DEPARTMENT OF HEALTH AND H	UMAN SERVICES	CENTERS FOR ME	DICARE & MEDICAID SERVICES
M	EDICARE/MEDICAID CERTIFIC	CATION AND TRANSMITTAL	ID: 7PAM
PA	RT I - TO BE COMPLETED BY T	THE STATE SURVEY AGENCY	Facility ID: 00924
1. MEDICARE/MEDICAID PROVIDER NO.(L1) <b>245234</b>		CIETY - WACONIA AND WESTVIEW	4. TYPE OF ACTION: 7/(L8) 1. Initial 2. Recertification
2. STATE VENDOR OR MEDICAID NO. (L2) 359057700	(L4) 333 FIFTH STREET WES (L5) WACONIA, MN	ST (L6) 55387	3. Termination 4. CHOW 5. Validation 6. Complaint 7. On-Site Visit 9. Other
5. EFFECTIVE DATE CHANGE OF OWNERSHI (L9)	P 7. PROVIDER/SUPPLIER CATEC 01 Hospital 05 HHA	GORY         02         (L7)           09 ESRD         13 PTIP         22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY     7/19/2016     0       8. ACCREDITATION STATUS:     0     0       0 Unaccredited     1     TJC       2 AOA     3     0ther		10 NF 14 CORF 11 ICF/IID 15 ASC 12 RHC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31
11LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12.Total Facility Beds         96 (I         13.Total Certified Beds	10.THE FACILITY IS CERTIFIED         A. In Compliance With         Program Requirements         Compliance Based On:        1. Acceptable POC         .18)         B. Not in Compliance with Program         .17)         B. Not in Compliance with Program         Requirements and/or Applied	And/Or Approved Waivers O 2. Technical Personne 3. 24 Hour RN 4. 7-Day RN (Rural S 5. Life Safety Code	7. Medical Director
14. LTC CERTIFIED BED BREAKDOWN	requirements and/or reprice	Waivers: * Code: A 15. FACILITY MEETS	(112)
	9 SNF ICF IID	1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) (	(L39) (L42) (L43)		
17. SURVEYOR SIGNATURE Gloria Derfus. Unit Supervisor	Date : 07/22/2016	18. STATE SURVEY AGENC	Y APPROVAL Date:
•	DE COMDI ETED DV HCEA DI	(L19) Camala Fiske-Downing, He	(L20)
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Participate</li> <li>2. Facility is not Eligible</li> </ol>	20. COMPLIANCE WITH RIGHTS ACT:	H CIVIL 21. 1. Statement of Fin	ancial Solvency (HCFA-2572) rol Interest Disclosure Stmt (HCFA-1513)
22. ORIGINAL DATE 23. LTC A	AGREEMENT 24. LTC AGREEM	MENT 26. TERMINATION ACTION	N: (L30)
	INNING DATE ENDING DA	TE <u>VOLUNTARY</u> <u>0</u> 01-Merger, Closure	0 INVOLUNTARY 05-Fail to Meet Health/Safety
(L24) (L41)	(L25)	02-Dissatisfaction W/ Reimbur 03-Risk of Involuntary Terminat	
	RNATIVE SANCTIONS spension of Admissions: (L44)	04-Other Reason for Withdrawa	UTHER
(L27) B. Re	scind Suspension Date:		
	(L45)		
28. TERMINATION DATE:	29. INTERMEDIARY/CARRIER NO.	30. REMARKS	
	00140		
(L28)		(L31)	
31. RO RECEIPT OF CMS-1539	32. DETERMINATION OF APPROVAI	L DATE	
(L32)		(L33) DETERMINATION APP	PROVAL



#### 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,

Kumala Fiske Downing

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



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,

Kumala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Minnesota Department of Health <u>Kamala.Fiske-Downing@state.mn.us</u> 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 /	MULTIPLE CONSTRUCTION			DATE OF REVIS	SIT
IDENTIFICATION NUMBER	A. Building				
245234 <sub>Y1</sub>	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		DATE	ITEM		DATE	ITEM			DATE
Y4		Y5	Y4		Y5	Y4			Y5
ID Prefix FC	0241	Correction	ID Prefix	F0279	Correction	ID Prefix	F0282		Correction
Reg. #	3.15(a)	Completed	Reg. #	483.20(d), 483.20(k	Completed	Reg. #	483.20(k)(3)(ii)		Completed
LSC		07/01/2016	LSC		07/01/2016	LSC			07/01/2016
ID Prefix FC	0312	Correction	ID Prefix	F0314	Correction	ID Prefix	F0315		Correction
Reg. #	3.25(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 STATE AGEI			DATE	SIGNATUR	E OF SURVEYOR			DATE	
		(INITIALS) GPN/kfd	7/22/201		3	1221			9/2016
REVIEWED CMS RO	вү	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOWUP 6/9/2016	P TO SURVE	COMPLETED ON		K FOR ANY UNCO	DRRECTED DEFICIEN IENCIES (CMS-2567)	ICIES. WAS SENT TO T	A SUMMARY OF HE FACILITY?		s 🗌 no

DEPARTMENT OF HEALT	H AND HUMA	N SERVICES			<b>CENTERS FOR MED</b>	ICARE & MEDICAID SERVICES
					AND TRANSMITTAL	ID: 7PAM
	PART I -	TO BE COMPI	LETED BY 1	THE STAT	TE SURVEY AGENCY	Facility ID: 00924
1. MEDICARE/MEDICAID PROVID (L1) 245234	ER NO.		IARITAN SO	CIETY - W	ACONIA AND WESTVIEW	<ol> <li>TYPE OF ACTION: <u>2</u>(L8)</li> <li>Initial 2. Recertification</li> </ol>
2.STATE VENDOR OR MEDICAID 1 (L2) 359057700	NO.	(L4) 333 FIFTH S (L5) WACONIA,		ST	(L6) <b>55387</b>	3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	IPPLIER CATEC <b>05 HHA</b>	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	8. Full Survey After Complaint
6. DATE OF SURVEY <b>06</b> /	<b>09/2016</b> <sup>(L34)</sup>	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	FISCAL YEAR ENDING DATE: (L35)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	' IS CERTIFIED	AS:		
From (a):		A. In Complia	nce With		And/Or Approved Waivers Of T	The Following Requirements:
To (b) :			equirements e Based On:		2. Technical Personnel	6. Scope of Services Limit
					3. 24 Hour RN	7. Medical Director
12. Total Facility Beds	<b>96</b> (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SNI	· · · ·
13.Total Certified Beds	<b>96</b> (L17)	X B. Not in Com	pliance with Pro	gram	5. Life Safety Code	9. Beds/Room
		Requirements	and/or Applied	Waivers:	* Code: <b>B</b> *	(L12)
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS	
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)
96						
(L37) (L38)	(L39)	(L42)	(L43)			
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):		
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY A	APPROVAL Date:
Carrie Euerle, HFE NE II		0	7/19/2016	(L19)	K <u>amala Fiske-Downing, Heal</u>	th Program Representative 07/22/2016 (L20)
PA	RT II - TO BE	COMPLETED F	BY HCFA RI	EGIONAI	OFFICE OR SINGLE ST	TATE AGENCY
19. DETERMINATION OF ELIGIBI	LITY		IPLIANCE WIT	H CIVIL	21. 1. Statement of Finan	
1. Facility is Eligible to 1	Participate	RIGH	ITS ACT:		<ol> <li>Ownership/Control</li> <li>Both of the Above</li> </ol>	Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible						· · · · · · · · · · · · · · · · · · ·
	(L21)					
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION:	(L30)
OF PARTICIPATION	BEGINNING	<b>J</b> DATE	ENDING DA	TE	VOLUNTARY 00	INVOLUNTARY
01/04/1980					01-Merger, Closure	05-Fail to Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburses	
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Termination	1 <u>OTHER</u>
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-Provider Status Change
(L27)	D. Descound St	uspension Date:	(L44)			00-Active
	B. Rescind Si	ispension Date.	(L45)			
28. TERMINATION DATE:	29	. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
		00140				
	(L28)			(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAI	L DATE		
	(L32)			(L33)	DETERMINATION APPR	OVAL



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

# <u>Informal Dispute Resolution</u> - 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;

Good Samaritan Society - Waconia And Westview Acre June 24, 2016 Page 3

- 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 Good Samaritan Society - Waconia And Westview Acre June 24, 2016 Page 4

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:

Good Samaritan Society - Waconia And Westview Acre June 24, 2016 Page 5

> 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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>

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,

Kumala Fiske Downing

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

		AND HUMAN SERVICES		FOI	RM APPROVED
STATEMENT	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X3) [	NO. 0938-0391 DATE SURVEY COMPLETED
		245234	B. WING		06/09/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RF	333 FIFTH STREET WEST WACONIA, MN 55387	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC 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			F 000		
	as your allegation of Department's acce enrolled in ePOC, y at the bottom of the	of correction (POC) will serve of compliance upon the ptance. Because you are your signature is not required a first page of the CMS-2567 ic submission of the POC will tion of compliance.			
F 241 SS=D	on-site revisit of yo validate that substa regulations has bee your verification.	acceptable electronic POC, an ur facility may be conducted to antial compliance with the en attained in accordance with YAND RESPECT OF	F 241		7/1/16
	manner and in an e enhances each res	omote care for residents in a environment that maintains or ident's dignity and respect in is or her individuality.			
	by: Based on observa review the facility fa dining experience f reviewed for activiti provide grooming ta residents (R122) re the facility failed to routines in a dignifi R92, R97) resident impaired and requi complete activities	NT is not met as evidenced tion, interview and document ailed to provide a dignified or 1 of 4 residents (R96) es of daily living and failed to o enhance the dignity of 1 of 1 eviewed for dignity. In addition, provide rising and morning ed manner for 3 of 3 (R21, s who were cognitively red extensive assistance to of daily living (ADLs).	NATURE	Preparation and execution of this response and plan of correction does no constitute an admission or agreement b 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	y n,
	r DIRECTOR'S OR PROVID ically Signed	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE 07/01/2016
	ically Signed				07/01/2010

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.

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES				APPROVE 0938-039
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY PLETED
		245234	B. WING _		06/	09/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, Z		
good s	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIOI DATE
F 241	Continued From pa	ge 1	F 24	41		
	Findings include: R96's quarterly min 3/9/16 indicated she impaired, required p personal hygiene at assistance to eat. A dated 1/7/16, indica assistance, a mech occasional extensiv dining. R96's care p self care deficit and to eat, offer her a s with fingers, and pro- On 6/6/16, at 5:00 p table in the dining ro wheel chair was red degrees. She was c and cubed carrots v present at the table fingers and had ribs She was not wearin p.m., R96 continued independently with food onto her chest her cake with her h 5:22 p.m., nursing a R96 at the table and had already consum walked away and d assistance. R96 co fingers. She had a carrots and cake do	imum data set (MDS) dated e was severely cognitively obysical assistance for nd required physical care area assessment (CAA) ated a need for physical anically altered diet, and re assistance needed for olan dated 5/16/13, indicated a directed staff to cue resident poon when observed eating ovide a napkin clip. 0.m., R96 was seated at a com unassisted by staff. Her clined back approximately 30 eating ground barbeque ribs with her fingers. No staff was . R96 continued to eat with her s and carrots on her chest. ng a clothing protector. At 5:06		constitutes the center's a compliance in accordance 7305 of the State Operat R96 care plan was review to accurately reflect her in extensive assist with eat were immediately made change with a alert that a electronic medical record completed on 6-29-2016 observed to have facial h when interviewed on 6-2 Care plan for R96 was re- updated to reflect curren need for assistance with done on 6-29-2016 and w communicated to nursing interviewed on 6-29-2010 to be free of facial hair in trimming. Nursing staff w by the DNS on 6-29-2011 importance for all residen with dignified cares inclu dining and choices surro PM cares. Social service all long term care residen R92 and R97 or their des responsible party for hea on their preferences or c to receive morning and b These interviews will be 7-15-2016. The nurse m	ce with section tions Manual. wed and updated need for ing. Nursing staff aware of this appears in the d. This was 5. R122 was nair now trimmed 9-2016. eviewed and t abilities and meals. This was g staff. R122 was 6 and was found n need of were re-educated 6 on the nts to be provided ding grooming, unding AM and es will interview nts including R21, signated alth care decisions sustoms for times pedtime cares. completed by angers will use	
	registered nurse (R	on 6/9/16, at 8:57 a.m., N)-A stated R96's level of uring meals. She stated		this information to update 7-22-2016. All nursing s re-educated by the DNS procedures on dignified re-education will be com	staff will be on the policy and care. This	

Facility ID: 00924

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		AND HUMAN SERVICES				FORM	07/19/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245234	B. WING			06/	09/2016
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	RE	33	TREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ( MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	times she would ea "for dignity" staff sh with her fingers. RN give her things that things like mixed ver During an interview director of nursing ( set up with meals a she would often tak stated he would exp clean R96 up as sh R122's Admission r dated 3/9/16, indica cognitively impaired assistance with dre plan dated 3/9/16, i related to impaired to assist with perso On 6/7/16, at 12:52 have several hairs to 1/2 inch long. On 6/8/16, at 8:05 a breakfast table in th several 1/4 inch lon chin. On 6/8/16, at 8:44 a and stated, "I have whiskers, that's not	uld eat with a spoon and other t with her fingers. RN-A stated ould intervene if R96 is eating N-A stated staff attempted to are easier to eat and stated egetables end up on the floor. To n 6/9/16, at 10:52 a.m., The (DON) stated R96 required and when staff assisted her, se over with her hands. He pect staff to re-organize and he was eating. minimum data set (MDS) ated she was severely d and required extensive ssing and grooming. Her care ndicated a self care deficit functioning and directed staff	F 2	41	7-15-2016. Audits (including R122 R21, R92, and a random sample o long term care residents) will be do check for compliance in provision of dignified care for activities of daily I that include dining, morning cares a facial hair for women will be condu- the nurse managers weekly x 4 and monthly x3 to be completed by Oct 31, 2016. Audit results will be report and reviewed in QA committee	f other one to of iving and cted by d then ober	

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245234	B. WING			06/	09/2016
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	-	33 FIFTH STREET WEST VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 241	On 6/8/16, at 9:11 a stated on bath day responsible for che shaving female resi was unable to requi- stated she was awa refused shaving and On 6/9/16, at 10:13 stated if staff notice hair they were supp On 6/9/16, at 10:44 (DON) stated if staff female resident the A facility policy and Samaritan Society I indicated the facility manner that mainta including grooming groomed. The polic residents dignity in practices demeanin A facility policy titled Resident Choice Di residents would rec members in a digni while giving assista R21's medical reco R21 had a diagnosi minimum data set ( dated 3/16/16, iden impaired. The MDS totally dependent up required extensive	a.m., nursing assistant (NA)-A the nursing assistants were cking skin, toenails and dents. She stated if a resident est, they offer to shave. She are of only one resident who d R122 was not that resident. a.m., registered nurse (RN)-A d a female resident with facial bosed to take care of it. a.m., the director of nursing f noticed facial hair on a y should offer to shave it. procedure titled Good Resident Dignity dated 2/13, would care for residents in a ined each resident's dignity residents as they wished to be y directed staff to promote dining and refrain from	F 2	241			

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245234	B. WING			06/	09/2016
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	-	33 FIFTH STREET WEST VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 241	mechanical lift for a R92 had a diagnosi assessment dated a "rarely/never unders assistance of two si transfers, toileting a R97 had a diagnosi MDS assessment of was severely cognit further identified R9 assistance from sta bed mobility. R97's identified R97 requi and a mechanical li bed mobility. On 6/8/16 at 7:09 a sleeping in bed. R2 and pink jacket and observed undernea calling out from her entered the room to morning cares were nursing assistants ( mechanical lift sling positioned R21 in to began to comb R21 glasses. NA-G was interview and indicated she d and put R21 back in her to get up. NA-G night shift and the r	red assistance of 2 staff and a Ill transfers. s of dementia. An MDS 4/6/16, indicated R92 was stood". Further, R92 required taff and a mechanical lift for	F 2	241			

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STATEMEN	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	0. 0938-039
ND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	COI	MPLETED
		245234	B. WING _		06	/09/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPP DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 241	require full assistant because the unit have indicated she got the ready to go" and the later in the morning other "lift" resident R97. NA-G indicated residents she assiss them must be "lift" On 6/8/16, at 7:41 as and R92 was observed dressed in a flower covering her and a observed to be place 8:24 a.m. R92 was with the same flower On 6/9/2016 at 6:13 and R97 was observed in a striped shirt co NA-I was interviewer indicated the night residents each. NA up" some of the ea for us. NA-I indicated night shift got up as for transfer assistant Registered Nurse ( 6/9/16 at 12:19 p.m night shift staff was wanted to get up. F that residents were do and residents were	<ul> <li>at be "lift" residents (those that the with a mechanical lift) and "so many lifts". NA-G me "lift" residents "dressed and en put them back in bed until g. NA-G further indicated the she assisted this morning was addit did not matter which ated in the morning but two of residents.</li> <li>a.m. R92's room light was on rved to be sleeping in bed ed shirt. R92 had a blanket mechanical lift sling was ced underneath her in bed. At observed at the morning meal ered shirt and a gray sweater.</li> <li>5 a.m. R97's room light was on rved sleeping in bed, dressed vered with a blanket.</li> <li>ed on 6/9/16, at 7:59 a.m. and shift staff is to assist 3 -I stated the night shift "gets rly risers and try to do a "lift" ed R97 was a resident that is she required a mechanical lift.</li> </ul>	F 24			

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STATE MEENT OF DEFICIENCIES       (N) PROVIDERSUPPLENCIA IDENTIFICATION NUMBER:       (A) MULTINE CONSTRUCTION A BUILDING       (VS) DATE SUPPLEY COMPLETED         AME OF PROVIDER OR SUPPLEN       245234       B. WING       OG(09/2016         GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE       STREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST WACONIA, MN SS387       SUMMARY STATEMENT OF DEFICIENCIES (EACH OCONFECTIVE VUST EE PRECEDED BY FULL RESULTORY OF US DEINTERVING TO FERCION PARTICIPANTION)       STREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST WACONIA, MN SS387         F1241       Continued From page 6 dependents so all the lift dependent residents were function one shift. TN-B. Indicated that this was to race at the facility did not begin until C00 a.n. unless a request by a resident ad choice about when they got up in the morning. Cares at the facility did not begin until C00 a.n. unless a request by a resident in the dat choice about when they got up in the morning. Cares at the facility did not begin until C00 a.n. unless a request by a resident in a choice about when they got up in the morning. Cares at the facility did not begin until C00 a.n. unless a request by a resident in bed for salection of which residents to assist in the morning. The DON stated that sub as a choice about when they got up in the morning cares and residents should not be placed back in bed for salection of which residents to assist in the morning. The DON stated that sub assist the resident from beginning to comprehensive plan of care.       F279         SS-D       COMPREHENSIVE CARE PLANS       F279         A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.<				AND HUMAN SERVICES			FORM	: 07/19/2016 APPROVED . 0938-0391
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE     333 FIFTH STREET WEST       COOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE     STREET ADDRESS, CITY, STATE, ZIP CODE     333 FIFTH STREET WEST       PREEX     ENUMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCE) WIST BE REACCEDED BY FULL RECOLLATORY OR LSC DENTIFYING INFORMATION)     IP     PREEX (CACONIA, MM & 5387       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.     F 241       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 that a choice about when they got up in the morning. The Dot state of that should not be dressed and placed in bed with the light on and indicated he was not aware how staff made the selection of which residents to assist in the endents night shift was to assist who morning cares. He confirmed the night shift was expected to assist 2 to 3 lift dependent residents from begining to completion of morning cares should be a continuous process. Staff should assist the resident's comprehensive plan of care.     F 279     7/1/16       F 279     SS-D     COMPRETENSIVE CARE PLANS     F 279     7/1/16	-						· · ·	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CTV, STREET, 20: CODE       GODD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE     33 FIFTH STREET WEST WACONIA, MN 5387       ID PREFX TAG     SUMMARY STATEMENT OF DEFICIENCIES REGULATORY OR LSC IDENTIFYING INFORMATION     ID PREFX REGULATORY OR LSC IDENTIFYING INFORMATION     PROVIDERS PLAN, DF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION     PROVIDERS PLAN, DF CORRECTION REGULATORY OR LSC IDENTIFYING INFORMATION       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.     F 241       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 unnit. 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 out aware how staff made the selection of which residents in the morning. The DON stated that should not be dressed and placed in bed with the light on and residents should not be placed back in bed for staff convenience.     F 279       F 279     SLAD     7/1/16       F 279     The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.     F 279       The lacility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.     F 279				245234	B. WING		06/	/09/2016
GOOD SAMARTIZAN SOCIETY - WACONIA AND WESTVIEW ACRE         WACONIA, MN 55387           Image: Construct of the construction of the constrelation of the construction of the construction of	NA	ME OF F	PROVIDER OR SUPPLIER				•	
Preferitiv TAG       IEADH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)       PREFX TAG       IEADH CORRECTIVE ACTION SHOULD BE CROSS-REPERRECEOT OT HE APPROPRIATE       COMPLETION DEFICIENCY)         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.       F 241         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 beign until 6:00 a.m. unless a request by a resident had been made. The DON indicated residents the a choice about when they got up in the morning. The DON indicated new as 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 new and aware how staff made the selection of which residents from beginning to completion of morning cares and residents should not be placed back in bed for staff convenience.       F 279         F 279       SS=D       COMPREHENSIVE CARE PLANS       F 279         A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.       F 279         The facility must develop a comprehensive care plan for each resident that includes measurable objectives and mertal and psychosocial needs that are identified in the comprehensive       F 279	GC	DOD SA	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RF			
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%/r6, 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 residents had a choice about when they got up in the morning. The DON indicated residents had a choice about when they got up in the morning. The DON indicated residents. The DON indicated he was aware there was a list of residents night shift was 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 279       F 279         F 23.20(), 48.20(k) (1) DEVELOP SS=D       COMPREHENSIVE CARE PLANS       F 279         A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.       F 279       F 279         The facility must use the results of the assessment to develop, review and revise the resident's comprehensive lan of care.       F 279       F 279         The facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care.       F 279       F 279         The facility must develop a comprehensive care plan for each resident that includes	PF	RÉFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION
	F	= 279	dependent so all the not on one shift. RN "keep it more fair" to further indicated sh in resident rooms if The Director of Nur on 6/9/16, at 1:30 p cares at the facility unless a request by The DON indicated when they got up in indicated he was av residents night shift cares. He confirment to assist 2 to 3 lift d indicated he was no selection of which r morning. The DON dressed and placed indicated morning of process. Staff should beginning to comple residents should no staff convenience. 483.20(d), 483.20(k COMPREHENSIVE A facility must use t to develop, review a comprehensive plan The facility must de plan for each reside objectives and time medical, nursing, an needs that are iden	e lift dependent residents were J-B indicated that this was to between the shifts. RN-B e expected lights to be shut off they were sleeping. sing (DON) was interviewed and indicated morning did not begin until 6:00 a.m. a resident had been made. residents had a choice about the morning. The DON ware there was a list of t was to assist with morning d the night shift was expected ependent residents. The DON ot aware how staff made the esidents to assist in the stated that should not be d in bed with the light on and cares should be a continuous Id assist the residents from etion of morning cares and ot be placed back in bed for ()(1) DEVELOP E CARE PLANS he results of the assessment and revise the resident's n of care. evelop a comprehensive care ent that includes measurable tables to meet a resident's nd mental and psychosocial				7/1/16

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CENTER		AND HUMAN SERVICES				APPROVEI 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION IG		E SURVEY PLETED
		245234	B. WING _		06/	09/2016
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 7	F 27	79		
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident' §483.10, including t under §483.10(b)(4					
	by: Based on observat review, the facility fi interventions to res residents (R56) rev In addition, the facili interventions to pre pressure ulcers for reviewed for pressu Findings include: R56's 14 day minim 5/4/16, indicated her required extensive transfers and toileti incontinent of blado toileting plan had no previous MDS date always continent of assessment dated incontinent of blado	num data set (MDS) dated e was cognitively intact, assistance of two staff for ng, and was occasionally ler. The MDS indicated a trial ot been attempted for R56. A d 4/7/16, indicated R56 was bladder. A bladder 9/29/15, indicated R56 was ler due to functional icated a check and change		Review of R56 care plan was do updated to reflect interventions to new or worsening pressure ulcer including plan to attempt to offloa surfaces. This was completed o 6-28-2016. Nursing staff were re-educated by the DNS on the r immediate attention to proper documentation of data and measurements of wounds to ens thorough evaluation of intervention prevent new or worsening press ulcers. All nursing staff will receive re-education by the DNS on the policy for management of reside have pressure ulcers or who are development of pressure ulcers re-education will include need fo wound data collection including measurements and assessment assessments are to be used to a proper care plans are developed interventions that are done to pre-	o prevent s ad seating n eed for ure ons to ure ve acility nts who at risk for and this proper s. These ssure to reflect	

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		AND HUMAN SERVICES				FORM	07/19/2016 APPROVED 0938-0391
-	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245234	B. WING _			06/0	09/2016
NAME OF I	PROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE		33 FIFTH STREET WEST ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 279	Continued From pa	ge 8	F 27	79			
	toileting program."	ed 9/24/15, indicated he			7-15-2016. Nurse managers will re all residents with a current open are who have been identified as being a	ea or	
	required assistance mechanical lift for the updated on 6/8/16,	e from two staff and a ransfers. The care plan was following inquiry by surveyor, with assist of two staff. The			for development of pressure ulcers indicated by a Braden Score of 18 c below. Nurse managers will review records for proper care planning wit	or these	
		ddress a toileting plan for R56 d a decline from being onal incontinence.			interventions that are done to preve or worsening of pressure ulcers. T reviews will be completed by 7-15-2 Review of R56 care plan was comp	hese 2016.	
	table in a standard was escorted to his	a.m., R56 was at the breakfast wheel chair. At 8:26 a.m., R56 room by staff where he 6 a.m. when he left the facility			as well as data collected regarding bladder continence over the past 9 months. A new 72 hour bladder dat collection tool was initiated on 6-28 This data will be used to complete f	ta -2016. resh	
	(NA)-B stated R56 void. She stated he	a.m., nursing assistant was on dialysis and did not would request the commode e a bowel movement.			assessment of R56 actual level of b control. This assessment will be us make a plan of care that accurately reflects his level of continence and possible intervention for restoration bladder function. This care plan wil	ed to any of	
		a.m., NA-A stated R56 was r and did not void due to			updated by 7-08-2016. Nurse mana will review all long term care resider records who are listed as being curr incontinent to look for changes note	agers nt rently	
	stated R56 had end received dialysis bu stated she was not level of urinary cont	p.m., registered nurse (RN)-A stage renal disease and it did void. Additionally, RN-A aware he had a change in his tinence. RN-A stated he e-assessed following that			MDS of bladder continence. Nurse managers will review the records to ensure that proper data collection, assessment and care plan updates done to reflect the current needs of residents. This review will be comp	were the	
	change. RN-A state plan and his care p of bladder but state stated he should be	ed R56 was not on a toileting lan indicated he was continent d, "that is incorrect." She e toileted upon rising, after efore bed as that was the			by 7-15-2016. Audits (that will include R56 and rar selection of other residents) of data collection, assessment and care pla process that includes the areas of pressure ulcers and bladder continence/retraining will be done b	an	

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT	0938-039 E SURVEY
	ST GOTTILE TION	DENTIFICATION NOMBER.	A. BUILDING	·	001	
		245234	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RF I	333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE
F 279	R56's 14 day minir 5/4/16, indicated h identified on 4/20/1 R56 was cognitive and required extern bed mobility, transi dated 3/23/16, ider directed staff to tur hours while in bed The care plan did r off-loading while R During continuous a.m., R56 was sitti room in a standard sling was undernea mid thighs. In his v cushion. At 8:26 a. R56 to his room wh reading a magazin to sit in his wheel of left to go to an app R56 had not been thirty nine minutes vehicle where he w wheelchair without and would not retu approximately 4 m During an observa R56 had an open a Licensed practical wound and stated one to two becaus On 6/8/16, at 12:48 stated R56 had a v	num data set (MDS) dated e had a stage II pressure ulcer I6. The MDS further indicated ly intact, incontinent of bladder, isive assistance of two staff for fers and toileting. His care plan ntified a skin impairment and rn and reposition R56 every 2-3 and provide an air mattress. not address repositioning or 56 was up in his wheel chair. cobservation on 6/8/16, at 7:27 ng at the table in the dining d wheel chair. A mechanical lift ath R56 from his shoulders to vheel chair was a blue foam m., a staff member escorted here he sat in his wheel chair e. At 9:39 am, R56 continued chair until 10:06 a.m. when he pointment outside the facility. repositioned for two hours and prior to getting in a transport yould continue to sit in his repositioning or off-loading rn to the facility for	F 279		letion	

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		AND HUMAN SERVICES & MEDICAID SERVICES			PRINTED: 07/19/2016 FORM APPROVED OMB NO. 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (	X3) DATE SURVEY COMPLETED	
		245234	B. WING		06/09/2016	
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	BE 3	TREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 279 F 282 SS=D	should have been r and going out for hi the mechanical lift s underneath him in t On 6/9/16, at 10:38 stated the nurse ma wounds on the unit see interventions in pressure. A facility policy titled Care Plan, dated 9/ would have an indiv of care directed tow optimal needs. The evaluate and updat quarterly and with a condition to reflect to the resident. 483.20(k)(3)(ii) SEF PERSONS/PER C/ The services provide must be provided b accordance with ea care. This REQUIREMEN by: Based on observat review, the facility failed to provide facility failed to provided to provide facility failed to provide to provide facility failed to provide to provide to provide facility failed to provide to prov	very two to three hours and he epositioned between breakfast s dialysis. She further stated sling should be removed form he chair. a.m., the director of nursing anager was responsible for . He stated he would expect to the care plan related to d Good Samaritan Society 12, indicated each resident vidualized comprehensive plan vard maintaining the residents policy directed staff to e the care plan at least a change in the residents the care currently required for RVICES BY QUALIFIED	F 279	R122 was interviewed on 6-29-2016 was found to be free of facial hair in of trimming. Nursing staff were re-educated by the DNS on the need for all residents to be provided with dignified cares including grooming o women's facial hair. R37 had review	need d to f	

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		AND HUMAN SERVICES				FORM	07/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245234	B. WING			06/0	09/2016
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE		33 FIFTH STREET WEST /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	Continued From pa	ge 11	F 2	82			
	Findings include:				care plan on 6-29-2016 that was for be accurate in reflection of the nee assistance with dining. Nursing sta	eds for aff were	
	dated 3/9/16, indica cognitively impaired	ninimum data set (MDS) ated she was severely d and required extensive ssing and grooming.			re-educated by the DNS on the ne provide necessary care planned assistance. All nursing staff will b re-educated by the DNS on the fac policy on provision of services per	e :ility	
	care deficit related	ated 3/9/16, identified a self to impaired functioning and sist with personal hygiene.			plan including areas of assistance grooming and dining assistance. S be re-educated by the DNS with th expectation to use existing tools to	with Staff will e	
		a.m., R122 was observed to on her chin approximately 1/4			made aware of what the care plan indicates. This re-education will be completed by 7-15-2016. Audits (including R122 and R37 along wit	Э	
	breakfast table in the several hairs appro protruding from the	a.m., R122 was sitting at the ne dining room. She had ximately 1/8th inch in length left side of her chin and ng hairs on the right side of her			random selection of other resident grooming and dining room assistan care plan will be done by the nurse managers weekly x4 and then mor with a planned completion date of 10-31-2016. Audit results will be bu to the QA committee for review.	nce per e nthly x3	
	stated on bath day	a.m., nursing assistant (NA)-A the nursing assistants were ving female residents.			to the QA committee for review.		
	stated if staff notice	a.m., registered nurse (RN)-A ed a female resident with facial posed to take care of it.					
	(DON) stated if stat	a.m., the director of nursing f noticed facial hair on a y should offer to shave it.					
	4/13/16, indicated h impaired and required	imum data set (MDS) dated ne was severely cognitively red physical assistance to eat. ment (CAA) dated 11/2/15,			ility ID: 00924		

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/19/2016 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		LE CONSTRUCTION		E SURVEY PLETED
		245234	B. WING			06/	09/2016
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	-	33 FIFTH STREET WEST VACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRON DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 282	identified the need t and nectar thickener problems that affec vision problems, im the need for physica activities of daily livit R37's care plan dat care deficit and dire and supervision wit directed staff to pro- when R37 was obse On 6/6/16, at 4:54 p at a table in the dini (NA)-D was standin 4:56 p.m., she walk and stood feeding h Another staff memb to assist another re- across from the sta with his fingers. At 4 spoon and walked a table and sat, not e- not eaten any more returned to assist h down next to R37. S more to eat. R37 st bite and left the tab than 25% of his foo offer him any more of his meal was une On 6/8/16, at 12:04 sandwich and a boy food in front of him the table holding a cup on the table and	for a mechanically altered diet de liquids as well as functional ted his ability to eat including, paired range of motion and al assistance to perform ing. ed 4/8/16, identified a self ected staff to provide set up h meals. The care plan further vide limited to extensive assist erved not eating. o.m., R37 was observed sitting ing room. Nursing assistant g at the table feeding him. At ed over to another resident her. NA-D then left the table. ber sat at the table and began sident. R37 was seated ff member eating his cake 5:05 p.m., NA-D gave R37 his away. He put the spoon on the ating. At 5:16 p.m., he still had of his food and staff had not im. At 5:25 p.m., NA-C sat She asked if he would like ated yes. NA-C fed R37 one le. R37 had consumed less d and staff did not return to assistance or food. The rest	F 2	282			

Facility ID: 00924

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	07/19/2016 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		PLE CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245234	B. WING	i		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE		333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 282	top piece of bread. his sandwich and di p.m., R37's sandwich had not eaten any of table but did not ass 12:17 p.m., NA-F gi was able to retrieve ate it. His soup was On 6/8/16, at 12:27 R37 could feed him needed help. She s foods on his own. N sitting at the table s noticed he was not On 6/8/16, at 12:29 R37 had his sandwi but otherwise did not did not offer him as asked to see if she the table to eat. NA assistance depende On 6/8/16, at 12:39 stated the level of a stated it depended of On 6/9/16, at 10:45 (DON) stated he ha R37 would not take on his own. A facility policy titleo Activities of Daily Li residents who are u daily living will recei maintain grooming a	He picked up the other half of ropped it in his lap. At 12:15 ch remained on his lap. He of his soup. NA-F sat at the sist R37 with his meal. At of up and left the table. R37 his sandwich from his lap and left untouched. p.m., NA-E stated sometimes self and sometimes he tated he was able to eat finger IA-E stated whoever was hould assist him if they eating. p.m., NA-F stated she saw ch in his hand during lunch ot look at him. She stated she sistance because she was could get the other resident at -F stated R37's level of ed on the day. p.m., registered nurse (RN)-B ssistance for R37 varied. She	F	282			

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		AND HUMAN SERVICES & MEDICAID SERVICES			FOR	D: 07/19/2016 M APPROVED D. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY DMPLETED
		245234	B. WING		0	6/09/2016
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	RE	3	TREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST /ACONIA, MN 55387	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282 F 312 SS=D	directed by the plan 483.25(a)(3) ADL C DEPENDENT RES A resident who is un daily living receives maintain good nutri and oral hygiene. This REQUIREMEN by: Based on observat review, the facility fo of 4 residents (R12 was unable to indep addition, the facility during meals for 1 of for activities of daily assistance with eat Findings include: R122's Admission r dated 3/9/16, indica cognitively impaired assistance with dre plan dated 3/9/16, i related to impaired to assist with perso On 6/7/16, at 12:52	ARE PROVIDED FOR IDENTS nable to carry out activities of the necessary services to tion, grooming, and personal NT is not met as evidenced ion, interview and document ailed to provide grooming for 1 22) reviewed for ADL's who bendently groom herself. In failed to provide assistance of 4 residents (R37) reviewed v living, who required ing.	F 2		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 resident to be provided with dignified cares including grooming of women's facial hai R37 had review of care plan that was found to be accurate in reflection of the needs for assistance with dining. Nursin 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	d s r. g I /
	On 6/8/16, at 8:05 a	a.m., R122 was sitting at the			will be done by the nurse managers	

Facility ID: 00924

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	07/19/2016 APPROVED 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED	
		245234	B. WING			06/09/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	33	TREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST VACONIA, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 312	several hairs approprotruding from the several 1/4 inch lor chin. On 6/8/16, at 8:44 a and stated, "I would would be very nice. On 6/8/16, at 9:11 a stated on bath day responsible for sha stated if a resident offer to shave. NAnot provide razors a supply their own. S only one resident w was not that reside On 6/9/16, at 10:13 stated if staff notice hair they were supply further stated the fainfection control real On 6/9/16, at 10:44 (DON) stated if staff male resident the stated the facility di should be contacte R37's quarterly mir 4/13/16, indicated h ineed and nectar thickend	he dining room. She had boximately 1/8th inch in length e left side of her chin and ng hairs on the right side of her a.m., R122 stroked her chin d like to get rid of them." "It " a.m., nursing assistant (NA)-A the nursing assistants were wing female residents. She was unable to request, they A further stated the facility did and residents needed to he stated she was aware of <i>v</i> ho refused shaving and R 122 nt. B a.m., registered nurse (RN)-A ed a female resident with facial bosed to take care of it. RN-A acility did not provide razors for asons. I a.m., the director of nursing ff noticed facial hair on a by should offer to shave it. He id not provide razors but family	F 3	;12	weekly x4 and then monthly x3 with planned completion date of 10-31- Audit findings will be brought to the committee for review.	2016.		

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		(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION		TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		245234	B. WING _		06	09/2016
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
F 312	Continued From pa	lge 16	F 31	12		
	vision problems, im the need for physic activities of daily liv 4/8/16, identified a staff to provide set meals. The care pla provide limited to e observed not eating	paired range of motion and al assistance to perform ing. R37's care plan dated self care deficit and directed up and supervision with an further directed staff to xtensive assist when R37 was g.				
	On 6/6/16, at 4:54 p.m., R37 was observ at a table in the dining room. Nursing ass (NA)-D was standing at the table feeding 4:56 p.m., she walked over to another re and stood feeding her. NA-D then left the Another staff member sat at the table an to assist another resident. R37 was seate across from the staff member eating his with his fingers. At 5:05 p.m., NA-D gave spoon and walked away. He put the spoo table and sat, not eating. At 5:16 p.m., he not eaten any more of his food and staff returned to assist him. At 5:25 p.m., NA- down next to R37. She asked if he would more to eat. R37 stated yes. NA-C fed R bite and left the table. R37 had consume than 25% of his food and staff did not ret offer him any more assistance or food. T of his meal was uneaten.	ing room. Nursing assistant ing at the table feeding him. At and at the table feeding him. At and over to another resident her. NA-D then left the table. Der sat at the table and began isident. R37 was seated off member eating his cake 5:05 p.m., NA-D gave R37 his away. He put the spoon on the ating. At 5:16 p.m., he still had of his food and staff had not im. At 5:25 p.m., NA-C sat She asked if he would like sated yes. NA-C fed R37 one le. R37 had consumed less of and staff did not return to assistance or food. The rest				
	sandwich and a bor food in front of him the table holding a cup on the table an with his left hand. H top piece of bread. his sandwich and d p.m., R37's sandwi	p.m., R37 was brought a cold wl of soup. Staff placed the and walked away. R37 sat at cup. At 12:11 p.m., he put his d reached for his sandwich le was able to grab only the He picked up the other half of ropped it in his lap. At 12:15 ch remained on his lap. He of his soup. NA-F sat at the				

Facility ID: 00924

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		AND HUMAN SERVICES				FORM	: 07/19/2016 1APPROVED . 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G	· · /	TE SURVEY MPLETED
		245234	B. WING	i		06	/09/2016
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	RE	:	STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	table but did not as: 12:17 p.m., NA-F g was able to retrieve ate it. His soup was On 6/8/16, at 12:27 R37 could feed him needed help. She s foods on his own. N sitting at the table s noticed he was not On 6/8/16, at 12:29 R37 had his sandw but otherwise did not did not offer him as asked to see if she the table to eat. NA assistance depended On 6/8/16, at 12:39 stated the level of a stated it depended waiting 15 minutes long." RN-B further could cue him at mo while feeding others responsible for assi assess as needed i trouble chewing or overseeing what he On 6/9/16, at 10:45 (DON) stated he km was behind they wo dining room. He sta morning that R37 w grab things on his o	sist R37 with his meal. At ot up and left the table. R37 e his sandwich from his lap and a left untouched. p.m., NA-E stated sometimes uself and sometimes he stated he was able to eat finger IA-E stated whoever was should assist him if they eating. p.m., NA-F stated she saw ich in his hand during lunch ot look at him. She stated she sistance because she was could get the other resident at -F stated R37's level of ed on the day. p.m., registered nurse (RN)-B assistance for R37 varied. She on his mood. She stated for assistance "might be too stated there was staff that eals, but they can't feed him s. RN-B stated she was essing R37's ability to eat and f an aide stated he was having swallowing, but staff should be	F	312	2		

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		AND HUMAN SERVICES & MEDICAID SERVICES		F	TED: 07/19/2016 ORM APPROVED NO. 0938-0391
-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3	3) DATE SURVEY COMPLETED
		245234	B. WING		06/09/2016
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	RF 3	STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLETION DATE
F 312 F 314 SS=D	by a nurse on admi as needed. A facility policy title Activities of Daily Li residents who were of daily living would services to maintain hygiene. The policy care, shaving, appli and nail care as we hydration. A facility policy titled Resident Choice Di residents would red members in a digni while providing ass 483.25(c) TREATM PREVENT/HEAL P Based on the comp resident, the facility who enters the faci does not develop p individual's clinical they were unavoida pressure sores red services to promote prevent new sores This REQUIREMEN by: Based on observat review, the facility fassistance with rep	d Good Samaritan Society ving, dated 9/12, indicated unable to carry out activities receive the necessary of grooming and personal directed staff to provide hair cation of makeup and skin Il as nourishment and d Good Samaritan Society ning dated 2/13, indicated reive assistance from staff fied manner including sitting istance rather than standing. ENT/SVCS TO RESSURE SORES orehensive assessment of a must ensure that a resident ity without pressure sores rescure sores unless the condition demonstrates that ble; and a resident having eives necessary treatment and a healing, prevent infection and	F 312		cers

Facility ID: 00924

If continuation sheet Page 19 of 26

		AND HUMAN SERVICES			F	ORM A	07/19/2016 PPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X:		SURVEY LETED
		245234	B. WING			06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER	•	·	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE		33 FIFTH STREET WEST /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 314	Continued From pa	-	F 3	14			
	Findings include:	iewed for pressure ulcers.			surfaces. This was completed on 6-28-2016. Nursing staff were updat via email on 6-29-2016 of the need fo		
	R56's 14 day minim	num data set (MDS) dated			immediate attention to proper documentation of data and		
	identified on 4/20/1	e had a stage II pressure ulcer 6. The MDS further indicated y intact, incontinent of bladder,			measurements of wounds to ensure thorough evaluation of interventions to prevent new or worsening pressure	o	
	and required extension	sive assistance of two staff for ers and toileting. His care plan			ulcers. All nursing staff will receive re-education by the DNS on the facilit	ty	
	directed staff to turn	tified a skin impairment and n and reposition R56 every 2-3			policy for management of residents w have pressure ulcers or who are at ris	sk for	
	The care plan did n	and provide an air mattress. ot address repositioning or 56 was up in his wheel chair.			development of pressure ulcers. This re-education will include need for prop wound data collection including		
	During continuous	observation on 6/8/16, at 7:27			measurements and assessments. The assessments are to be used to assure	e	
	room in a standard	ng at the table in the dining wheel chair. A mechanical lift th R56 from his shoulders to			proper care plans are developed to re interventions that are done to prevent or worsening pressure ulcers. This		
	mid thighs. In his w	heel chair was a blue foam n., a staff member escorted			re-education will be completed by 7-15-2016. Nurse managers will revie	ew all	
	reading a magazine	ere he sat in his wheel chair e. At 9:39 am, R56 continued hair until 10:06 a.m. when he			residents with a current open area or have been identified as being at risk f development of pressure ulcers as		
	R56 had not been r	pintment outside the facility. repositioned for two hours and			indicated by a Braden Score of 18 or below. Nurse managers are to review	w	
	vehicle where he w wheelchair without	prior to getting in a transport ould continue to sit in his repositioning or off-loading			these records for proper care planning with interventions that are done to pre- new or worsening of pressure ulcers.	event	
	and would not retur approximately 4 mc				This review will be completed by 7-15-2016. Audits (including R56 and random selection of residents) of data		
	R56 had an open a	ion on 6/9/16, at 7:38 a.m., rea to the right of his coccyx.			collection, assessment and care plan process that includes the areas of	1	
	two other areas tha Licensed practical r	sue was reddened and he had t appeared to be healing. hurse (LPN)-A described the			pressure ulcers will be done by the numerical managers weekly x 4 and then month 3 with a planned completion date of	nly x	
	wound and stated "	I would call the wound a stage			10-31-2016. Audit results will be revie	ewed	

Facility ID: 00924

		AND HUMAN SERVICES				FORM	07/19/2016 APPROVED 0938-0391
			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245234		B. WING			06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACR			RE		33 FIFTH STREET WEST /ACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 314	one to two because A review of a Good Data Collection too had a wound on his pinpoint areas of pr further described a: was open from layin not include measure Good Samaritan So tool dated 4/25/16, have a wound on h include measure description of the w Society Wound Dat 4/28/16, identified t include measure wound. A Good Sa Collection tool date on R56's coccyx. N of the wound was p Society Wound Dat 5/22/16, indicated a measurement or de provided. A Good Sa Collection tool date continued to have a	ge 20 e there are some open areas." Samaritan Society Wound I dated 4/20/16, indicated R56 a coccyx described as "small ressure." The wound was is a small area on coccyx that ing on his bottom. The tool did ements of R56's wound. A poiety Wound Data Collection indicated R56 continued to is coccyx. The tool did not ents, nor was there any round. A Good Samaritan is Collection tool dated he coccyx wound but did not ents or description of the maritan Society Wound Data d 5/16/16, identified a wound o measurement or description provided. A Good Samaritan is Collection tool dated a wound on the coccyx. No escription of the wound was camaritan Society Wound Data d 5/25/16, indicated R56 a wound on his coccyx. No surement of the wound was	F 3	314	by the QA committee.		
	identified the coccy centimeter (cm) x 0 wound bed was 100 (Regeneration of ep surface). A Good S Assessment dated wound as a pressu was 100% epithelia decreased in size.	Ilection tool dated 5/31/16, x wound measuring 1 0.5 cm and indicated the D% epithelialized tissue bidermis across a wound amaritan Society Wound RN 6/1/16, identified R56's coccyx re ulcer, indicated the wound Ilized tissue and had No measurement was 6, a Wound data Collection					

Facility ID: 00924

If continuation sheet Page 21 of 26

		AND HUMAN SERVICES				FORM	: 07/19/2016 APPROVED : 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245234		B. WING	B. WING			09/2016
NAME OF F	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE		333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	Continued From pa	lge 21	F 3	314	L		
	6/6/16, a Wound da coccyx wound mea increase in size from No further description	escription was included. On ata Collection tool identified a suring 1 cm $\times$ 0.9 cm, an m the previous measurement. on of the wound was included.					
	(NA)-B stated R56 transfers. She state every two hours wh	a.m., nursing assistant required a mechanical lift for ed he should be repositioned then he is in his chair. NA-B get repositioned today" and to dialysis.					
	around 7:00 a.m. o She stated he woul	a.m., NA-A stated R56 got up n the days he went to dialysis. d usually ask if he wanted to o we do not ask him."					
	stated R56 had a w developed on 4/26/ pressure I would th responsible for wou not seen the wound stated the floor nur- tool and the registe do a weekly assess based on R56's ski and repositioned ev should have been r and going out for hi the mechanical lift s underneath him in t	5 p.m., registered nurse (RN)-A yound on his coccyx that '16. RN-A stated "that would be ink." RN-A stated she was und rounds on the unit but had d on R56's coccyx lately. She se completed a data collection red nurse was responsible to sment. RN-A further stated n issues he should be turned very two to three hours and he repositioned between breakfast is dialysis. She further stated sling should be removed form the chair. nt interview on 6/9/16, at 10:24					
	a.m., registered nur never seen the wou stated the wound a completed on the p	rse (RN)-A stated she had und on R56's coccyx. She ssessment had been revious evening and was ge II pressure ulcer measuring					

If continuation sheet Page 22 of 26

		AND HUMAN SERVICES			FORM	: 07/19/2016 APPROVED . 0938-0391
	NT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION		E SURVEY IPLETED
		245234	B. WING		06	/09/2016
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	RE	STREET ADDRESS, CITY, STATE, ZIP CODE 333 FIFTH STREET WEST WACONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 314	designated person facility. On 6/9/16, at 10:38 stated the nurse ma wounds on the unit see interventions in pressure, weekly m assessment comple A policy titled Good Ulcers, dated 9/12, policy titled Good S Pressure Ulcer Pre Requirements, date staff to systematica regard to skin breat techniques and pre for residents at risk policy further indica pressure ulcer wou treatment and servi prevent new ulcers pressure ulcer is id staff to assess the a Wound RN Assess 483.25(d) NO CATH RESTORE BLADD Based on the reside assessment, the fa resident who enters indwelling catheter resident's clinical co catheterization was who is incontinent of	A stated there was no managing wounds for the a.m., the director of nursing anager was responsible for . He stated he would expect to the care plan related to reasurements and a weekly eted by a registered nurse. Samaritan Society, Pressure was reviewed along with a famaritan Society Procedure, vention and Documentation ed 9/12. The policies directed illy assess residents with kdown and use prevention ssure redistributing surfaces for pressure ulcers. The tted a resident who had a ld receive the necessary ices to promote healing and from developing. If a entified, the policies directed area at least weekly on the ment. HETER, PREVENT UTI,	F 3			7/1/16

Facility ID: 00924

If continuation sheet Page 23 of 26

		AND HUMAN SERVICES				FORM	07/19/2016 APPROVED 0938-0391
	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245234					06/0	09/2016
NAME OF F	PROVIDER OR SUPPLIER		·	STRE	EET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE		FIFTH STREET WEST CONIA, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 315	function as possible This REQUIREMEN by: Based on observat	store as much normal bladder e. NT is not met as evidenced tion, interview and document	F 31		Review was done on 6-28-2016 o		
	assess a decline in implement interven bladder function for reviewed for urinary Findings include: R56's 14 day minim 5/4/16, indicated he	ailed to comprehensively urinary incontinence and tions to promote restoration of 1 of 3 residents (R56) y continence. hum data set (MDS) dated was cognitively intact, assistance of two staff for		b n c T a c n r p	care plan and data collected regard pladder continence over the past 9 months. A new 72 hour bladder da collection tool was initiated on 6-28 This data will be used to complete assessment of R56 actual level of control. This assessment will be u make a plan of care that accurately eflects his level of continence and possible intervention for restoration pladder function. This care plan w	ata 5-2016. fresh bladder sed to y any of	
	incontinent of blade toileting plan had ne previous MDS date always continent of assessment dated incontinent of blade impairment and ind program to manage Recommendations included, "none at t toileting program."	9/29/15, indicated R56 was ler due to functional icated a check and change e incontinence. based on the assessment his time, continue current		r v ir N r d u n c v r T	updated by July 8th. Nurse manageview all long term care resident r who are listed as being currently ncontinent to look for changes not MDS of bladder continence. We we eview the records to ensure that p data collection, assessment and ca updates were done to reflect the cu- needs of the residents. This review completed by 7-15-2016. All nursi will receive re- education on facility regarding restoration of bladder fur This will be completed by 7-15-201	ecords ed in vill vroper are plan urrent w will be ng staff y policy nction. 6.	
	required assistance mechanical lift for the updated on 6/8/16, to include toileting v care plan did not ac	ed 9/24/15, indicated he e from two staff and a ransfers. The care plan was following inquiry by surveyor, with assist of two staff. The ddress a toileting plan for R56 d a decline from being onal incontinence.		ra a ir C n n	Audits (including R56 and a selection andom residents) of data collection assessment and care plan process includes the areas of bladder continence/retraining will be done hourse managers weekly x 4 and the monthly x 3 with a planned complet date of 10-31-2016. Audit results we	n, s that oy the en tion	

Facility ID: 00924

If continuation sheet Page 24 of 26

		AND HUMAN SERVICES				FORM	07/19/2016 APPROVED 0938-0391
-	TATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         ND PLAN OF CORRECTION       IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245234	B. WING _			06/	09/2016
	PROVIDER OR SUPPLIER	- WACONIA AND WESTVIEW AC	RE	33	TREET ADDRESS, CITY, STATE, ZIP CODE 33 FIFTH STREET WEST /ACONIA, MN 55387	• • • • • •	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 315	table in a standard was escorted to his remained until 10:0 for an appointment. On 6/8/16, at 10:09 (NA)-B stated R56 void. She stated he if he needed to hav On 6/8/16, at 11:42 continent of bladde dialysis. On 6/8/16, at 12:45 stated R56 had end received dialysis bu stated she was not level of urinary cont should have been r change. RN-A state plan and his care p of bladder but state stated he should be meals, naps and be facility's standard p On 6/8/16, at 1:52 p (DON) stated he wo residents to be toile after meals, at bed While R56 had a ch no evidence the fac determine a pattern	a.m., R56 was at the breakfast wheel chair. At 8:26 a.m., R56 room by staff where he 6 a.m. when he left the facility a.m., nursing assistant was on dialysis and did not would request the commode e a bowel movement. a.m., NA-A stated R56 was r and did not void due to p.m., registered nurse (RN)-A d stage renal disease and at did void. Additionally, RN-A aware he had a change in his tinence. RN-A stated he e-assessed following that ed R56 was not on a toileting lan indicated he was continent d, "that is incorrect." She e toileted upon rising, after efore bed as that was the ractice.	F 3	15	reviewed by the QA committee.		

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED . 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245234	B. WING		06/	09/2016	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SA	AMARITAN SOCIETY	- WACONIA AND WESTVIEW AC	RE	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(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 31	5			
		AND HUMAN SERV & MEDICAID SERV		F5.	234025	FORM	06/17/2016 APPROVED 0.0938-0391
--------------------------	--	---	--	---------------------	--	----------------------	---------------------------------------
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM	R/CLIA	1 Y	DLE CONSTRUCTION	(X3) DATE S COMPL	URVEY
		245234		B. WING		06/0	7/2016
	ROVIDER OR SUPPLIER						
GOODS	AMARITAN SOCIE	FY - WACONIA AND		TH STREE			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE F BE PRECEDED BY FULL I INTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMEN	rs		K 000			
	Minnesota Departm Fire Marshal Divisio time of this survey, Waconia was found compliance with the in Medicare/Medica 483.70(a), Life Safe edition of National I (NFPA) 101, Life Safe edition of National I (NFPA) 101, Life Safe Existing Health Car Good Samaritan Se constructed as follo The original buildin three-stories in heig fire sprinkler protect of Type II(111) cons The 2015 addition no basement, is ful was determined to The facility has a fil detection in the cor corridors which is r department notifica capacity of 96 beds time of the survey.	ociety Waconia was bws: g was constructed in ght, has no basemer sted and was determ struction; is three stories in hei ly fire sprinkler prote be of Type II(111) co re alarm system with ridors and spaces of nonitored for automa ation. The facility has s and had a census of	State At the ciety articipation art 2000 ciation chapter 19 1979, is at, is fully ined to be ght, has cted and nstruction. smoke ben to the atic fire a of 80 at				
LABORATO	RY DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRES	ENTATIVE'S SIG	SNATURE	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.

	MENT OF HEALTH			1	F5234025	FORM	06/17/2016 APPROVED 0.0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		1 '	PLE CONSTRUCTION	(X3) DATE S COMPLE	
		245234		B. WING		06/0	7/2016
GOODS	AMARITAN SOCIET	Y - WACONIA AND		IA, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST	ATEMENT OF DEFICIENCIE BE PRECEDED BY FULL I NTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
K 000	INITIAL COMMENT	ſS		K 000			
LABORATO	Building 2 is a 3-sto partial basement ar medical facility built to be of Type II (111 fully sprinkled prote has a fire alarm sys resident rooms, cor corridors that is mo department notifica building was not oc survey. In April 20 remodeled 14 beds core areas on these station and related commons/dining ar	eas, an Oxygen Roc en with a Denlar hoc	with a o the termined ouilding is e facility ection in open to the c fire the ave been he center e nurse om, and a od on each	NATURE	TITLE		(X6) DATE
LABORATO	INT DIRECTOR'S OR PROV	UDER/SUPPLIER REPRES	INTATIVE'S SIG	NATURE			

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 provide. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.



Protecting, Maintaining and Improving the Health of 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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. 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

An equal opportunity employer

Good Samaritan Society - Waconia And Westview Acre June 24, 2016 Page 2

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,

Kumala Fiske Downing

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

Minnesc	ta Department of He	alth					IT NOVED
	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPP IDENTIFICATION				(X3) DATE COMP	SURVEY LETED
		00924		B. WING		06/0	9/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- WACONIA AND		STREET W			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIEN MUST BE PRECEDED SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Initial Comments			2 000			
	****ATTEI	NTION*****					
	NH LICENSING	CORRECTION O	RDER				
	In accordance with 144A.10, this correct pursuant to a surve found that the defic herein are not correct not corrected shall with a schedule of f the Minnesota Depa Determination of will corrected requires of requirements of the number and MN Ru When a rule contain comply with any of lack of compliance. re-inspection with a result in the assess that was violated du corrected.	ction order has be y. If, upon reinspe- iency or deficienci ected, a fine for ea- be assessed in ac- ines promulgated artment of Health. nether a violation h compliance with a rule provided at t ile number indicat ns several items, f the items will be c Lack of compliar ment of a fine ever	en issued ection, it is es cited ch violation cordance by rule of has been ll he tag ed below. ailure to onsidered nce upon art rule will en if the item				
	You may request a that may result from orders provided tha the Department with notice of assessme	n non-compliance t a written request hin 15 days of reco	with these t is made to eipt of a				
	INITIAL COMMENT You have agreed to receipt of State lice the Minnesota Depa Informational Bullet http://www.health.st obul.htm The Stat delineated on the a	participate in the nsure orders cons artment of Health in 14-01, available tate.mn.us/divs/fp e licensing orders	sistent with e at c/profinfo/inf are				
ABORATOR	epartment of Health Y DIRECTOR'S OR PROVIE ically Signed	DER/SUPPLIER REPRES	SENTATIVE'S SIG	NATURE	TITLE		(X6) DATE 07/01/16

Electronically Signed

STATE FORM

If continuation sheet 1 of 29

	It OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00924	_		06/	09/2016
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			05/2010
GOOD S	AMARITAN SOCIETY		H STREET WE IA, MN 55387	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 000	Continued From pa	age 1	2 000			
	you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro completion date, th	Alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rrected" in the box available for n indicate in the electronic cess, under the heading le date your orders will be electronically submitting to the nent of Health.				
	Department's staff, the following correct Please indicate in y correction that you	June 9, 2016 surveyors of this visited the above provider and ction orders are issued. your electronic plan of have reviewed these orders, the when they will be completed	k			
	the State Licensing federal software. Ta	nent of Health is documenting correction Orders using ag numbers have been sota state statutes/rules for omes.				
	column entitled "IC statute/rule out of o "Summary Stateme and replaces the "T correction order. TI findings which are after the statement evidence by." Follo	number appears in the far left D Prefix Tag." The state compliance is listed in the ent of Deficiencies" column To Comply" portion of the his column also includes the in violation of the state statute c, "This Rule is not met as wing the surveyors findings Method of Correction and rrection.				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	ARD THE HEADING OF THE N WHICH STATES, AN OF CORRECTION." THIS ERAL DEFICIENCIES ONLY. IR ON EACH PAGE.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	X3) DATE SURVEY COMPLETED
		00924	B. WING		06/09/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- WACONIA AND	H STREET W A, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET
2 000	Continued From pa	ge 2	2 000		
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.			
2 560	MN Rule 4658.0409 Plan of Care; Conte	5 Subp. 2 Comprehensive ents	2 560		7/1/16
	comprehensive plat objectives and time long- and short-tern and mental and psy identified in the com assessment. The c must include the inc	of plan of care. The n of care must list measurable tables to meet the resident's n goals for medical, nursing, rchosocial needs that are nprehensive resident comprehensive plan of care dividual abuse prevention plan ota Statutes, section 626.557, agraph (b).			
	by: Based on observati review, the facility fa interventions to rest residents (R56) rev In addition, the facil interventions to pre-	vent new or worsening 1 of 2 residents (R56)		Acknowledged	
	Findings include:				
	5/4/16, indicated he required extensive transfers and toiletii incontinent of bladd toileting plan had no	num data set (MDS) dated e was cognitively intact, assistance of two staff for ng, and was occasionally ler. The MDS indicated a trial of been attempted for R56. A d 4/7/16, indicated R56 was			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00924	B. WING	B. WING		06/09/2016	
AME OF F	PROVIDER OR SUPPLIEF	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE			
OOD S	AMARITAN SOCIET		H STREET WE IA, MN 55387	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE	
2 560	Continued From p	age 3	2 560				
	assessment dated incontinent of blad impairment and in program to manage Recommendations included, "none at toileting program." R56's care plan da required assistance mechanical lift for updated on 6/8/16	s based on the assessment this time, continue current ated 9/24/15, indicated he ee from two staff and a transfers. The care plan was , following inquiry by surveyor,					
	care plan did not a even though he ha continent to occas On 6/8/16, at 7:27 table in a standard was escorted to hi remained until 10:	with assist of two staff. The address a toileting plan for R56 ad a decline from being ional incontinence. a.m., R56 was at the breakfas wheel chair. At 8:26 a.m., R56 s room by staff where he 06 a.m. when he left the facility	3				
	(NA)-B stated R56 void. She stated h	9 a.m., nursing assistant was on dialysis and did not e would request the commode ve a bowel movement.					
		2 a.m., NA-A stated R56 was er and did not void due to					
	stated R56 had en received dialysis b stated she was no level of urinary con should have been	5 p.m., registered nurse (RN)-A ad stage renal disease and out did void. Additionally, RN-A t aware he had a change in his ntinence. RN-A stated he re-assessed following that ted R56 was not on a toileting					

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED	
		00924	B. WING		06/	06/09/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- ΨΔΩΟΝΙΔ ΔΝΠ	H STREET WE A, MN 55387	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 560	Continued From pa	ge 4	2 560				
	of bladder but state stated he should be	lan indicated he was continent d, "that is incorrect." She e toileted upon rising, after fore bed as that was the ractice.					
	5/4/16, indicated he identified on 4/20/10 R56 was cognitively and required extens bed mobility, transfe dated 3/23/16, iden directed staff to turn hours while in bed a The care plan did n	hum data set (MDS) dated e had a stage II pressure ulcer 6. The MDS further indicated y intact, incontinent of bladder, sive assistance of two staff for ers and toileting. His care plan tified a skin impairment and n and reposition R56 every 2-3 and provide an air mattress. ot address repositioning or 56 was up in his wheel chair.					
	a.m., R56 was sittir room in a standard sling was undernea mid thighs. In his w cushion. At 8:26 a.r R56 to his room wh reading a magazine to sit in his wheel cl left to go to an appo R56 had not been r thirty nine minutes p vehicle where he w						
	R56 had an open a Licensed practical r wound and stated "	ion on 6/9/16, at 7:38 a.m., rea to the right of his coccyx. hurse (LPN)-A described the I would call the wound a stage there are some open areas."					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			-			
		00924	B. WING		06/	09/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
OOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	:51		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE
2 560	Continued From pa	age 5	2 560			
	stated R56 had a w developed on 4/26/ pressure I would th based on R56's ski and repositioned ev should have been r and going out for h the mechanical lift underneath him in On 6/9/16, at 10:38 stated the nurse m wounds on the unit	5 p.m., registered nurse (RN)-A vound on his coccyx that (16. RN-A stated "that would be ink." RN-A further stated in issues he should be turned very two to three hours and he repositioned between breakfas is dialysis. She further stated sling should be removed form the chair. B a.m., the director of nursing anager was responsible for the stated he would expect to the care plan related to	t			
	Care Plan, dated 9 would have an indir of care directed tow optimal needs. The evaluate and updat quarterly and with a	d Good Samaritan Society /12, indicated each resident vidualized comprehensive plan vard maintaining the residents e policy directed staff to te the care plan at least a change in the residents the care currently required for				
	director of nursing develop policies an of care are approprimanner. The DON staff on this proces	THOD OF CORRECTION: The (DON) or his designee could of procedures to ensure plans riately updated in a timely could educate all appropriate s. The DON or designee could systems to ensure ongoing				
	TIME PERIOD FO (21) days.	R CORRECTION: Twenty-one				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION (X3)	DATE SURVEY COMPLETED
		00924	B. WING		06/09/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		"H STREET V IA, MN 5538"		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	(X5) COMPLET DATE
2 565	Continued From pa	ge 6	2 565		
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565		7/1/16
		omprehensive plan of care personnel involved in the			
	by: Based on observati review, the facility fa interventions for 1 c dependent on staff facility failed to prov	ent is not met as evidenced on, interview and document ailed to provide care planned of 3 residents (R122) who was for grooming. In addition the vide care planned interventions (R37) who was dependent on		Acknowledged	
	Findings include:				
	dated 3/9/16, indica cognitively impaired	ninimum data set (MDS) ated she was severely and required extensive ssing and grooming.			
	care deficit related	ated 3/9/16, identified a self to impaired functioning and sist with personal hygiene.			
		a.m., R122 was observed to on her chin approximately 1/4			
	breakfast table in th several hairs appro protruding from the	a.m., R122 was sitting at the ne dining room. She had ximately 1/8th inch in length left side of her chin and ng hairs on the right side of her			

STATEMEN	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00924	B. WING		06/	06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 565	Continued From pa	ge 7	2 565				
	chin.						
	stated on bath day	a.m., nursing assistant (NA)-A the nursing assistants were ving female residents.					
	stated if staff notice	a.m., registered nurse (RN)-A ed a female resident with facial posed to take care of it.					
	(DON) stated if stat	a.m., the director of nursing f noticed facial hair on a y should offer to shave it.					
	4/13/16, indicated h impaired and requir A care area assess identified the need and nectar thickene problems that affect vision problems, im	imum data set (MDS) dated ne was severely cognitively red physical assistance to eat. ment (CAA) dated 11/2/15, for a mechanically altered diet ed liquids as well as functional ted his ability to eat including, paired range of motion and al assistance to perform ing.					
	care deficit and dire and supervision wit	ed 4/8/16, identified a self ected staff to provide set up h meals. The care plan further vide limited to extensive assist erved not eating.					
	at a table in the din (NA)-D was standir 4:56 p.m., she walk and stood feeding h Another staff memb to assist another re across from the staff	b.m., R37 was observed sitting ing room. Nursing assistant ing at the table feeding him. At ed over to another resident her. NA-D then left the table. ber sat at the table and began sident. R37 was seated ff member eating his cake 5:05 p.m., NA-D gave R37 his					

	IT OF DEFICIENCIES OF CORRECTION	Ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00924	B. WING		06/	06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- ΨΑΩΟΝΙΑ ΑΝΠ	H STREET WE A, MN 55387	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 565	Continued From pa	age 8	2 565				
	not eaten any more returned to assist h down next to R37. more to eat. R37 st bite and left the tab than 25% of his foc offer him any more of his meal was un-						
	sandwich and a bo food in front of him the table holding a cup on the table an with his left hand. H top piece of bread. his sandwich and d p.m., R37's sandwi had not eaten any o table but did not as 12:17 p.m., NA-F g	I p.m., R37 was brought a cold wl of soup. Staff placed the and walked away. R37 sat at cup. At 12:11 p.m., he put his id reached for his sandwich He was able to grab only the He picked up the other half of fropped it in his lap. At 12:15 ich remained on his lap. He of his soup. NA-F sat at the esist R37 with his meal. At pot up and left the table. R37 e his sandwich from his lap and s left untouched.					
	R37 could feed him needed help. She s foods on his own. N	7 p.m., NA-E stated sometimes nself and sometimes he stated he was able to eat finger NA-E stated whoever was should assist him if they eating.					
	R37 had his sandw but otherwise did n did not offer him as asked to see if she	9 p.m., NA-F stated she saw vich in his hand during lunch ot look at him. She stated she ssistance because she was could get the other resident at A-F stated R37's level of ad on the day.					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
		00924	B. WING	B. WING		
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ΨΔΩΟΝΙΔ ΔΝΠ	H STREET WE A, MN 55387	EST		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 565	Continued From pa	age 9	2 565			
	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.					
	(DON) stated he ha	a.m., the director of nursing ad noticed that morning that hold of food and grab things				
	Activities of Daily L residents who are u daily living will rece maintain grooming policy directed staff	d Good Samaritan Society iving, dated 9/12, indicated unable to carry out activities of ive the necessary services to and personal hygiene. The f to provide hair care, shaving, eup and skin and nail care as n of care.				
	director of nursing develop systems to followed. The DON staff on how to follo or his designee cou	THOD OF CORRECTION: The (DON) or his designee could o ensure care plans are could educate all appropriate ow the plan of care. The DON uld develop monitoring ongoing compliance.				
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one				
2 900	MN Rule 4658.052 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			7/1/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the nursing care plan which				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY PLETED
		00924	B. WING		06/09/2016	
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET V A, MN 5538			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	ige 10	2 900			
	without pressure s pressure sores unle condition demonstr authenticates, that B. a resident w receives necessar promote healing, pr new sores from dev					
	by: Based on observati review, the facility f assistance with rep worsening pressure	ent is not met as evidenced ion, interview, and document ailed to provide timely ositioning to prevent e ulcer development for 1 of 2 riewed for pressure ulcers.		Acknowledged		
	Findings include:					
	5/4/16, indicated he identified on 4/20/1 R56 was cognitively and required extensibed mobility, transf dated 3/23/16, iden directed staff to turn hours while in bed a The care plan did n	num data set (MDS) dated e had a stage II pressure ulcer 6. The MDS further indicated y intact, incontinent of bladder, sive assistance of two staff for ers and toileting. His care plan tified a skin impairment and n and reposition R56 every 2-3 and provide an air mattress. tot address repositioning or 56 was up in his wheel chair.				
	a.m., R56 was sittir room in a standard sling was undernea mid thighs. In his w	observation on 6/8/16, at 7:27 ng at the table in the dining wheel chair. A mechanical lift ath R56 from his shoulders to theel chair was a blue foam m., a staff member escorted				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00924	B. WING		06/	09/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	EST		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
2 900	Continued From pa	age 11	2 900			
	reading a magazine to sit in his wheel c left to go to an apport R56 had not been in thirty nine minutes vehicle where he w wheelchair without and would not return approximately 4 mo	ore hours.				
	R56 had an open a The surrounding tis two other areas tha Licensed practical i wound and stated " one to two because A review of a Good Data Collection too had a wound on his pinpoint areas of pr further described a was open from layin not include measure Good Samaritan So tool dated 4/25/16, have a wound on h include measure description of the w Society Wound Dat 4/28/16, identified t include measure wound. A Good San Collection tool date on R56's coccyx. N	tion on 6/9/16, at 7:38 a.m., area to the right of his coccyx. asue was reddened and he had at appeared to be healing. nurse (LPN)-A described the 'I would call the wound a stage there are some open areas." Samaritan Society Wound at dated 4/20/16, indicated R56 s coccyx described as "small ressure." The wound was s a small area on coccyx that ng on his bottom. The tool did rements of R56's wound. A ociety Wound Data Collection indicated R56 continued to is coccyx. The tool did not ents, nor was there any wound. A Good Samaritan ta Collection tool dated the coccyx wound but did not ents or description of the maritan Society Wound Data ed 5/16/16, identified a wound to measurement or description provided. A Good Samaritan				
	Society Wound Dat 5/22/16, indicated a	ta Collection tool dated a wound on the coccyx. No escription of the wound was				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00924	B. WING		06/	06/09/2016	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST			
(X4) ID	SUMMARY STA		A, MIN 55567	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	i i	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE	
2 900	Continued From pa	age 12	2 900				
	Collection tool date continued to have a description or meas provided. A data co- identified the coccy centimeter (cm) x 0 wound bed was 100 (Regeneration of ep- surface). A Good S Assessment dated wound as a pressu was 100% epithelia decreased in size. provided. On 6/3/16 tool identified the w measurement or de 6/6/16, a Wound da coccyx wound mea- increase in size fro No further descripti On 6/8/16, at 10:09 (NA)-B stated R56 transfers. She state every two hours wh stated R56 "did not stated he left to go On 6/8/16, at 11:42 around 7:00 a.m. o She stated he would be repositioned, "so On 6/8/16, at 12:45 stated R56 had a w developed on 4/26/ pressure I would th	Samaritan Society Wound Data ad 5/25/16, indicated R56 a wound on his coccyx. No surement of the wound was ollection tool dated 5/31/16, ix wound measuring 1 0.5 cm and indicated the 0% epithelialized tissue pidermis across a wound amaritan Society Wound RN 6/1/16, identified R56's coccyx re ulcer, indicated the wound alized tissue and had No measurement was 5, a Wound data Collection round on the coccyx. No escription was included. On ata Collection tool identified a usuring 1 cm x 0.9 cm, an im the previous measurement. fon of the wound was included. 0 a.m., nursing assistant required a mechanical lift for ed he should be repositioned hen he is in his chair. NA-B is get repositioned today" and to dialysis. c a.m., NA-A stated R56 got up in the days he went to dialysis. Id usually ask if he wanted to be we do not ask him." 5 p.m., registered nurse (RN)-A round on his coccyx that (16. RN-A stated "that would be ink." RN-A stated she was and rounds on the unit but had					

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:		(X3) DATE SU COMPLE	
		00924	- B. WING		06/09/2016	
	PROVIDER OR SUPPLIER		DRESS, CITY, S			2010
		333 FIFT	H STREET WE			
GOOD S	AMARITAN SOCIETY	- WACONIA AND WACONI	A, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 900	Continued From pa	age 13	2 900			
	tool and the register do a weekly assess based on R56's ski and repositioned ev should have been r and going out for hi the mechanical lift underneath him in t During a subseque a.m., registered nu never seen the would stated the wound a completed on the p described as a stag 1 cm x 0.9 cm. RN- designated person facility.	nt interview on 6/9/16, at 10:24 rse (RN)-A stated she had und on R56's coccyx. She issessment had been previous evening and was ge II pressure ulcer measuring -A stated there was no managing wounds for the				
	stated the nurse ma wounds on the unit see interventions in pressure, weekly m	B a.m., the director of nursing anager was responsible for . He stated he would expect to the care plan related to neasurements and a weekly eted by a registered nurse.				
	Ulcers, dated 9/12, policy titled Good S Pressure Ulcer Pre Requirements, date staff to systematica	Samaritan Society, Pressure was reviewed along with a samaritan Society Procedure, evention and Documentation ed 9/12. The policies directed ally assess residents with				
	techniques and pre for residents at risk policy further indica pressure ulcer wou	kdown and use prevention essure redistributing surfaces a for pressure ulcers. The ated a resident who had a ald receive the necessary ices to promote healing and				
	prevent new ulcers	from developing. If a entified, the policies directed				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00924	B. WING		06/	06/09/2016	
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 900	Continued From pa	ige 14	2 900				
	staff to assess the Wound RN Assess	area at least weekly on the ment.					
	director of nursing of develop systems to appropriately treate possible. The DON staff on pressure up The DON could dev	THOD OF CORRECTION: The (DON) or his designee could be ensure pressure ulcers are and prevented to the extent could educate all appropriate leer treatment and prevention. velop monitoring systems to mpliance with pressure ulcer ention.					
2 910	(21) days.	R CORRECTION: Twenty-one 5 Subp. 5 A.B Rehab -	2 910			7/1/16	
	Incontinence Subp. 5. Incontinent have a continuous management to rec unnecessary use of comprehensive res home must ensure A. a resident w without an indwellin unless the resident that catheterization B. a resident wh receives appropriat prevent urinary trace	nce. A nursing home must program of bowel and bladder duce incontinence and the f catheters. Based on the ident assessment, a nursing					
	This MN Requirem by:	ent is not met as evidenced					

	ta Department of He					APPROVED
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE COMP	LETED
		00924	B. WING		- 06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		I STREET W A, MN 55387			
(X4) ID		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO		(X5) COMPLETE
PREFIX TAG	i i	SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)		DATE
2 910	Continued From pa	ge 15	2 910			
	review, the facility fa assess a decline in implement intervent bladder function for reviewed for urinary Findings include: R56's 14 day minim 5/4/16, indicated he required extensive a transfers and toiletii incontinent of bladd toileting plan had no	num data set (MDS) dated e was cognitively intact, assistance of two staff for ng, and was occasionally ler. The MDS indicated a trial ot been attempted for R56. A d 4/7/16, indicated R56 was		Acknowledged		
	assessment dated incontinent of bladd impairment and ind program to manage Recommendations	9/29/15, indicated R56 was ler due to functional icated a check and change				
	required assistance mechanical lift for tr updated on 6/8/16, to include toileting v care plan did not ac	ed 9/24/15, indicated he e from two staff and a ransfers. The care plan was following inquiry by surveyor, with assist of two staff. The ddress a toileting plan for R56 d a decline from being onal incontinence.				
	table in a standard was escorted to his	a.m., R56 was at the breakfast wheel chair. At 8:26 a.m., R56 room by staff where he 6 a.m. when he left the facility				

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED	
		00924	B. WING		06/	06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- ΨΔΩΟΝΙΔ ΔΝΠ	H STREET WE A, MN 55387	EST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
2 910	Continued From pa	age 16	2 910				
	(NA)-B stated R56 void. She stated he	a.m., nursing assistant was on dialysis and did not would request the commode ve a bowel movement.					
		a.m., NA-A stated R56 was and did not void due to					
	stated R56 had end received dialysis bu stated she was not level of urinary con should have been i change. RN-A state plan and his care p of bladder but state stated he should bu	5 p.m., registered nurse (RN)-A d stage renal disease and ut did void. Additionally, RN-A aware he had a change in his tinence. RN-A stated he re-assessed following that ed R56 was not on a toileting lan indicated he was continent ed, "that is incorrect." She e toileted upon rising, after efore bed as that was the practice.					
	(DON) stated he ware residents to be toile	p.m., the director of nursing ould expect incontinent eted upon rising, before and time and as needed.					
	no evidence the fac determine a pattern	hange in continence, there was cility re-assessed the decline to n, nor were interventions t with restoring as much possible for R56.					
	Bladder Assessme dated 9/12 indicate bladder incontinent treatment and serv normal bowel and I	I Samaritan Society Bowel and nt Evaluation and Retraining, d each resident with bowel or ce would receive appropriate ices to restore as much bladder functioning as y further indicated when a					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00924	B. WING		06/09/2016	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		'H STREET W IA, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE	(X5) COMPLET DATE
2 910	decline in functionir would be re-evaluat SUGGESTED MET director of nursing ( develop systems to individually address DON could educate importance of indivi incontinence. The E systems to ensure of TIME PERIOD FOR	ng occurred, the resident				
2 920	Subp. 6. Activities comprehensive res home must ensure B. a resident who activities of daily live	is unable to carry out ing receives the necessary n good nutrition, grooming,	2 920			7/1/16
	by: Based on observati review, the facility fa of 4 residents (R12 was unable to indep addition, the facility during meals for 1 d	ent is not met as evidenced on, interview and document ailed to provide grooming for 1 22) reviewed for ADL's who bendently groom herself. In failed to provide assistance of 4 residents (R37) reviewed v living, who required ing.		Acknowledged		
	Findings include:					

7PAM11

If continuation sheet 18 of 29

	ta Department of He T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00924	B. WING		06/	09/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
2 920	Continued From pa	age 18	2 920			
	dated 3/9/16, indica cognitively impaired assistance with dre plan dated 3/9/16, i related to impaired to assist with perso On 6/7/16, at 12:52	minimum data set (MDS) ated she was severely d and required extensive essing and grooming. Her care identified a self care deficit functioning and directed staff onal hygiene. 2 a.m., R122 was observed to on her chin approximately 1/4				
	breakfast table in the several hairs approprotruding from the	a.m., R122 was sitting at the he dining room. She had oximately 1/8th inch in length e left side of her chin and ng hairs on the right side of her				
		a.m., R122 stroked her chin d like to get rid of them." "It ."				
	stated on bath day responsible for sha stated if a resident offer to shave. NA- not provide razors supply their own. S	a.m., nursing assistant (NA)-A the nursing assistants were aving female residents. She was unable to request, they A further stated the facility did and residents needed to the stated she was aware of who refused shaving and R 122 ant.	2			
	stated if staff notice hair they were supp	3 a.m., registered nurse (RN)-A ed a female resident with facia posed to take care of it. RN-A acility did not provide razors for asons.				
	On 6/9/16, at 10:44	a.m., the director of nursing				

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00924	B. WING	B. WING		06/09/2016	
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	EST			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
2 920	Continued From pa	age 19	2 920				
	female resident the	ff noticed facial hair on a by should offer to shave it. He id not provide razors but family d to bring one in.					
	4/13/16, indicated h impaired and required A care area assess identified the need and nectar thicken problems that affect vision problems, im the need for physic activities of daily liv 4/8/16, identified a staff to provide set meals. The care pla	nimum data set (MDS) dated ne was severely cognitively red physical assistance to eat. sment (CAA) dated 11/2/15, for a mechanically altered diet ed liquids as well as functional cted his ability to eat including, npaired range of motion and ral assistance to perform ring. R37's care plan dated self care deficit and directed up and supervision with an further directed staff to xtensive assist when R37 was g.					
	at a table in the din (NA)-D was standir 4:56 p.m., she walk and stood feeding I Another staff mem to assist another re across from the sta with his fingers. At spoon and walked table and sat, not e not eaten any more returned to assist h down next to R37. more to eat. R37 st	p.m., R37 was observed sitting ing room. Nursing assistant ng at the table feeding him. At ked over to another resident her. NA-D then left the table. ber sat at the table and began esident. R37 was seated aff member eating his cake 5:05 p.m., NA-D gave R37 his away. He put the spoon on the eating. At 5:16 p.m., he still had of his food and staff had not him. At 5:25 p.m., NA-C sat She asked if he would like tated yes. NA-C fed R37 one					
	than 25% of his foo	ble. R37 had consumed less and staff did not return to assistance or food. The rest eaten.					

STATEMEN	Ita Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00924	B. WING		06/	09/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, S	TATE, ZIP CODE		
		333 FIFT	H STREET WE			
GOOD S	AMARITAN SOCIETY		A, MN 55387			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	i.	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO		COMPLET DATE
IAG			ind	DEFICIENC		
2 920	Continued From pa	age 20	2 920			
2 520	Continued From pa		2 320			
		p.m., R37 was brought a cold				
		wl of soup. Staff placed the				
		and walked away. R37 sat at cup. At 12:11 p.m., he put his				
		id reached for his sandwich				
		le was able to grab only the				
		He picked up the other half of				
		lropped it in his lap. At 12:15				
		ch remained on his lap. He				
		of his soup. NA-F sat at the				
		sist R37 with his meal. At				
		ot up and left the table. R37				
		his sandwich from his lap and	i			
	ate it. His soup was					
	0 0/0/40 1.40.07					
		' p.m., NA-E stated sometimes				
		self and sometimes he				
		stated he was able to eat finger				
		should assist him if they				
	noticed he was not					
		cating.				
	On 6/8/16, at 12:29	p.m., NA-F stated she saw				
		rich in his hand during lunch				
		ot look at him. She stated she				
	did not offer him as	sistance because she was				
	asked to see if she	could get the other resident at				
		-F stated R37's level of				
	assistance depende	ed on the day.				
	$O_{\rm m}  C/0/10$ at 10.00	n m. registered surge (DN)				
		p.m., registered nurse (RN)-B	'			
		assistance for R37 varied. She on his mood. She stated				
		for assistance "might be too				
		stated there was staff that				
		eals, but they can't feed him				
		s. RN-B stated she was				
		essing R37's ability to eat and				
		if an aide stated he was having				
	epartment of Health		<b>/</b> II			1

	ta Department of He TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00924	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 920	Continued From pa	ge 21	2 920			
	trouble chewing or overseeing what he	swallowing, but staff should be e is doing.				
	(DON) stated he kr was behind they we dining room. He st morning that R37 w grab things on his c resident dining asse	a.m., the director of nursing new R37 well and when staff buld call him to assist in the ated he had noticed that yould not take hold of food and own. The DON stated a essment should be completed ssion, quarterly, annually, and				
	Activities of Daily Li residents who were of daily living would services to maintain hygiene. The policy care, shaving, appli	d Good Samaritan Society iving, dated 9/12, indicated e unable to carry out activities receive the necessary n grooming and personal directed staff to provide hair ication of makeup and skin ell as nourishment and				
	Resident Choice Di residents would rec members in a digni	d Good Samaritan Society ining dated 2/13, indicated ceive assistance from staff fied manner including sitting istance rather than standing.				
	director of nursing of systems to ensure appropriate level of DON could educate systems. The DON	HOD OF CORRECTION: The or his designee could develop residents receive the assistance with ADL's. The all appropriate staff on these could develop monitoring ongoing compliance.				
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X	(3) DATE SURVEY COMPLETED
		00924	B. WING		06/09/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		H STREET W A, MN 55387		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
21805	Continued From pa	ge 22	21805		
21805	MN St. Statute 144 Residents of HC Fa	.651 Subd. 5 Patients & ac.Bill of Rights	21805		7/1/16
	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.				
	by: Based on observati review the facility fa dining experience for reviewed for activiti provide grooming to residents (R122) re the facility failed to routines in a dignifie R92, R97) residents impaired and require	ent is not met as evidenced on, interview and document illed to provide a dignified or 1 of 4 residents (R96) es of daily living and failed to o enhance the dignity of 1 of 1 viewed for dignity. In addition, provide rising and morning ed manner for 3 of 3 (R21, s who were cognitively red extensive assistance to of daily living (ADLs).		Acknowledged	
	3/9/16 indicated she impaired, required p personal hygiene at assistance to eat. A dated 1/7/16, indica assistance, a mech occasional extensiv dining. R96's care p self care deficit and	imum data set (MDS) dated e was severely cognitively ohysical assistance for nd required physical care area assessment (CAA) anically altered diet, and re assistance needed for olan dated 5/16/13, indicated a I directed staff to cue resident poon when observed eating ovide a napkin clip.			

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00924	B. WING		06/	09/2016
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		H STREET WE IA, MN 55387	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ige 23	21805			
	table in the dining r wheel chair was red degrees. She was a and cubed carrots of present at the table fingers and had ribs She was not wearin p.m., R96 continue independently with food onto her chest her cake with her h 5:22 p.m., nursing a R96 at the table an had already consur walked away and d assistance. R96 co fingers. She had a carrots and cake do her dress.	her fingers, dropping more t. At 5:08 p.m., she picked up ands and began eating it. At assistant (NA)-C stood next to d offered R96 a spoon, R96 ned 60% of her meal. NA-C id not return or offer ontinued to eat with her large amount of barbeque ribs own the front of her chest and				
	registered nurse (F assistance varied of sometimes R96 wo times she would ea "for dignity" staff sh with her fingers. RN give her things that	on 6/9/16, at 8:57 a.m., N)-A stated R96's level of luring meals. She stated ould eat with a spoon and othe at with her fingers. RN-A stated ould intervene if R96 is eating N-A stated staff attempted to are easier to eat and stated egetables end up on the floor.	ł			
	director of nursing set up with meals a she would often tak	on 6/9/16, at 10:52 a.m., The (DON) stated R96 required and when staff assisted her, we over with her hands. He pect staff to re-organize and he was eating.				
	R122's Admission r	minimum data set (MDS)				

				(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED
		00924	B. WING		06/	09/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- ΨΔΩΟΝΙΔ ΔΝΠ	H STREET WE A, MN 55387	EST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN(	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 24	21805			
	cognitively impaired assistance with dre plan dated 3/9/16, i related to impaired to assist with perso On 6/7/16, at 12:52 have several hairs of to 1/2 inch long. On 6/8/16, at 8:05 a breakfast table in th several hairs appro protruding from the	ated she was severely d and required extensive ssing and grooming. Her care ndicated a self care deficit functioning and directed staff nal hygiene. p.m., R122 was observed to on her chin approximately 1/4 a.m., R122 was sitting at the he dining room. She had ximately 1/8th inch in length left side of her chin and ig hairs on the right side of her				
	and stated, "I have whiskers, that's not	a.m., R122 stroked her chin been saving my chin for a lady." She further to get rid of them." "It would				
	stated on bath day responsible for che shaving female resi was unable to requi stated she was awa	a.m., nursing assistant (NA)-A the nursing assistants were cking skin, toenails and idents. She stated if a resident est, they offer to shave. She are of only one resident who d R122 was not that resident.				
	stated if staff notice	a.m., registered nurse (RN)-A ed a female resident with facial posed to take care of it.				
	(DON) stated if staf	a.m., the director of nursing f noticed facial hair on a y should offer to shave it.				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
		00924	B. WING		06/	09/2016
IAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	ge 25	21805			
	Samaritan Society I indicated the facility manner that mainta including grooming groomed. The polic residents dignity in practices demeanin A facility policy titled Resident Choice Di residents would rec members in a digni while giving assista R21's medical reco R21 had a diagnosi minimum data set ( dated 3/16/16, iden impaired. The MDS totally dependent up required extensive toileting and bed me identified R21 requi mechanical lift for a R92 had a diagnosi assessment dated "rarely/never under assistance of two s transfers, toileting a R97 had a diagnosi MDS assessment of was severely cognit further identified R2 assistance from sta	d Good Samaritan Society ning dated 2/13, indicated reive assistance from staff fied manner including sitting nce rather than standing. rd was reviewed and revealed is of Alzheimer's disease. A MDS) annual assessment tified R21 was cognitively of urther identified R21 was pon staff for transfers and assistance of two staff for obility. R21's 1/17/13, careplan ired assistance of 2 staff and a ull transfers. is of dementia. An MDS 4/6/16, indicated R92 was stood". Further, R92 required taff and a mechanical lift for and bed mobility. is of dementia. A quarterly dated 2/24/16, identified R97 tively impaired. The MDS 07 required extensive off for transfers, toileting and careplan dated 5/30/14,				

		ealth (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00924	B. WING		06/	09/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21805	Continued From pa	age 26	21805			
	bed mobility.					
	and pink jacket and observed undernea calling out from her entered the room to morning cares were nursing assistants mechanical lift sling positioned R21 in to	21 was dressed in a pink top d a mechanical lift sling was ath R21. At 7:22 a.m R21 was r bed. Two nursing assistants o assist R21 out of bed. No e provided to R21. The two (NA-G, NA-H) hooked up the g to the mechanical lift and o her wheelchair. NA-G then 1's hair and provided R21 her				
	and indicated she of and put R21 back i her to get up. NA-G night shift and the r residents they need the night shift "gets the 5 residents mus require full assistar because the unit ha indicated she got th ready to go" and th later in the morning other "lift" resident R97. NA-G indicated	ved on 6/8/16, at 7:32 a.m. dressed R21 around 6:00 a.m. nto bed as it was too early for à indicated she worked the night shift had a list of ded to get up. NA-G indicated up" 5 residents and that 2 of st be "lift" residents (those that nee with a mechanical lift) ad "so many lifts". NA-G ne "lift" residents "dressed and en put them back in bed until y. NA-G further indicated the she assisted this morning was ad it did not matter which teted in the morning but two of residents.				
	and R92 was obset dressed in a flower covering her and a observed to be place 8:24 a.m. R92 was	a.m. R92's room light was on rved to be sleeping in bed ed shirt. R92 had a blanket mechanical lift sling was ced underneath her in bed. At observed at the morning meal ered shirt and a gray sweater.				

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00924	B. WING		06/	09/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		H STREET WE A, MN 55387	ST		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	THE APPROPRIATE	COMPLET DATE
21805	Continued From pa	lge 27	21805			
	and R97 was obse	5 a.m. R97's room light was on rved sleeping in bed, dressed vered with a blanket.				
	indicated the night a residents each. NA up" some of the ea for us. NA-I indicate	ed on 6/9/16, at 7:59 a.m. and shift staff is to assist 3 -I stated the night shift "gets rly risers and try to do a "lift" ed R97 was a resident that s she required a mechanical lift nce.				
	6/9/16 at 12:19 p.n night shift staff was wanted to get up. R that residents were do and residents were do and residents were do and residents were they choose. RN-B expected to get up dependent so all th not on one shift. RN "keep it more fair" to further indicated sh	RN)-B was interviewed on n. and indicated the plan for to get up residents who RN-B stated it was important able to do what they want to ere encouraged to sleep in if stated night shift staff was a couple residents that are lift e lift dependent residents were N-B indicated that this was to between the shifts. RN-B ie expected lights to be shut off they were sleeping.				
	on 6/9/16, at 1:30 p cares at the facility unless a request by The DON indicated when they got up in indicated he was av residents night shift cares. He confirme to assist 2 to 3 lift d indicated he was no	rsing (DON) was interviewed o.m. and indicated morning did not begin until 6:00 a.m. a resident had been made. residents had a choice about the morning. The DON ware there was a list of t was to assist with morning d the night shift was expected lependent residents. The DON of aware how staff made the residents to assist in the				

			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		E SURVEY PLETED	
		00924	B. WING	B. WING		09/2016
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			00/2010
		333 FIFT	H STREET WE			
1000 5	AMARITAN SOCIETY	- WACONIA AND WACONI	A, MN 55387			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21805	Continued From pa	age 28	21805			
	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.					
	social service perso systems to ensure dignity and respect could educate all si dignity is maintaine designee could wo person on a monito compliance.	THOD OF CORRECTION: The on or designee could develop all residents are treated with . The social service person taff on ensuring resident ed. The administrator or rk with the social service oring system to ensure ongoing R CORRECTION: Twenty-one	1			