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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7PAM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00924

1. MEDICARE/MEDICAID PROVIDER NO.(L1) **245234**

2. STATE VENDOR OR MEDICAID NO. (L2) **359057700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW**
(L4) **333 FIFTH STREET WEST**
(L5) **WACONIA, MN** (L6) **55387**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **7/19/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

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

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: A (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date : Gloria Derfus, Unit Supervisor 07/22/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date: Kamala Fiske-Downing, Health Program Representative 07/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **01/04/1980** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

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

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245234

July 25, 2016

Ms. Rebecca Bollig, Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Dear Ms. Bollig:

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

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

Effective July 1, 2016 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
July 22, 2016

Ms. Rebecca Bollig, Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: Project Number S5234027

Dear Ms. Bollig:

On June 24, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 9, 2016 that included an investigation of complaint number . This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On July 19, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 9, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 1, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 9, 2016, effective July 1, 2016 and therefore remedies outlined in our letter to you dated June 24, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245234 Y1	A. Building B. Wing Y2	7/19/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0241	Correction	ID Prefix F0279	Correction	ID Prefix F0282	Correction
Reg. # 483.15(a)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed	Reg. # 483.20(k)(3)(ii)	Completed
LSC	07/01/2016	LSC	07/01/2016	LSC	07/01/2016
ID Prefix F0312	Correction	ID Prefix F0314	Correction	ID Prefix F0315	Correction
Reg. # 483.25(a)(3)	Completed	Reg. # 483.25(c)	Completed	Reg. # 483.25(d)	Completed
LSC	07/01/2016	LSC	07/01/2016	LSC	07/01/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GPN/kfd	7/22/2016	31221	7/19/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
6/9/2016	☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: 7PAM

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00924

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245234**
2.STATE VENDOR OR MEDICAID NO.
(L2) **359057700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW**
(L4) **333 FIFTH STREET WEST**
(L5) **WACONIA, MN** (L6) **55387**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/09/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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13.Total Certified Beds **96** (L17)

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A. In Compliance With Program Requirements Compliance Based On:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Carrie Euerle, HFE NE II 07/19/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Health Program Representative 07/22/2016 (L20)

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

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

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/04/1980
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
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02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered

June 24, 2016

Ms. Rebecca Bollig, Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: Project Number S5234027

Dear Ms. Bollig:

On June 9, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Gloria Derfus, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900
gloria.derfus@state.mn.us
Telephone: (651) 201-3792 Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by July 19, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 9, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 9, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 4 residents (R96) reviewed for activities of daily living and failed to provide grooming to enhance the dignity of 1 of 1 residents (R122) reviewed for dignity. In addition, the facility failed to provide rising and morning routines in a dignified manner for 3 of 3 (R21, R92, R97) residents who were cognitively impaired and required extensive assistance to complete activities of daily living (ADLs).	F 241	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it 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	7/1/16

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

Electronically Signed | 07/01/2016

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 241	Continued From page 1 Findings include: R96's quarterly minimum data set (MDS) dated 3/9/16 indicated she was severely cognitively impaired, required physical assistance for personal hygiene and required physical assistance to eat. A care area assessment (CAA) dated 1/7/16, indicated a need for physical assistance, a mechanically altered diet, and occasional extensive assistance needed for dining. R96's care plan dated 5/16/13, indicated a self care deficit and directed staff to cue resident to eat, offer her a spoon when observed eating with fingers, and provide a napkin clip. On 6/6/16, at 5:00 p.m., R96 was seated at a table in the dining room unassisted by staff. Her wheel chair was reclined back approximately 30 degrees. She was eating ground barbeque ribs and cubed carrots with her fingers. No staff was present at the table. R96 continued to eat with her fingers and had ribs and carrots on her chest. She was not wearing a clothing protector. At 5:06 p.m., R96 continued to eat her food independently with her fingers, dropping more food onto her chest. At 5:08 p.m., she picked up her cake with her hands and began eating it. At 5:22 p.m., nursing assistant (NA)-C stood next to R96 at the table and offered R96 a spoon, R96 had already consumed 60% of her meal. NA-C walked away and did not return or offer assistance. R96 continued to eat with her fingers. She had a large amount of barbeque ribs, carrots and cake down the front of her chest and her dress. During an interview on 6/9/16, at 8:57 a.m., registered nurse (RN)-A stated R96's level of assistance varied during meals. She stated	F 241	constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. R96 care plan was reviewed and updated to accurately reflect her need for extensive assist with eating. Nursing staff were immediately made aware of this change with a alert that appears in the electronic medical record. This was completed on 6-29-2016. R122 was observed to have facial hair now trimmed when interviewed on 6-29-2016. Care plan for R96 was reviewed and updated to reflect current abilities and need for assistance with meals. This was done on 6-29-2016 and was communicated to nursing staff. R122 was interviewed on 6-29-2016 and was found to be free of facial hair in need of trimming. Nursing staff were re-educated by the DNS on 6-29-2016 on the importance for all residents to be provided with dignified cares including grooming, dining and choices surrounding AM and PM cares. Social services will interview all long term care residents including R21, R92 and R97 or their designated responsible party for health care decisions on their preferences or customs for times to receive morning and bedtime cares. These interviews will be completed by 7-15-2016. The nurse mangers will use this information to update care plans by 7-22-2016. All nursing staff will be re-educated by the DNS on the policy and procedures on dignified care. This re-education will be completed by	

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F 241	Continued From page 2 sometimes R96 would eat with a spoon and other times she would eat with her fingers. RN-A stated "for dignity" staff should intervene if R96 is eating with her fingers. RN-A stated staff attempted to give her things that are easier to eat and stated things like mixed vegetables end up on the floor. During an interview on 6/9/16, at 10:52 a.m., The director of nursing (DON) stated R96 required set up with meals and when staff assisted her, she would often take over with her hands. He stated he would expect staff to re-organize and clean R96 up as she was eating. R122's Admission minimum data set (MDS) dated 3/9/16, indicated she was severely cognitively impaired and required extensive assistance with dressing and grooming. Her care plan dated 3/9/16, indicated a self care deficit related to impaired functioning and directed staff to assist with personal hygiene. On 6/7/16, at 12:52 p.m., R122 was observed to have several hairs on her chin approximately 1/4 to 1/2 inch long. On 6/8/16, at 8:05 a.m., R122 was sitting at the breakfast table in the dining room. She had several hairs approximately 1/8th inch in length protruding from the left side of her chin and several 1/4 inch long hairs on the right side of her chin. On 6/8/16, at 8:44 a.m., R122 stroked her chin and stated, "I have been saving my chin whiskers, that's not for a lady." She further stated, "I would like to get rid of them." "It would be very nice."	F 241	7-15-2016. Audits (including R122, R96, R21, R92, and a random sample of other long term care residents) will be done to check for compliance in provision of dignified care for activities of daily living that include dining, morning cares and facial hair for women will be conducted by the nurse managers weekly x 4 and then monthly x3 to be completed by October 31, 2016. Audit results will be reported and reviewed in QA committee	

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F 241	Continued From page 3 On 6/8/16, at 9:11 a.m., nursing assistant (NA)-A stated on bath day the nursing assistants were responsible for checking skin, toenails and shaving female residents. She stated if a resident was unable to request, they offer to shave. She stated she was aware of only one resident who refused shaving and R122 was not that resident. On 6/9/16, at 10:13 a.m., registered nurse (RN)-A stated if staff noticed a female resident with facial hair they were supposed to take care of it. On 6/9/16, at 10:44 a.m., the director of nursing (DON) stated if staff noticed facial hair on a female resident they should offer to shave it. A facility policy and procedure titled Good Samaritan Society Resident Dignity dated 2/13, indicated the facility would care for residents in a manner that maintained each resident's dignity including grooming residents as they wished to be groomed. The policy directed staff to promote residents dignity in dining and refrain from practices demeaning to residents. A facility policy titled Good Samaritan Society Resident Choice Dining dated 2/13, indicated residents would receive assistance from staff members in a dignified manner including sitting while giving assistance rather than standing. R21's medical record was reviewed and revealed R21 had a diagnosis of Alzheimer's disease. A minimum data set (MDS) annual assessment dated 3/16/16, identified R21 was cognitively impaired. The MDS further identified R21 was totally dependent upon staff for transfers and required extensive assistance of two staff for toileting and bed mobility. R21's 1/17/13, careplan	F 241		

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identified R21 required assistance of 2 staff and a mechanical lift for all transfers.

R92 had a diagnosis of dementia. An MDS assessment dated 4/6/16, indicated R92 was "rarely/never understood". Further, R92 required assistance of two staff and a mechanical lift for transfers, toileting and bed mobility.

R97 had a diagnosis of dementia. A quarterly MDS assessment dated 2/24/16, identified R97 was severely cognitively impaired. The MDS further identified R97 required extensive assistance from staff for transfers, toileting and bed mobility. R97's careplan dated 5/30/14, identified R97 required assistance of two staff and a mechanical lift for transfers, toileting and bed mobility.

On 6/8/16 at 7:09 a.m. R21 was observed to be sleeping in bed. R21 was dressed in a pink top and pink jacket and a mechanical lift sling was observed underneath R21. At 7:22 a.m.. R21 was calling out from her bed. Two nursing assistants entered the room to assist R21 out of bed. No morning cares were provided to R21. The two nursing assistants (NA-G, NA-H) hooked up the mechanical lift sling to the mechanical lift and positioned R21 in to her wheelchair. NA-G then began to comb R21's hair and provided R21 her glasses.

NA-G was interviewed on 6/8/16, at 7:32 a.m. and indicated she dressed R21 around 6:00 a.m. and put R21 back into bed as it was too early for her to get up. NA-G indicated she worked the night shift and the night shift had a list of residents they needed to get up. NA-G indicated the night shift "gets up" 5 residents and that 2 of

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the 5 residents must be "lift" residents (those that require full assistance with a mechanical lift) because the unit had "so many lifts". NA-G indicated she got the "lift" residents "dressed and ready to go" and then put them back in bed until later in the morning. NA-G further indicated the other "lift" resident she assisted this morning was R97. NA-G indicated it did not matter which residents she assisted in the morning but two of them must be "lift" residents.

On 6/8/16, at 7:41 a.m. R92's room light was on and R92 was observed to be sleeping in bed dressed in a flowered shirt. R92 had a blanket covering her and a mechanical lift sling was observed to be placed underneath her in bed. At 8:24 a.m. R92 was observed at the morning meal with the same flowered shirt and a gray sweater.

On 6/9/2016 at 6:15 a.m. R97's room light was on and R97 was observed sleeping in bed, dressed in a striped shirt covered with a blanket.

NA-I was interviewed on 6/9/16, at 7:59 a.m. and indicated the night shift staff is to assist 3 residents each. NA-I stated the night shift "gets up" some of the early risers and try to do a "lift" for us. NA-I indicated R97 was a resident that night shift got up as she required a mechanical lift for transfer assistance.

Registered Nurse (RN)-B was interviewed on 6/9/16 at 12:19 p.m. and indicated the plan for night shift staff was to get up residents who wanted to get up. RN-B stated it was important that residents were able to do what they want to do and residents were encouraged to sleep in if they choose. RN-B stated night shift staff was expected to get up a couple residents that are lift

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F 241	Continued From page 6 dependent so all the lift dependent residents were not on one shift. RN-B indicated that this was to "keep it more fair" between the shifts. RN-B further indicated she expected lights to be shut off in resident rooms if they were sleeping. The Director of Nursing (DON) was interviewed on 6/9/16, at 1:30 p.m. and indicated morning cares at the facility did not begin until 6:00 a.m. unless a request by a resident had been made. The DON indicated residents had a choice about when they got up in the morning. The DON indicated he was aware there was a list of residents night shift was to assist with morning cares. He confirmed the night shift was expected to assist 2 to 3 lift dependent residents. The DON indicated he was not aware how staff made the selection of which residents to assist in the morning. The DON stated that should not be dressed and placed in bed with the light on and indicated morning cares should be a continuous process. Staff should assist the residents from beginning to completion of morning cares and residents should not be placed back in bed for staff convenience.	F 241		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment.	F 279		7/1/16

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F 279	Continued From page 7 The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care planned interventions to restore bladder function for 1 of 3 residents (R56) reviewed for urinary incontinence. In addition, the facility failed to develop interventions to prevent new or worsening pressure ulcers for 1 of 2 residents (R56) reviewed for pressure ulcers. Findings include: R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he was cognitively intact, required extensive assistance of two staff for transfers and toileting, and was occasionally incontinent of bladder. The MDS indicated a trial toileting plan had not been attempted for R56. A previous MDS dated 4/7/16, indicated R56 was always continent of bladder. A bladder assessment dated 9/29/15, indicated R56 was incontinent of bladder due to functional impairment and indicated a check and change program to manage incontinence. Recommendations based on the assessment included, "none at this time, continue current	F 279	Review of R56 care plan was done and updated to reflect interventions to prevent new or worsening pressure ulcers including plan to attempt to offload seating surfaces. This was completed on 6-28-2016. Nursing staff were re-educated by the DNS on the need for immediate attention to proper documentation of data and measurements of wounds to ensure thorough evaluation of interventions to prevent new or worsening pressure ulcers. All nursing staff will receive re-education by the DNS on the facility policy for management of residents who have pressure ulcers or who are at risk for development of pressure ulcers and this re-education will include need for proper wound data collection including measurements and assessments. These assessments are to be used to assure proper care plans are developed to reflect interventions that are done to prevent new or worsening pressure ulcers. The re-education will be completed by	

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F 279	Continued From page 8 toileting program." R56's care plan dated 9/24/15, indicated he required assistance from two staff and a mechanical lift for transfers. The care plan was updated on 6/8/16, following inquiry by surveyor, to include toileting with assist of two staff. The care plan did not address a toileting plan for R56 even though he had a decline from being continent to occasional incontinence. On 6/8/16, at 7:27 a.m., R56 was at the breakfast table in a standard wheel chair. At 8:26 a.m., R56 was escorted to his room by staff where he remained until 10:06 a.m. when he left the facility for an appointment. On 6/8/16, at 10:09 a.m., nursing assistant (NA)-B stated R56 was on dialysis and did not void. She stated he would request the commode if he needed to have a bowel movement. On 6/8/16, at 11:42 a.m., NA-A stated R56 was continent of bladder and did not void due to dialysis. On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had end stage renal disease and received dialysis but did void. Additionally, RN-A stated she was not aware he had a change in his level of urinary continence. RN-A stated he should have been re-assessed following that change. RN-A stated R56 was not on a toileting plan and his care plan indicated he was continent of bladder but stated, "that is incorrect." She stated he should be toileted upon rising, after meals, naps and before bed as that was the facility's standard practice.	F 279	7-15-2016. Nurse managers will review all residents with a current open area or who have been identified as being at risk for development of pressure ulcers as indicated by a Braden Score of 18 or below. Nurse managers will review these records for proper care planning with interventions that are done to prevent new or worsening of pressure ulcers. These reviews will be completed by 7-15-2016. Review of R56 care plan was completed as well as data collected regarding bladder continence over the past 9 months. A new 72 hour bladder data collection tool was initiated on 6-28-2016. This data will be used to complete fresh assessment of R56 actual level of bladder control. This assessment will be used to make a plan of care that accurately reflects his level of continence and any possible intervention for restoration of bladder function. This care plan will be updated by 7-08-2016. Nurse managers will review all long term care resident records who are listed as being currently incontinent to look for changes noted in MDS of bladder continence. Nurse managers will review the records to ensure that proper data collection, assessment and care plan updates were done to reflect the current needs of the residents. This review will be completed by 7-15-2016. Audits (that will include R56 and random selection of other residents) of data collection, assessment and care plan process that includes the areas of pressure ulcers and bladder continence/retraining will be done by the	

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F 279	Continued From page 9 R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he had a stage II pressure ulcer identified on 4/20/16. The MDS further indicated R56 was cognitively intact, incontinent of bladder, and required extensive assistance of two staff for bed mobility, transfers and toileting. His care plan dated 3/23/16, identified a skin impairment and directed staff to turn and reposition R56 every 2-3 hours while in bed and provide an air mattress. The care plan did not address repositioning or off-loading while R56 was up in his wheel chair. During continuous observation on 6/8/16, at 7:27 a.m., R56 was sitting at the table in the dining room in a standard wheel chair. A mechanical lift sling was underneath R56 from his shoulders to mid thighs. In his wheel chair was a blue foam cushion. At 8:26 a.m., a staff member escorted R56 to his room where he sat in his wheel chair reading a magazine. At 9:39 am, R56 continued to sit in his wheel chair until 10:06 a.m. when he left to go to an appointment outside the facility. R56 had not been repositioned for two hours and thirty nine minutes prior to getting in a transport vehicle where he would continue to sit in his wheelchair without repositioning or off-loading and would not return to the facility for approximately 4 more hours. During an observation on 6/9/16, at 7:38 a.m., R56 had an open area to the right of his coccyx. Licensed practical nurse (LPN)-A described the wound and stated "I would call the wound a stage one to two because there are some open areas." On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had a wound on his coccyx that developed on 4/26/16. RN-A stated "that would be pressure I would think." RN-A further stated based on R56's skin issues he should be turned	F 279	nurse managers weekly x 4 and then monthly x 3 with a planned completion date of 10-31-2016. Audit results will be reported and reviewed in the QA committee.	

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F 279	Continued From page 10 and repositioned every two to three hours and he should have been repositioned between breakfast and going out for his dialysis. She further stated the mechanical lift sling should be removed form underneath him in the chair. On 6/9/16, at 10:38 a.m., the director of nursing stated the nurse manager was responsible for wounds on the unit. He stated he would expect to see interventions in the care plan related to pressure. A facility policy titled Good Samaritan Society Care Plan, dated 9/12, indicated each resident would have an individualized comprehensive plan of care directed toward maintaining the residents optimal needs. The policy directed staff to evaluate and update the care plan at least quarterly and with a change in the residents condition to reflect the care currently required for the resident.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care planned interventions for 1 of 3 residents (R122) who was dependent on staff for grooming. In addition the facility failed to provide care planned interventions for 1 of residents (R37) who was dependent on staff for eating.	F 282	R122 was interviewed on 6-29-2016 and was found to be free of facial hair in need of trimming. Nursing staff were re-educated by the DNS on the need to for all residents to be provided with dignified cares including grooming of women's facial hair. R37 had review of	7/1/16

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F 282	Continued From page 11 Findings include: R122's Admission minimum data set (MDS) dated 3/9/16, indicated she was severely cognitively impaired and required extensive assistance with dressing and grooming. R122's care plan dated 3/9/16, identified a self care deficit related to impaired functioning and directed staff to assist with personal hygiene. On 6/7/16, at 12:52 a.m., R122 was observed to have several hairs on her chin approximately 1/4 to 1/2 inch long. On 6/8/16, at 8:05 a.m., R122 was sitting at the breakfast table in the dining room. She had several hairs approximately 1/8th inch in length protruding from the left side of her chin and several 1/4 inch long hairs on the right side of her chin. On 6/8/16, at 9:11 a.m., nursing assistant (NA)-A stated on bath day the nursing assistants were responsible for shaving female residents. On 6/9/16, at 10:13 a.m., registered nurse (RN)-A stated if staff noticed a female resident with facial hair they were supposed to take care of it. On 6/9/16, at 10:44 a.m., the director of nursing (DON) stated if staff noticed facial hair on a female resident they should offer to shave it. R37's quarterly minimum data set (MDS) dated 4/13/16, indicated he was severely cognitively impaired and required physical assistance to eat. A care area assessment (CAA) dated 11/2/15,	F 282	care plan on 6-29-2016 that was found to be accurate in reflection of the needs for assistance with dining. Nursing staff were re-educated by the DNS on the need to provide necessary care planned assistance. All nursing staff will be re-educated by the DNS on the facility policy on provision of services per care plan including areas of assistance with grooming and dining assistance. Staff will be re-educated by the DNS with the expectation to use existing tools to be made aware of what the care plan indicates. This re-education will be completed by 7-15-2016. Audits (including R122 and R37 along with a random selection of other residents) of grooming and dining room assistance per care plan will be done by the nurse managers weekly x4 and then monthly x3 with a planned completion date of 10-31-2016. Audit results will be brought to the QA committee for review.	

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GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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
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identified the need for a mechanically altered diet and nectar thickened liquids as well as functional problems that affected his ability to eat including, vision problems, impaired range of motion and the need for physical assistance to perform activities of daily living.

R37's care plan dated 4/8/16, identified a self care deficit and directed staff to provide set up and supervision with meals. The care plan further directed staff to provide limited to extensive assist when R37 was observed not eating.

On 6/6/16, at 4:54 p.m., R37 was observed sitting at a table in the dining room. Nursing assistant (NA)-D was standing at the table feeding him. At 4:56 p.m., she walked over to another resident and stood feeding her. NA-D then left the table. Another staff member sat at the table and began to assist another resident. R37 was seated across from the staff member eating his cake with his fingers. At 5:05 p.m., NA-D gave R37 his spoon and walked away. He put the spoon on the table and sat, not eating. At 5:16 p.m., he still had not eaten any more of his food and staff had not returned to assist him. At 5:25 p.m., NA-C sat down next to R37. She asked if he would like more to eat. R37 stated yes. NA-C fed R37 one bite and left the table. R37 had consumed less than 25% of his food and staff did not return to offer him any more assistance or food. The rest of his meal was uneaten.

On 6/8/16, at 12:04 p.m., R37 was brought a cold sandwich and a bowl of soup. Staff placed the food in front of him and walked away. R37 sat at the table holding a cup. At 12:11 p.m., he put his cup on the table and reached for his sandwich with his left hand. He was able to grab only the

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top piece of bread. He picked up the other half of his sandwich and dropped it in his lap. At 12:15 p.m., R37's sandwich remained on his lap. He had not eaten any of his soup. NA-F sat at the table but did not assist R37 with his meal. At 12:17 p.m., NA-F got up and left the table. R37 was able to retrieve his sandwich from his lap and ate it. His soup was left untouched.

On 6/8/16, at 12:27 p.m., NA-E stated sometimes R37 could feed himself and sometimes he needed help. She stated he was able to eat finger foods on his own. NA-E stated whoever was sitting at the table should assist him if they noticed he was not eating.

On 6/8/16, at 12:29 p.m., NA-F stated she saw R37 had his sandwich in his hand during lunch but otherwise did not look at him. She stated she did not offer him assistance because she was asked to see if she could get the other resident at the table to eat. NA-F stated R37's level of assistance depended on the day.

On 6/8/16, at 12:39 p.m., registered nurse (RN)-B stated the level of assistance for R37 varied. She stated it depended on his mood.

On 6/9/16, at 10:45 a.m., the director of nursing (DON) stated he had noticed that morning that R37 would not take hold of food and grab things on his own.

A facility policy titled Good Samaritan Society Activities of Daily Living, dated 9/12, indicated residents who are unable to carry out activities of daily living will receive the necessary services to maintain grooming and personal hygiene. The policy directed staff to provide hair care, shaving,

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F 282	Continued From page 14 application of makeup and skin and nail care as directed by the plan of care.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming for 1 of 4 residents (R122) reviewed for ADL's who was unable to independently groom herself. In addition, the facility failed to provide assistance during meals for 1 of 4 residents (R37) reviewed for activities of daily living, who required assistance with eating. Findings include: R122's Admission minimum data set (MDS) dated 3/9/16, indicated she was severely cognitively impaired and required extensive assistance with dressing and grooming. Her care plan dated 3/9/16, identified a self care deficit related to impaired functioning and directed staff to assist with personal hygiene. On 6/7/16, at 12:52 a.m., R122 was observed to have several hairs on her chin approximately 1/4 to 1/2 inch long. On 6/8/16, at 8:05 a.m., R122 was sitting at the	F 312	R122 was interviewed on 6-29-2016 and was found to be free of facial hair in need of trimming. Nursing staff were educated by the DNS of the need to for all residents to be provided with dignified cares including grooming of women's facial hair. R37 had review of care plan that was found to be accurate in reflection of the needs for assistance with dining. Nursing staff were updated via email and posting of the need to provide necessary care planned assistance. All nursing staff will be re-educated by the DNS on the facility policy on provision of services per care plan including areas of assistance with grooming and dining assistance. Staff will be re-educated by the DNS with the expectation to use existing tools to be made aware of what the care plan indicates. This re-education will be completed by 7-15-2016. An audit (including R37 and R122) of grooming and dining room assistance per care plan will be done by the nurse managers	7/1/16

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F 312	Continued From page 15 breakfast table in the dining room. She had several hairs approximately 1/8th inch in length protruding from the left side of her chin and several 1/4 inch long hairs on the right side of her chin. On 6/8/16, at 8:44 a.m., R122 stroked her chin and stated, "I would like to get rid of them." "It would be very nice." On 6/8/16, at 9:11 a.m., nursing assistant (NA)-A stated on bath day the nursing assistants were responsible for shaving female residents. She stated if a resident was unable to request, they offer to shave. NA-A further stated the facility did not provide razors and residents needed to supply their own. She stated she was aware of only one resident who refused shaving and R 122 was not that resident. On 6/9/16, at 10:13 a.m., registered nurse (RN)-A stated if staff noticed a female resident with facial hair they were supposed to take care of it. RN-A further stated the facility did not provide razors for infection control reasons. On 6/9/16, at 10:44 a.m., the director of nursing (DON) stated if staff noticed facial hair on a female resident they should offer to shave it. He stated the facility did not provide razors but family should be contacted to bring one in. R37's quarterly minimum data set (MDS) dated 4/13/16, indicated he was severely cognitively impaired and required physical assistance to eat. A care area assessment (CAA) dated 11/2/15, identified the need for a mechanically altered diet and nectar thickened liquids as well as functional problems that affected his ability to eat including,	F 312	weekly x4 and then monthly x3 with a planned completion date of 10-31-2016. Audit findings will be brought to the QA committee for review.	

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vision problems, impaired range of motion and the need for physical assistance to perform activities of daily living. R37's care plan dated 4/8/16, identified a self care deficit and directed staff to provide set up and supervision with meals. The care plan further directed staff to provide limited to extensive assist when R37 was observed not eating.

On 6/6/16, at 4:54 p.m., R37 was observed sitting at a table in the dining room. Nursing assistant (NA)-D was standing at the table feeding him. At 4:56 p.m., she walked over to another resident and stood feeding her. NA-D then left the table. Another staff member sat at the table and began to assist another resident. R37 was seated across from the staff member eating his cake with his fingers. At 5:05 p.m., NA-D gave R37 his spoon and walked away. He put the spoon on the table and sat, not eating. At 5:16 p.m., he still had not eaten any more of his food and staff had not returned to assist him. At 5:25 p.m., NA-C sat down next to R37. She asked if he would like more to eat. R37 stated yes. NA-C fed R37 one bite and left the table. R37 had consumed less than 25% of his food and staff did not return to offer him any more assistance or food. The rest of his meal was uneaten.

On 6/8/16, at 12:04 p.m., R37 was brought a cold sandwich and a bowl of soup. Staff placed the food in front of him and walked away. R37 sat at the table holding a cup. At 12:11 p.m., he put his cup on the table and reached for his sandwich with his left hand. He was able to grab only the top piece of bread. He picked up the other half of his sandwich and dropped it in his lap. At 12:15 p.m., R37's sandwich remained on his lap. He had not eaten any of his soup. NA-F sat at the

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table but did not assist R37 with his meal. At 12:17 p.m., NA-F got up and left the table. R37 was able to retrieve his sandwich from his lap and ate it. His soup was left untouched.

On 6/8/16, at 12:27 p.m., NA-E stated sometimes R37 could feed himself and sometimes he needed help. She stated he was able to eat finger foods on his own. NA-E stated whoever was sitting at the table should assist him if they noticed he was not eating.

On 6/8/16, at 12:29 p.m., NA-F stated she saw R37 had his sandwich in his hand during lunch but otherwise did not look at him. She stated she did not offer him assistance because she was asked to see if she could get the other resident at the table to eat. NA-F stated R37's level of assistance depended on the day.

On 6/8/16, at 12:39 p.m., registered nurse (RN)-B stated the level of assistance for R37 varied. She stated it depended on his mood. She stated waiting 15 minutes for assistance "might be too long." RN-B further stated there was staff that could cue him at meals, but they can't feed him while feeding others. RN-B stated she was responsible for assessing R37's ability to eat and assess as needed if an aide stated he was having trouble chewing or swallowing, but staff should be overseeing what he is doing.

On 6/9/16, at 10:45 a.m., the director of nursing (DON) stated he knew R37 well and when staff was behind they would call him to assist in the dining room. He stated he had noticed that morning that R37 would not take hold of food and grab things on his own. The DON stated a resident dining assessment should be completed

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F 312	Continued From page 18 by a nurse on admission, quarterly, annually, and as needed. A facility policy titled Good Samaritan Society Activities of Daily Living, dated 9/12, indicated residents who were unable to carry out activities of daily living would receive the necessary services to maintain grooming and personal hygiene. The policy directed staff to provide hair care, shaving, application of makeup and skin and nail care as well as nourishment and hydration. A facility policy titled Good Samaritan Society Resident Choice Dining dated 2/13, indicated residents would receive assistance from staff members in a dignified manner including sitting while providing assistance rather than standing.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with repositioning to prevent worsening pressure ulcer development for 1 of 2	F 314	Review of R56 care plan was done on and updated to reflect interventions to prevent new or worsening pressure ulcers including plan to attempt to offload seating	7/1/16

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F 314	Continued From page 19 residents (R56) reviewed for pressure ulcers. Findings include: R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he had a stage II pressure ulcer identified on 4/20/16. The MDS further indicated R56 was cognitively intact, incontinent of bladder, and required extensive assistance of two staff for bed mobility, transfers and toileting. His care plan dated 3/23/16, identified a skin impairment and directed staff to turn and reposition R56 every 2-3 hours while in bed and provide an air mattress. The care plan did not address repositioning or off-loading while R56 was up in his wheel chair. During continuous observation on 6/8/16, at 7:27 a.m., R56 was sitting at the table in the dining room in a standard wheel chair. A mechanical lift sling was underneath R56 from his shoulders to mid thighs. In his wheel chair was a blue foam cushion. At 8:26 a.m., a staff member escorted R56 to his room where he sat in his wheel chair reading a magazine. At 9:39 am, R56 continued to sit in his wheel chair until 10:06 a.m. when he left to go to an appointment outside the facility. R56 had not been repositioned for two hours and thirty nine minutes prior to getting in a transport vehicle where he would continue to sit in his wheelchair without repositioning or off-loading and would not return to the facility for approximately 4 more hours. During an observation on 6/9/16, at 7:38 a.m., R56 had an open area to the right of his coccyx. The surrounding tissue was reddened and he had two other areas that appeared to be healing. Licensed practical nurse (LPN)-A described the wound and stated "I would call the wound a stage	F 314	surfaces. This was completed on 6-28-2016. Nursing staff were updated via email on 6-29-2016 of the need for immediate attention to proper documentation of data and measurements of wounds to ensure thorough evaluation of interventions to prevent new or worsening pressure ulcers. All nursing staff will receive re-education by the DNS on the facility policy for management of residents who have pressure ulcers or who are at risk for development of pressure ulcers. This re-education will include need for proper wound data collection including measurements and assessments. These assessments are to be used to assure proper care plans are developed to reflect interventions that are done to prevent new or worsening pressure ulcers. This re-education will be completed by 7-15-2016. Nurse managers will review all residents with a current open area or who have been identified as being at risk for development of pressure ulcers as indicated by a Braden Score of 18 or below. Nurse managers are to review these records for proper care planning with interventions that are done to prevent new or worsening of pressure ulcers. This review will be completed by 7-15-2016. Audits (including R56 and a random selection of residents) of data collection, assessment and care plan process that includes the areas of pressure ulcers will be done by the nurse managers weekly x 4 and then monthly x 3 with a planned completion date of 10-31-2016. Audit results will be reviewed	

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F 314	Continued From page 20 one to two because there are some open areas." A review of a Good Samaritan Society Wound Data Collection tool dated 4/20/16, indicated R56 had a wound on his coccyx described as "small pinpoint areas of pressure." The wound was further described as a small area on coccyx that was open from laying on his bottom. The tool did not include measurements of R56's wound. A Good Samaritan Society Wound Data Collection tool dated 4/25/16, indicated R56 continued to have a wound on his coccyx. The tool did not include measurements, nor was there any description of the wound. A Good Samaritan Society Wound Data Collection tool dated 4/28/16, identified the coccyx wound but did not include measurements or description of the wound. A Good Samaritan Society Wound Data Collection tool dated 5/16/16, identified a wound on R56's coccyx. No measurement or description of the wound was provided. A Good Samaritan Society Wound Data Collection tool dated 5/22/16, indicated a wound on the coccyx. No measurement or description of the wound was provided. A Good Samaritan Society Wound Data Collection tool dated 5/25/16, indicated R56 continued to have a wound on his coccyx. No description or measurement of the wound was provided. A data collection tool dated 5/31/16, identified the coccyx wound measuring 1 centimeter (cm) x 0.5 cm and indicated the wound bed was 100% epithelialized tissue (Regeneration of epidermis across a wound surface). A Good Samaritan Society Wound RN Assessment dated 6/1/16, identified R56's coccyx wound as a pressure ulcer, indicated the wound was 100% epithelialized tissue and had decreased in size. No measurement was provided. On 6/3/16, a Wound data Collection tool identified the wound on the coccyx. No	F 314	by the QA committee.	

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measurement or description was included. On 6/6/16, a Wound data Collection tool identified a coccyx wound measuring 1 cm x 0.9 cm, an increase in size from the previous measurement. No further description of the wound was included.

On 6/8/16, at 10:09 a.m., nursing assistant (NA)-B stated R56 required a mechanical lift for transfers. She stated he should be repositioned every two hours when he is in his chair. NA-B stated R56 "did not get repositioned today" and stated he left to go to dialysis.

On 6/8/16, at 11:42 a.m., NA-A stated R56 got up around 7:00 a.m. on the days he went to dialysis. She stated he would usually ask if he wanted to be repositioned, "so we do not ask him."

On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had a wound on his coccyx that developed on 4/26/16. RN-A stated "that would be pressure I would think." RN-A stated she was responsible for wound rounds on the unit but had not seen the wound on R56's coccyx lately. She stated the floor nurse completed a data collection tool and the registered nurse was responsible to do a weekly assessment. RN-A further stated based on R56's skin issues he should be turned and repositioned every two to three hours and he should have been repositioned between breakfast and going out for his dialysis. She further stated the mechanical lift sling should be removed form underneath him in the chair.
During a subsequent interview on 6/9/16, at 10:24 a.m., registered nurse (RN)-A stated she had never seen the wound on R56's coccyx. She stated the wound assessment had been completed on the previous evening and was described as a stage II pressure ulcer measuring

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F 314	Continued From page 22 1 cm x 0.9 cm. RN-A stated there was no designated person managing wounds for the facility. On 6/9/16, at 10:38 a.m., the director of nursing stated the nurse manager was responsible for wounds on the unit. He stated he would expect to see interventions in the care plan related to pressure, weekly measurements and a weekly assessment completed by a registered nurse. A policy titled Good Samaritan Society, Pressure Ulcers, dated 9/12, was reviewed along with a policy titled Good Samaritan Society Procedure, Pressure Ulcer Prevention and Documentation Requirements, dated 9/12. The policies directed staff to systematically assess residents with regard to skin breakdown and use prevention techniques and pressure redistributing surfaces for residents at risk for pressure ulcers. The policy further indicated a resident who had a pressure ulcer would receive the necessary treatment and services to promote healing and prevent new ulcers from developing. If a pressure ulcer is identified, the policies directed staff to assess the area at least weekly on the Wound RN Assessment.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract	F 315		7/1/16

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F 315	Continued From page 23 infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess a decline in urinary incontinence and implement interventions to promote restoration of bladder function for 1 of 3 residents (R56) reviewed for urinary continence. Findings include: R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he was cognitively intact, required extensive assistance of two staff for transfers and toileting, and was occasionally incontinent of bladder. The MDS indicated a trial toileting plan had not been attempted for R56. A previous MDS dated 4/7/16, indicated R56 was always continent of bladder. A bladder assessment dated 9/29/15, indicated R56 was incontinent of bladder due to functional impairment and indicated a check and change program to manage incontinence. Recommendations based on the assessment included, "none at this time, continue current toileting program." R56's care plan dated 9/24/15, indicated he required assistance from two staff and a mechanical lift for transfers. The care plan was updated on 6/8/16, following inquiry by surveyor, to include toileting with assist of two staff. The care plan did not address a toileting plan for R56 even though he had a decline from being continent to occasional incontinence.	F 315	Review was done on 6-28-2016 of R56 care plan and data collected regarding bladder continence over the past 9 months. A new 72 hour bladder data collection tool was initiated on 6-28-2016. This data will be used to complete fresh assessment of R56 actual level of bladder control. This assessment will be used to make a plan of care that accurately reflects his level of continence and any possible intervention for restoration of bladder function. This care plan will be updated by July 8th. Nurse managers will review all long term care resident records who are listed as being currently incontinent to look for changes noted in MDS of bladder continence. We will review the records to ensure that proper data collection, assessment and care plan updates were done to reflect the current needs of the residents. This review will be completed by 7-15-2016. All nursing staff will receive re- education on facility policy regarding restoration of bladder function. This will be completed by 7-15-2016. Audits (including R56 and a selection of random residents) of data collection, assessment and care plan process that includes the areas of bladder continence/retraining will be done by the nurse managers weekly x 4 and then monthly x 3 with a planned completion date of 10-31-2016. Audit results will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

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F 315	Continued From page 24 On 6/8/16, at 7:27 a.m., R56 was at the breakfast table in a standard wheel chair. At 8:26 a.m., R56 was escorted to his room by staff where he remained until 10:06 a.m. when he left the facility for an appointment. On 6/8/16, at 10:09 a.m., nursing assistant (NA)-B stated R56 was on dialysis and did not void. She stated he would request the commode if he needed to have a bowel movement. On 6/8/16, at 11:42 a.m., NA-A stated R56 was continent of bladder and did not void due to dialysis. On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had end stage renal disease and received dialysis but did void. Additionally, RN-A stated she was not aware he had a change in his level of urinary continence. RN-A stated he should have been re-assessed following that change. RN-A stated R56 was not on a toileting plan and his care plan indicated he was continent of bladder but stated, "that is incorrect." She stated he should be toileted upon rising, after meals, naps and before bed as that was the facility's standard practice. On 6/8/16, at 1:52 p.m., the director of nursing (DON) stated he would expect incontinent residents to be toileted upon rising, before and after meals, at bed time and as needed. While R56 had a change in continence, there was no evidence the facility re-assessed the decline to determine a pattern, nor were interventions developed to assist with restoring as much bladder function as possible for R56.	F 315	reviewed by the QA committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 25 A policy titled Good Samaritan Society Bowel and Bladder Assessment Evaluation and Retraining, dated 9/12 indicated each resident with bowel or bladder incontinence would receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. The policy further indicated when a decline in functioning occurred, the resident would be re-evaluated.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**06/07/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	**333 FIFTH STREET WEST WACONIA, MN 55387**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on June 7, 2016. At the time of this survey, Good Samaritan Society Waconia was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. Good Samaritan Society Waconia was constructed as follows: The original building was constructed in 1979, is three-stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction; The 2015 addition is three stories in height, has no basement, is fully fire sprinkler protected and was determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 96 beds and had a census of 80 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING **03 - 2ND 3RD FLOOR WING** B. WING _____	**06/07/2016**

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GOOD SAMARITAN SOCIETY - WACONIA AND	**333 FIFTH STREET WEST WACONIA, MN 55387**

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K 000	INITIAL COMMENTS Good Samaritan Society Waconia Care Center Building 2 is a 3-story building addition with a partial basement and a tunnel leading to the medical facility built in 2015 and was determined to be of Type II (111) construction. The building is fully sprinkled protected throughout. The facility has a fire alarm system with smoke detection in resident rooms, corridors and spaces open to the corridors that is monitored for automatic fire department notification. This portion of the building was not occupied at the time of the survey. In April 2016, Floors 2 and 3 have been remodeled 14 beds on each floor, and the center core areas on these floors, including the nurse station and related service areas, commons/dining areas, an Oxygen Room, and a neighborhood kitchen with a Denlar hood on each floor.	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.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
June 24, 2016

Ms. Rebecca Bollig, Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5234027

Dear Ms. Bollig:

The above facility was surveyed on June 6, 2016 through June 9, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. 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 that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 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 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 deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted 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 after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Kamala.Fiske-Downing@state.mn.us
Telephone: (651) 201-4112 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	06/09/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 6 through June 9, 2016 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Board and Care Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop care planned interventions to restore bladder function for 1 of 3 residents (R56) reviewed for urinary incontinence. In addition, the facility failed to develop interventions to prevent new or worsening pressure ulcers for 1 of 2 residents (R56) reviewed for pressure ulcers. Findings include: R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he was cognitively intact, required extensive assistance of two staff for transfers and toileting, and was occasionally incontinent of bladder. The MDS indicated a trial toileting plan had not been attempted for R56. A previous MDS dated 4/7/16, indicated R56 was	2 560	Acknowledged	7/1/16

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2 560	Continued From page 3 always continent of bladder. A bladder assessment dated 9/29/15, indicated R56 was incontinent of bladder due to functional impairment and indicated a check and change program to manage incontinence. Recommendations based on the assessment included, "none at this time, continue current toileting program." R56's care plan dated 9/24/15, indicated he required assistance from two staff and a mechanical lift for transfers. The care plan was updated on 6/8/16, following inquiry by surveyor, to include toileting with assist of two staff. The care plan did not address a toileting plan for R56 even though he had a decline from being continent to occasional incontinence. On 6/8/16, at 7:27 a.m., R56 was at the breakfast table in a standard wheel chair. At 8:26 a.m., R56 was escorted to his room by staff where he remained until 10:06 a.m. when he left the facility for an appointment. On 6/8/16, at 10:09 a.m., nursing assistant (NA)-B stated R56 was on dialysis and did not void. She stated he would request the commode if he needed to have a bowel movement. On 6/8/16, at 11:42 a.m., NA-A stated R56 was continent of bladder and did not void due to dialysis. On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had end stage renal disease and received dialysis but did void. Additionally, RN-A stated she was not aware he had a change in his level of urinary continence. RN-A stated he should have been re-assessed following that change. RN-A stated R56 was not on a toileting	2 560		

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2 560	Continued From page 4 plan and his care plan indicated he was continent of bladder but stated, "that is incorrect." She stated he should be toileted upon rising, after meals, naps and before bed as that was the facility's standard practice. R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he had a stage II pressure ulcer identified on 4/20/16. The MDS further indicated R56 was cognitively intact, incontinent of bladder, and required extensive assistance of two staff for bed mobility, transfers and toileting. His care plan dated 3/23/16, identified a skin impairment and directed staff to turn and reposition R56 every 2-3 hours while in bed and provide an air mattress. The care plan did not address repositioning or off-loading while R56 was up in his wheel chair. During continuous observation on 6/8/16, at 7:27 a.m., R56 was sitting at the table in the dining room in a standard wheel chair. A mechanical lift sling was underneath R56 from his shoulders to mid thighs. In his wheel chair was a blue foam cushion. At 8:26 a.m., a staff member escorted R56 to his room where he sat in his wheel chair reading a magazine. At 9:39 am, R56 continued to sit in his wheel chair until 10:06 a.m. when he left to go to an appointment outside the facility. R56 had not been repositioned for two hours and thirty nine minutes prior to getting in a transport vehicle where he would continue to sit in his wheelchair without repositioning or off-loading and would not return to the facility for approximately 4 more hours. During an observation on 6/9/16, at 7:38 a.m., R56 had an open area to the right of his coccyx. Licensed practical nurse (LPN)-A described the wound and stated "I would call the wound a stage one to two because there are some open areas."	2 560		

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2 560	Continued From page 5 On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had a wound on his coccyx that developed on 4/26/16. RN-A stated "that would be pressure I would think." RN-A further stated based on R56's skin issues he should be turned and repositioned every two to three hours and he should have been repositioned between breakfast and going out for his dialysis. She further stated the mechanical lift sling should be removed form underneath him in the chair. On 6/9/16, at 10:38 a.m., the director of nursing stated the nurse manager was responsible for wounds on the unit. He stated he would expect to see interventions in the care plan related to pressure. A facility policy titled Good Samaritan Society Care Plan, dated 9/12, indicated each resident would have an individualized comprehensive plan of care directed toward maintaining the residents optimal needs. The policy directed staff to evaluate and update the care plan at least quarterly and with a change in the residents condition to reflect the care currently required for the resident. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his designee could develop policies and procedures to ensure plans of care are appropriately updated in a timely manner. The DON could educate all appropriate staff on this process. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 565	Continued From page 6	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care planned interventions for 1 of 3 residents (R122) who was dependent on staff for grooming. In addition the facility failed to provide care planned interventions for 1 of residents (R37) who was dependent on staff for eating. Findings include: R122's Admission minimum data set (MDS) dated 3/9/16, indicated she was severely cognitively impaired and required extensive assistance with dressing and grooming. R122's care plan dated 3/9/16, identified a self care deficit related to impaired functioning and directed staff to assist with personal hygiene. On 6/7/16, at 12:52 a.m., R122 was observed to have several hairs on her chin approximately 1/4 to 1/2 inch long. On 6/8/16, at 8:05 a.m., R122 was sitting at the breakfast table in the dining room. She had several hairs approximately 1/8th inch in length protruding from the left side of her chin and several 1/4 inch long hairs on the right side of her	2 565	Acknowledged	7/1/16

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2 565	Continued From page 7 chin. On 6/8/16, at 9:11 a.m., nursing assistant (NA)-A stated on bath day the nursing assistants were responsible for shaving female residents. On 6/9/16, at 10:13 a.m., registered nurse (RN)-A stated if staff noticed a female resident with facial hair they were supposed to take care of it. On 6/9/16, at 10:44 a.m., the director of nursing (DON) stated if staff noticed facial hair on a female resident they should offer to shave it. R37's quarterly minimum data set (MDS) dated 4/13/16, indicated he was severely cognitively impaired and required physical assistance to eat. A care area assessment (CAA) dated 11/2/15, identified the need for a mechanically altered diet and nectar thickened liquids as well as functional problems that affected his ability to eat including, vision problems, impaired range of motion and the need for physical assistance to perform activities of daily living. R37's care plan dated 4/8/16, identified a self care deficit and directed staff to provide set up and supervision with meals. The care plan further directed staff to provide limited to extensive assist when R37 was observed not eating. On 6/6/16, at 4:54 p.m., R37 was observed sitting at a table in the dining room. Nursing assistant (NA)-D was standing at the table feeding him. At 4:56 p.m., she walked over to another resident and stood feeding her. NA-D then left the table. Another staff member sat at the table and began to assist another resident. R37 was seated across from the staff member eating his cake with his fingers. At 5:05 p.m., NA-D gave R37 his	2 565		

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2 565	Continued From page 8	2 565		

spoon and walked away. He put the spoon on the table and sat, not eating. At 5:16 p.m., he still had not eaten any more of his food and staff had not returned to assist him. At 5:25 p.m., NA-C sat down next to R37. She asked if he would like more to eat. R37 stated yes. NA-C fed R37 one bite and left the table. R37 had consumed less than 25% of his food and staff did not return to offer him any more assistance or food. The rest of his meal was uneaten.

On 6/8/16, at 12:04 p.m., R37 was brought a cold sandwich and a bowl of soup. Staff placed the food in front of him and walked away. R37 sat at the table holding a cup. At 12:11 p.m., he put his cup on the table and reached for his sandwich with his left hand. He was able to grab only the top piece of bread. He picked up the other half of his sandwich and dropped it in his lap. At 12:15 p.m., R37's sandwich remained on his lap. He had not eaten any of his soup. NA-F sat at the table but did not assist R37 with his meal. At 12:17 p.m., NA-F got up and left the table. R37 was able to retrieve his sandwich from his lap and ate it. His soup was left untouched.

On 6/8/16, at 12:27 p.m., NA-E stated sometimes R37 could feed himself and sometimes he needed help. She stated he was able to eat finger foods on his own. NA-E stated whoever was sitting at the table should assist him if they noticed he was not eating.

On 6/8/16, at 12:29 p.m., NA-F stated she saw R37 had his sandwich in his hand during lunch but otherwise did not look at him. She stated she did not offer him assistance because she was asked to see if she could get the other resident at the table to eat. NA-F stated R37's level of assistance depended on the day.

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2 565	Continued From page 9 On 6/8/16, at 12:39 p.m., registered nurse (RN)-B stated the level of assistance for R37 varied. She stated it depended on his mood. On 6/9/16, at 10:45 a.m., the director of nursing (DON) stated he had noticed that morning that R37 would not take hold of food and grab things on his own. A facility policy titled Good Samaritan Society Activities of Daily Living, dated 9/12, indicated residents who are unable to carry out activities of daily living will receive the necessary services to maintain grooming and personal hygiene. The policy directed staff to provide hair care, shaving, application of makeup and skin and nail care as directed by the plan of care. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his designee could develop systems to ensure care plans are followed. The DON could educate all appropriate staff on how to follow the plan of care. The DON or his designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that:	2 900		7/1/16

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2 900	Continued From page 10 A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide timely assistance with repositioning to prevent worsening pressure ulcer development for 1 of 2 residents (R56) reviewed for pressure ulcers. Findings include: R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he had a stage II pressure ulcer identified on 4/20/16. The MDS further indicated R56 was cognitively intact, incontinent of bladder, and required extensive assistance of two staff for bed mobility, transfers and toileting. His care plan dated 3/23/16, identified a skin impairment and directed staff to turn and reposition R56 every 2-3 hours while in bed and provide an air mattress. The care plan did not address repositioning or off-loading while R56 was up in his wheel chair. During continuous observation on 6/8/16, at 7:27 a.m., R56 was sitting at the table in the dining room in a standard wheel chair. A mechanical lift sling was underneath R56 from his shoulders to mid thighs. In his wheel chair was a blue foam cushion. At 8:26 a.m., a staff member escorted	2 900	Acknowledged	

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2 900	Continued From page 11 R56 to his room where he sat in his wheel chair reading a magazine. At 9:39 am, R56 continued to sit in his wheel chair until 10:06 a.m. when he left to go to an appointment outside the facility. R56 had not been repositioned for two hours and thirty nine minutes prior to getting in a transport vehicle where he would continue to sit in his wheelchair without repositioning or off-loading and would not return to the facility for approximately 4 more hours. During an observation on 6/9/16, at 7:38 a.m., R56 had an open area to the right of his coccyx. The surrounding tissue was reddened and he had two other areas that appeared to be healing. Licensed practical nurse (LPN)-A described the wound and stated "I would call the wound a stage one to two because there are some open areas." A review of a Good Samaritan Society Wound Data Collection tool dated 4/20/16, indicated R56 had a wound on his coccyx described as "small pinpoint areas of pressure." The wound was further described as a small area on coccyx that was open from laying on his bottom. The tool did not include measurements of R56's wound. A Good Samaritan Society Wound Data Collection tool dated 4/25/16, indicated R56 continued to have a wound on his coccyx. The tool did not include measurements, nor was there any description of the wound. A Good Samaritan Society Wound Data Collection tool dated 4/28/16, identified the coccyx wound but did not include measurements or description of the wound. A Good Samaritan Society Wound Data Collection tool dated 5/16/16, identified a wound on R56's coccyx. No measurement or description of the wound was provided. A Good Samaritan Society Wound Data Collection tool dated 5/22/16, indicated a wound on the coccyx. No measurement or description of the wound was	2 900		

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2 900	Continued From page 12	2 900		

provided. A Good Samaritan Society Wound Data Collection tool dated 5/25/16, indicated R56 continued to have a wound on his coccyx. No description or measurement of the wound was provided. A data collection tool dated 5/31/16, identified the coccyx wound measuring 1 centimeter (cm) x 0.5 cm and indicated the wound bed was 100% epithelialized tissue (Regeneration of epidermis across a wound surface). A Good Samaritan Society Wound RN Assessment dated 6/1/16, identified R56's coccyx wound as a pressure ulcer, indicated the wound was 100% epithelialized tissue and had decreased in size. No measurement was provided. On 6/3/16, a Wound data Collection tool identified the wound on the coccyx. No measurement or description was included. On 6/6/16, a Wound data Collection tool identified a coccyx wound measuring 1 cm x 0.9 cm, an increase in size from the previous measurement. No further description of the wound was included.

On 6/8/16, at 10:09 a.m., nursing assistant (NA)-B stated R56 required a mechanical lift for transfers. She stated he should be repositioned every two hours when he is in his chair. NA-B stated R56 "did not get repositioned today" and stated he left to go to dialysis.

On 6/8/16, at 11:42 a.m., NA-A stated R56 got up around 7:00 a.m. on the days he went to dialysis. She stated he would usually ask if he wanted to be repositioned, "so we do not ask him."

On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had a wound on his coccyx that developed on 4/26/16. RN-A stated "that would be pressure I would think." RN-A stated she was responsible for wound rounds on the unit but had not seen the wound on R56's coccyx lately. She

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2 900	Continued From page 13 stated the floor nurse completed a data collection tool and the registered nurse was responsible to do a weekly assessment. RN-A further stated based on R56's skin issues he should be turned and repositioned every two to three hours and he should have been repositioned between breakfast and going out for his dialysis. She further stated the mechanical lift sling should be removed form underneath him in the chair. During a subsequent interview on 6/9/16, at 10:24 a.m., registered nurse (RN)-A stated she had never seen the wound on R56's coccyx. She stated the wound assessment had been completed on the previous evening and was described as a stage II pressure ulcer measuring 1 cm x 0.9 cm. RN-A stated there was no designated person managing wounds for the facility. On 6/9/16, at 10:38 a.m., the director of nursing stated the nurse manager was responsible for wounds on the unit. He stated he would expect to see interventions in the care plan related to pressure, weekly measurements and a weekly assessment completed by a registered nurse. A policy titled Good Samaritan Society, Pressure Ulcers, dated 9/12, was reviewed along with a policy titled Good Samaritan Society Procedure, Pressure Ulcer Prevention and Documentation Requirements, dated 9/12. The policies directed staff to systematically assess residents with regard to skin breakdown and use prevention techniques and pressure redistributing surfaces for residents at risk for pressure ulcers. The policy further indicated a resident who had a pressure ulcer would receive the necessary treatment and services to promote healing and prevent new ulcers from developing. If a pressure ulcer is identified, the policies directed	2 900		

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2 900	Continued From page 14 staff to assess the area at least weekly on the Wound RN Assessment. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his designee could develop systems to ensure pressure ulcers are appropriately treated and prevented to the extent possible. The DON could educate all appropriate staff on pressure ulcer treatment and prevention. The DON could develop monitoring systems to ensure ongoing compliance with pressure ulcer treatment and prevention. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by:	2 910		7/1/16

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2 910	Continued From page 15 Based on observation, interview and document review, the facility failed to comprehensively assess a decline in urinary incontinence and implement interventions to promote restoration of bladder function for 1 of 3 residents (R56) reviewed for urinary continence. Findings include: R56's 14 day minimum data set (MDS) dated 5/4/16, indicated he was cognitively intact, required extensive assistance of two staff for transfers and toileting, and was occasionally incontinent of bladder. The MDS indicated a trial toileting plan had not been attempted for R56. A previous MDS dated 4/7/16, indicated R56 was always continent of bladder. A bladder assessment dated 9/29/15, indicated R56 was incontinent of bladder due to functional impairment and indicated a check and change program to manage incontinence. Recommendations based on the assessment included, "none at this time, continue current toileting program." R56's care plan dated 9/24/15, indicated he required assistance from two staff and a mechanical lift for transfers. The care plan was updated on 6/8/16, following inquiry by surveyor, to include toileting with assist of two staff. The care plan did not address a toileting plan for R56 even though he had a decline from being continent to occasional incontinence. On 6/8/16, at 7:27 a.m., R56 was at the breakfast table in a standard wheel chair. At 8:26 a.m., R56 was escorted to his room by staff where he remained until 10:06 a.m. when he left the facility for an appointment.	2 910	Acknowledged	

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2 910	Continued From page 16 On 6/8/16, at 10:09 a.m., nursing assistant (NA)-B stated R56 was on dialysis and did not void. She stated he would request the commode if he needed to have a bowel movement. On 6/8/16, at 11:42 a.m., NA-A stated R56 was continent of bladder and did not void due to dialysis. On 6/8/16, at 12:45 p.m., registered nurse (RN)-A stated R56 had end stage renal disease and received dialysis but did void. Additionally, RN-A stated she was not aware he had a change in his level of urinary continence. RN-A stated he should have been re-assessed following that change. RN-A stated R56 was not on a toileting plan and his care plan indicated he was continent of bladder but stated, "that is incorrect." She stated he should be toileted upon rising, after meals, naps and before bed as that was the facility's standard practice. On 6/8/16, at 1:52 p.m., the director of nursing (DON) stated he would expect incontinent residents to be toileted upon rising, before and after meals, at bed time and as needed. While R56 had a change in continence, there was no evidence the facility re-assessed the decline to determine a pattern, nor were interventions developed to assist with restoring as much bladder function as possible for R56. A policy titled Good Samaritan Society Bowel and Bladder Assessment Evaluation and Retraining, dated 9/12 indicated each resident with bowel or bladder incontinence would receive appropriate treatment and services to restore as much normal bowel and bladder functioning as possible. The policy further indicated when a	2 910		

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2 910	Continued From page 17 decline in functioning occurred, the resident would be re-evaluated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or his designee could develop systems to ensure incontinence is individually addressed for each resident. The DON could educate all appropriate staff on the importance of individualized interventions for incontinence. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming for 1 of 4 residents (R122) reviewed for ADL's who was unable to independently groom herself. In addition, the facility failed to provide assistance during meals for 1 of 4 residents (R37) reviewed for activities of daily living, who required assistance with eating. Findings include:	2 920	Acknowledged	7/1/16

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2 920	Continued From page 18 R122's Admission minimum data set (MDS) dated 3/9/16, indicated she was severely cognitively impaired and required extensive assistance with dressing and grooming. Her care plan dated 3/9/16, identified a self care deficit related to impaired functioning and directed staff to assist with personal hygiene. On 6/7/16, at 12:52 a.m., R122 was observed to have several hairs on her chin approximately 1/4 to 1/2 inch long. On 6/8/16, at 8:05 a.m., R122 was sitting at the breakfast table in the dining room. She had several hairs approximately 1/8th inch in length protruding from the left side of her chin and several 1/4 inch long hairs on the right side of her chin. On 6/8/16, at 8:44 a.m., R122 stroked her chin and stated, "I would like to get rid of them." "It would be very nice." On 6/8/16, at 9:11 a.m., nursing assistant (NA)-A stated on bath day the nursing assistants were responsible for shaving female residents. She stated if a resident was unable to request, they offer to shave. NA-A further stated the facility did not provide razors and residents needed to supply their own. She stated she was aware of only one resident who refused shaving and R 122 was not that resident. On 6/9/16, at 10:13 a.m., registered nurse (RN)-A stated if staff noticed a female resident with facial hair they were supposed to take care of it. RN-A further stated the facility did not provide razors for infection control reasons. On 6/9/16, at 10:44 a.m., the director of nursing	2 920		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 920	Continued From page 19 (DON) stated if staff noticed facial hair on a female resident they should offer to shave it. He stated the facility did not provide razors but family should be contacted to bring one in. R37's quarterly minimum data set (MDS) dated 4/13/16, indicated he was severely cognitively impaired and required physical assistance to eat. A care area assessment (CAA) dated 11/2/15, identified the need for a mechanically altered diet and nectar thickened liquids as well as functional problems that affected his ability to eat including, vision problems, impaired range of motion and the need for physical assistance to perform activities of daily living. R37's care plan dated 4/8/16, identified a self care deficit and directed staff to provide set up and supervision with meals. The care plan further directed staff to provide limited to extensive assist when R37 was observed not eating. On 6/6/16, at 4:54 p.m., R37 was observed sitting at a table in the dining room. Nursing assistant (NA)-D was standing at the table feeding him. At 4:56 p.m., she walked over to another resident and stood feeding her. NA-D then left the table. Another staff member sat at the table and began to assist another resident. R37 was seated across from the staff member eating his cake with his fingers. At 5:05 p.m., NA-D gave R37 his spoon and walked away. He put the spoon on the table and sat, not eating. At 5:16 p.m., he still had not eaten any more of his food and staff had not returned to assist him. At 5:25 p.m., NA-C sat down next to R37. She asked if he would like more to eat. R37 stated yes. NA-C fed R37 one bite and left the table. R37 had consumed less than 25% of his food and staff did not return to offer him any more assistance or food. The rest of his meal was uneaten.	2 920		

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	00924	A. BUILDING: _____ B. WING _____	06/09/2016

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2 920	Continued From page 20 On 6/8/16, at 12:04 p.m., R37 was brought a cold sandwich and a bowl of soup. Staff placed the food in front of him and walked away. R37 sat at the table holding a cup. At 12:11 p.m., he put his cup on the table and reached for his sandwich with his left hand. He was able to grab only the top piece of bread. He picked up the other half of his sandwich and dropped it in his lap. At 12:15 p.m., R37's sandwich remained on his lap. He had not eaten any of his soup. NA-F sat at the table but did not assist R37 with his meal. At 12:17 p.m., NA-F got up and left the table. R37 was able to retrieve his sandwich from his lap and ate it. His soup was left untouched. On 6/8/16, at 12:27 p.m., NA-E stated sometimes R37 could feed himself and sometimes he needed help. She stated he was able to eat finger foods on his own. NA-E stated whoever was sitting at the table should assist him if they noticed he was not eating. On 6/8/16, at 12:29 p.m., NA-F stated she saw R37 had his sandwich in his hand during lunch but otherwise did not look at him. She stated she did not offer him assistance because she was asked to see if she could get the other resident at the table to eat. NA-F stated R37's level of assistance depended on the day. On 6/8/16, at 12:39 p.m., registered nurse (RN)-B stated the level of assistance for R37 varied. She stated it depended on his mood. She stated waiting 15 minutes for assistance "might be too long." RN-B further stated there was staff that could cue him at meals, but they can't feed him while feeding others. RN-B stated she was responsible for assessing R37's ability to eat and assess as needed if an aide stated he was having	2 920		

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2 920	Continued From page 21 trouble chewing or swallowing, but staff should be overseeing what he is doing. On 6/9/16, at 10:45 a.m., the director of nursing (DON) stated he knew R37 well and when staff was behind they would call him to assist in the dining room. He stated he had noticed that morning that R37 would not take hold of food and grab things on his own. The DON stated a resident dining assessment should be completed by a nurse on admission, quarterly, annually, and as needed. A facility policy titled Good Samaritan Society Activities of Daily Living, dated 9/12, indicated residents who were unable to carry out activities of daily living would receive the necessary services to maintain grooming and personal hygiene. The policy directed staff to provide hair care, shaving, application of makeup and skin and nail care as well as nourishment and hydration. A facility policy titled Good Samaritan Society Resident Choice Dining dated 2/13, indicated residents would receive assistance from staff members in a dignified manner including sitting while providing assistance rather than standing. SUGGESTED METHOD OF CORRECTION: The director of nursing or his designee could develop systems to ensure residents receive the appropriate level of assistance with ADL's. The DON could educate all appropriate staff on these systems. The DON could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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21805	Continued From page 22	21805		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide a dignified dining experience for 1 of 4 residents (R96) reviewed for activities of daily living and failed to provide grooming to enhance the dignity of 1 of 1 residents (R122) reviewed for dignity. In addition, the facility failed to provide rising and morning routines in a dignified manner for 3 of 3 (R21, R92, R97) residents who were cognitively impaired and required extensive assistance to complete activities of daily living (ADLs). Findings include: R96's quarterly minimum data set (MDS) dated 3/9/16 indicated she was severely cognitively impaired, required physical assistance for personal hygiene and required physical assistance to eat. A care area assessment (CAA) dated 1/7/16, indicated a need for physical assistance, a mechanically altered diet, and occasional extensive assistance needed for dining. R96's care plan dated 5/16/13, indicated a self care deficit and directed staff to cue resident to eat, offer her a spoon when observed eating with fingers, and provide a napkin clip.	21805	Acknowledged	7/1/16

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21805	Continued From page 23 On 6/6/16, at 5:00 p.m., R96 was seated at a table in the dining room unassisted by staff. Her wheel chair was reclined back approximately 30 degrees. She was eating ground barbeque ribs and cubed carrots with her fingers. No staff was present at the table. R96 continued to eat with her fingers and had ribs and carrots on her chest. She was not wearing a clothing protector. At 5:06 p.m., R96 continued to eat her food independently with her fingers, dropping more food onto her chest. At 5:08 p.m., she picked up her cake with her hands and began eating it. At 5:22 p.m., nursing assistant (NA)-C stood next to R96 at the table and offered R96 a spoon, R96 had already consumed 60% of her meal. NA-C walked away and did not return or offer assistance. R96 continued to eat with her fingers. She had a large amount of barbeque ribs, carrots and cake down the front of her chest and her dress. During an interview on 6/9/16, at 8:57 a.m., registered nurse (RN)-A stated R96's level of assistance varied during meals. She stated sometimes R96 would eat with a spoon and other times she would eat with her fingers. RN-A stated "for dignity" staff should intervene if R96 is eating with her fingers. RN-A stated staff attempted to give her things that are easier to eat and stated things like mixed vegetables end up on the floor. During an interview on 6/9/16, at 10:52 a.m., The director of nursing (DON) stated R96 required set up with meals and when staff assisted her, she would often take over with her hands. He stated he would expect staff to re-organize and clean R96 up as she was eating. R122's Admission minimum data set (MDS)	21805		

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21805	Continued From page 24 dated 3/9/16, indicated she was severely cognitively impaired and required extensive assistance with dressing and grooming. Her care plan dated 3/9/16, indicated a self care deficit related to impaired functioning and directed staff to assist with personal hygiene. On 6/7/16, at 12:52 p.m., R122 was observed to have several hairs on her chin approximately 1/4 to 1/2 inch long. On 6/8/16, at 8:05 a.m., R122 was sitting at the breakfast table in the dining room. She had several hairs approximately 1/8th inch in length protruding from the left side of her chin and several 1/4 inch long hairs on the right side of her chin. On 6/8/16, at 8:44 a.m., R122 stroked her chin and stated, "I have been saving my chin whiskers, that's not for a lady." She further stated, "I would like to get rid of them." "It would be very nice." On 6/8/16, at 9:11 a.m., nursing assistant (NA)-A stated on bath day the nursing assistants were responsible for checking skin, toenails and shaving female residents. She stated if a resident was unable to request, they offer to shave. She stated she was aware of only one resident who refused shaving and R122 was not that resident. On 6/9/16, at 10:13 a.m., registered nurse (RN)-A stated if staff noticed a female resident with facial hair they were supposed to take care of it. On 6/9/16, at 10:44 a.m., the director of nursing (DON) stated if staff noticed facial hair on a female resident they should offer to shave it.	21805		

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21805	Continued From page 25 A facility policy and procedure titled Good Samaritan Society Resident Dignity dated 2/13, indicated the facility would care for residents in a manner that maintained each resident's dignity including grooming residents as they wished to be groomed. The policy directed staff to promote residents dignity in dining and refrain from practices demeaning to residents. A facility policy titled Good Samaritan Society Resident Choice Dining dated 2/13, indicated residents would receive assistance from staff members in a dignified manner including sitting while giving assistance rather than standing. R21's medical record was reviewed and revealed R21 had a diagnosis of Alzheimer's disease. A minimum data set (MDS) annual assessment dated 3/16/16, identified R21 was cognitively impaired. The MDS further identified R21 was totally dependent upon staff for transfers and required extensive assistance of two staff for toileting and bed mobility. R21's 1/17/13, careplan identified R21 required assistance of 2 staff and a mechanical lift for all transfers. R92 had a diagnosis of dementia. An MDS assessment dated 4/6/16, indicated R92 was "rarely/never understood". Further, R92 required assistance of two staff and a mechanical lift for transfers, toileting and bed mobility. R97 had a diagnosis of dementia. A quarterly MDS assessment dated 2/24/16, identified R97 was severely cognitively impaired. The MDS further identified R97 required extensive assistance from staff for transfers, toileting and bed mobility. R97's careplan dated 5/30/14, identified R97 required assistance of two staff and a mechanical lift for transfers, toileting and	21805		

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21805	Continued From page 26 bed mobility. On 6/8/16 at 7:09 a.m. R21 was observed to be sleeping in bed. R21 was dressed in a pink top and pink jacket and a mechanical lift sling was observed underneath R21. At 7:22 a.m.. R21 was calling out from her bed. Two nursing assistants entered the room to assist R21 out of bed. No morning cares were provided to R21. The two nursing assistants (NA-G, NA-H) hooked up the mechanical lift sling to the mechanical lift and positioned R21 in to her wheelchair. NA-G then began to comb R21's hair and provided R21 her glasses. NA-G was interviewed on 6/8/16, at 7:32 a.m. and indicated she dressed R21 around 6:00 a.m. and put R21 back into bed as it was too early for her to get up. NA-G indicated she worked the night shift and the night shift had a list of residents they needed to get up. NA-G indicated the night shift "gets up" 5 residents and that 2 of the 5 residents must be "lift" residents (those that require full assistance with a mechanical lift) because the unit had "so many lifts". NA-G indicated she got the "lift" residents "dressed and ready to go" and then put them back in bed until later in the morning. NA-G further indicated the other "lift" resident she assisted this morning was R97. NA-G indicated it did not matter which residents she assisted in the morning but two of them must be "lift" residents. On 6/8/16, at 7:41 a.m. R92's room light was on and R92 was observed to be sleeping in bed dressed in a flowered shirt. R92 had a blanket covering her and a mechanical lift sling was observed to be placed underneath her in bed. At 8:24 a.m. R92 was observed at the morning meal with the same flowered shirt and a gray sweater.	21805		

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21805	Continued From page 27 On 6/9/2016 at 6:15 a.m. R97's room light was on and R97 was observed sleeping in bed, dressed in a striped shirt covered with a blanket. NA-I was interviewed on 6/9/16, at 7:59 a.m. and indicated the night shift staff is to assist 3 residents each. NA-I stated the night shift "gets up" some of the early risers and try to do a "lift" for us. NA-I indicated R97 was a resident that night shift got up as she required a mechanical lift for transfer assistance. Registered Nurse (RN)-B was interviewed on 6/9/16 at 12:19 p.m. and indicated the plan for night shift staff was to get up residents who wanted to get up. RN-B stated it was important that residents were able to do what they want to do and residents were encouraged to sleep in if they choose. RN-B stated night shift staff was expected to get up a couple residents that are lift dependent so all the lift dependent residents were not on one shift. RN-B indicated that this was to "keep it more fair" between the shifts. RN-B further indicated she expected lights to be shut off in resident rooms if they were sleeping. The Director of Nursing (DON) was interviewed on 6/9/16, at 1:30 p.m. and indicated morning cares at the facility did not begin until 6:00 a.m. unless a request by a resident had been made. The DON indicated residents had a choice about when they got up in the morning. The DON indicated he was aware there was a list of residents night shift was to assist with morning cares. He confirmed the night shift was expected to assist 2 to 3 lift dependent residents. The DON indicated he was not aware how staff made the selection of which residents to assist in the morning. The DON stated that should not be	21805		

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21805	Continued From page 28 dressed and placed in bed with the light on and indicated morning cares should be a continuous process. Staff should assist the residents from beginning to completion of morning cares and residents should not be placed back in bed for staff convenience. Euerle, Carrie SUGGESTED METHOD OF CORRECTION: The social service person or designee could develop systems to ensure all residents are treated with dignity and respect. The social service person could educate all staff on ensuring resident dignity is maintained. The administrator or designee could work with the social service person on a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		