduled medications which included an antidepressant, pain medications, and an antipsychotic medication. R15's care plan dated 8/31/23, indicated R15 used antidepressant medication r/t depression and interventions included: consult with pharmacy, healthcare provider, etc. to consider dosage reduction with clinically appropriate; psychopharmacological medications r/t psychotic disorder e/b (evidenced by) taking an antipsychotic medication and interventions included discuss with health care provider, re ongoing for use of medication, monitor resident condition based on clinical practice guidelines clinical standards of use r/t of anti-psychotic. R15's review of consultant pharmacist progress notes in the EMR indicated the following repeat requests to provider: --6/20/23, No response to GDR yet, there has been a change in DON's, will send last months to her resending last month's note to new DON. --5/18/23, resending GDR --4/14/23, no response to last month's GDR yet. R10's facesheet printed on 8/31/23, included diagnoses of depression, dementia, and anxiety. R10's quarterly Minimum Data Set (MDS) assessment dated 8/4/23, indicated R10 had moderately impaired cognition and required extensive assistance of one staff for most activities of daily living (ADL's). R10's physician orders included multiple	21530		

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21530	Continued From page 20 scheduled medications including an antidepressant, antipsychotic and a medication for anxiety. R10's care plan with revised date of 7/7/22, indicated R10 was on an antidepressant medication and to discuss with health care provider and family, ongoing need for use of medication; to consult with pharmacy and/or health care provider to consider dosage reduction when clinically appropriate. Review of consultant pharmacist progress notes in the electronic medical record (EMR), indicated the following repeat requests to provider: --5/18/23: Recommendation: antidepressant gradual dose reduction (GDR) --6/20/23: GDR not responded to yet; will send to new DON. --7/25/23: Fluoxetine (antidepressant) GDR resent. --8/29/23: No response to previous antidepressant GDR yet - will resend. R18's facesheet printed on 8/31/23, included diagnoses of depression and paranoid personality disorder. R18's quarterly MDS assessment dated 7/6/23, indicated R18 had moderately impaired cognition and required limited assistance of staff when moving about the facility in a wheelchair. R18's physician orders included multiple scheduled medications including an antipsychotic and antidepressant. R18's care plan with revised date of 7/25/23, indicated R18 was on antipsychotic and antidepressant medications and to consult with	21530		

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	00697	A. BUILDING: _____ B. WING _____	C 08/31/2023

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21530	Continued From page 21 pharmacy and health care provider to consider dosage reduction when clinically appropriate. Review of consultant pharmacist progress notes in the EMR, indicated the following repeat requests to provider: --5/18/23: Resending psych GDR from March. --6/20/23: No response to last months notes yet. --7/25/23: No response to May's notes yet - will resend. --8/29/23: Antipsychotic GDR. During an interview on 8/30/23 at 11:09 a.m., the interim director of nursing (DON) stated written pharmacy consultant recommendations had not been routed to a provider for response since she started in June 2023. The DON who started an interim position in June, stated she recently realized there had been no discussions about resident GDR's, and subsequently contacted the consultant pharmacist (CP)-C for an update. According to the interim DON, the CP-C had informed her she had been emailing pharmacy consultant recommendations to her but they had not been acted upon. During an interview on 8/30/23 at 7:17 p.m., together with the interim DON, reviewed R10 and R18's pharmacy consultant recommendations in the progress notes in the EMR; noting the repeated pharmacist requests for GDR's. The interim DON agreed they should have been followed up on, but there had been no process in place to do so. During an interview on 8/31/23 at 10:29 a.m., nurse practitioner (NP)-D stated staff were supposed to give her pharmacy recommendation sheets for her to review and provide a response, but this had not occurred for several months.	21530		

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21530	Continued From page 22 During a phone interview on 8/31/23 at 12:20 p.m., CP-C stated she had been emailing the DON (current and former) each month with pharmacy consult reports but had not seen provider follow up in the EMR for several months. CP-C stated when the DON started in June, CP-C spoke to her in person about the process for pharmacy consult reports and informed her she would email the DON the reports each month in order for the DON to obtain provider response. According to CP-C, the first email with pharmacy reports had been sent to the DON on 6/20/23. During an interview on 8/31/23 at 2:48 p.m., the DON admitted when she had started the interim role, there were many competing priorities. The interim DON stated she had received many emails which may have included pharmacy consultant recommendations that she did not recognize. The facility policy Medication Drug Regimen Review dated 2/10/23, indicated: Purpose: -To prevent medication errors that could cause harm to a resident or result in resident hospitalization. - To identify the potential for adverse events. Monthly Drug Regimen Review: 3. The pharmacist will complete a written report noting any drug irregularities or issues of concern for each resident reviewed the pharmacist will also complete the medication regimen review summary QAPI committee document. Both reports will be given to the director of nursing services upon completion of each monthly DRR (drug regimen review). The reports must be	21530		

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21530	Continued From page 23 shared with the attending physician and the locations medical director and these reports must be acted upon. 6. Drug irregularities will be reported to the medical director and attending physician by the director of nursing services or designee. all location must designate someone to ensure that these reports have been acted upon within 30 calendar days of the review and have been documented. 7. The consultant pharmacy report will be scanned into OnBase/EMR upon receipt, under document type pharmacy consultant report. 8. Regarding psychopharmacological medication the location will ensure that residents who have not used psychopharmacological medications and sedative hypnotics are not given these unless that therapy is necessary to treat a specific condition, as diagnosed and documented in the medical record. In addition, those residents who do not use these types of medications will receive gradual dose reductions or behavioral interventions unless clinically contraindicated, in an effort to discontinue the drugs. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee and the consulting pharmacist should develop and/or revise policies to monitor medications to ensure recommendations are acted upon. The director of nursing (DON) or designee and the consulting pharmacist should educate physicians and staff on the importance of ensuring recommendations are acted upon as soon as possible. Audits should be developed to monitor timeliness of action from physician, using appropriate timeframe's for a specific and measurable amount of time. The DON and/or designee should take those findings/education to the Quality Assurance Performance Improvement	21530		

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21530	Continued From page 24 (APIA) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21530		
21942	MN St. Statute 144A.10 Subd. 8b Establish Resident and Family Councils Resident advisory council. Each nursing home or boarding care home shall establish a resident advisory council and a family council, unless fewer than three persons express an interest in participating. If one or both councils do not function, the nursing home or boarding care home shall document its attempts to establish the council or councils at least once each calendar year. This subdivision does not alter the rights of residents and families provided by section 144.651, subdivision 27. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to establish a family council within the past 12 months. This had the potential to effect all 25 residents residing in the facility. Findings include: On 8/31/23 11:48 a.m., social services (SS)-A worker verified no attempts to form a family council had been made within the last 12 months. Further SS-A confirmed family council attempts were required On 8/31/23, at 11:55 a.m. the interim	21942	Corrected.	9/29/23

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21942	Continued From page 25 administrator confirmed the facility did not have a family council and stated there was no documentation one had been attempted in the last year. The facility did not provide a policy regarding family council. SUGGESTED METHOD OF CORRECTION: The facility's social worker could contact resident family members via any method, to invite to participate in a family council meeting. The frequency of the family council meetings could be determined by the family council. Documentation of all meetings and attempts should be maintained. If the first attempt does not yield results, the facility could make another attempt later in the same year. The administrator or designee could monitor the attempts to organize a family council. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21942		

APPROVED
By Travis Z. Ahrens at 11:15 am, Sep 20, 2023

Travis Z. Ahrens 49207

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

F5593034

PRINTED: 09/20/2023
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
	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/31/2023**

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GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET** **ST JAMES, MN 56081**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 08/31/2023. At the time of this survey, Good Samaritan Society-St. James 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) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, the Health Care Facilities Code. This one-story with partial basement facility was determined to be of Type V(000) construction and is fully sprinklered throughout. The original building was constructed in 1963 with building additions in 1965, 1993, 1996, 2002. The facility has a capacity of 44 beds and had a census of 26 at time of the survey.	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.