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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 9DHU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00078

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245523**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - CLEARBROOK**
(L4) **305 3RD AVENUE SOUTHWEST**
(L5) **CLEARBROOK, MN** (L6) **56634**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/13/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 04/15/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/15/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 04/22/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/26/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245523

April 15, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

Dear Mr. Hormann:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 25, 2015 the above facility is certified for or recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Telephone: (651) 201-4118 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
April 15, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

RE: Project Number S5523023

Dear Mr. Hormann:

On March 5, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 20, 2015. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 13, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 30, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 20, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 20, 2015, effective March 25, 2015 and therefore remedies outlined in our letter to you dated March 5, 2015, 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 related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5523s15

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245523	A. Building B. Wing	4/13/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/25/2015**
ID Prefix **F0311** Reg. # **483.25(a)(2)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/25/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **03/25/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/25/2015**	ID Prefix **F0520** Reg. # **483.75(o)(1)** LSC	Correction Completed **03/25/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	04/15/2015	28035	04/13/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/20/2015	

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245523	A. Building B. Wing 01 - 1953 BUILDING WITH ADDITIONS	3/30/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix Reg. # NFPA 101 LSC K0029	Correction Completed 03/25/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** PS/mm	**Date:** 04/15/2015	**Signature of Surveyor:** 27200	**Date:** 03/30/2015
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 2/19/2015		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9DHU

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00078

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245523**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - CLEARBROOK**
(L4) **305 3RD AVENUE SOUTHWEST**
(L5) **CLEARBROOK, MN** (L6) **56634**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/20/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)

13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Vienna Andresen, HFE NEII 03/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/25/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 03/26/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 5, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, MN 56634

RE: Project Number S5523023

Dear Mr. Hormann:

On February 20, 2015, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

Remedies - 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;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

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 April 1, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 1, 2015 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 20, 2015 (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 August 20, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

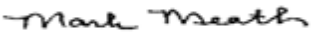
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice

Sincerely,



Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File 5523s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/20/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 248 SS=D	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure activity's had been offered according to the assessed need for 1 of 3 residents (R10) reviewed for activities. Findings include: R10's diagnosis report dated 2/20/15, indicated R10 was diagnosed with Alzheimer's disease, osteoarthrosis, dysphagia and depressive	F 248	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statements of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation,	3/25/15

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

Electronically Signed | 03/13/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/20/2015

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F 248	Continued From page 1 disorder. R10's annual Minimum Data Set (MDS) dated 7/4/14, indicated R10 had severely impaired cognition, required extensive assistance of two staff with transfers and locomotion on the unit. The MDS further indicated R10 felt the following activities of interest were very important to her: - listen to music - participating in favorite activities - participate in religious services or practice R10's comprehensive activities assessment completed 7/2/14, indicated R10 enjoyed the following activity interests: Children/youth, Entertainment, poetry, tending garden, 1:1 activities, music activities that involved old time and Christian music, movies, television shows that involved family type interaction such as Little House on the Prairie, beach ball toss, humor and conversing, clergy visits, devotions, worship services and sitting outdoors. R10's care plan dated as last revised on 1/13/15, indicated R10 was dependent on staff for activities, cognitive stimulation and social interaction. The care plan directed staff to provide R10 1:1 bedside/in-room activities if unable to attend out of room events as well as preferred activities such as conversation, music, prefers to stay in room, naps, children, outdoor and spiritual events. The care plan had not identified how often 1:1 activities were to be provided to R10 who preferred to stay in her room nor the frequency of the directive to encourage ongoing family involvement, invite residents and family to	F 248	this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. R10 was reassessed for her activity preferences and her ability to participate in activities. Also considered is her ability to tolerate extended periods of sitting. Care plan was updated and new plan of care was initiated. Ability to tolerate sitting too long was addressed by inviting to shorter activities and bringing her to her room if she says she needs to lay down. 2. All current residents Care Plans reviewed and updated as appropriate with activity preferences and abilities. 3. A system of staff notification sheets is being developed to inform staff of residents that prefer certain activities. Changes will be monitored for and updated Quarterly with MDS and prn by Activity Staff. a. There will be a notification sheet for each activity topic b. On each sheet will be the names of residents that prefer this activity Staff will be able to track resident preferences with these notification sheets and be able to invite to activities of their choice Staff educated on 3-10-15 and 3-11-15 to introduce new system of staff notification and documentation of resident refusals for activities. 4. Activity staff will audit this system by picking a different activity each day and check if residents with that preference are	

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F 248	Continued From page 2 attend special events, activities and meals. On 2/17/15, from 4:45 p.m. until 7:30 p.m. R10 was observed being assisted to eat the evening meal and assisted to bed at 7:23 p.m. R10 was not involved with any activities. On 2/18/15, at 9:30 a.m. R10 was observed seated in her room. No television or radio on. At 11:36 a.m. R10 was observed seated in the common corridor waiting to go into the dinning room for the noon meal. On 2/19/2015, at 8:44 a.m. R10 was observed in the dining room, eating breakfast. On 2/19/2015, at 9:34 a.m. R10 was observed seated in front of the television with other residents while the morning news show was on. R10 had her eyes closed and did not appear to be engaged in watching the television. On 2/19/2015, at 11:03 a.m. Church service was held and R10 was not assisted to the service / activity. On 2/19/2015, at 1:00 p.m. R10 was observed seated in the common lounge area just watching the people go by. 2/19/14, at 2:00 p.m. a monthly resident birthday party was held. However, R10 was not asked or	F 248	attending. Will do these 5 days a week for 2 weeks, then 1x a week x1 month, then q2weeks x 1 month. All findings will be reported to QA committee for further recommendations. Activity Director will be responsible. 5. Corrective action will be completed by 3/25/2015	

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F 248	Continued From page 3 assisted to join the birthday party / activity. Review of R10's activity documentation indicated that on 2/19/14, R10 had attended / participated in 2 activities, however it was unclear by the documentation what activities R10 had been provided and if R10 actually participated in the activity or even liked the activity. Further review of the activity participation documentation in February 2015, revealed R10 had participated in 22 1:1 activities and 11 group activities. However, the actual type of activity and the length of the activity was not identified. The documentation included a checkmark by a time and a checkmark that indicated an activity had occurred. On 2/20/15, at 10:18 a.m. the activity director (AD) was asked what activities R10 had participated in on 2/19/15. The AD confirmed the 2/19/15, activity documentation and stated the first activity which took place at 1:03 p.m. was an educational / cognitive activity. When the surveyor asked what the actual activity was and if R10 had participated or enjoyed the activity, the AD stated she could not tell by the documentation exactly what the activity actually was nor how long the activity lasted. The AD stated she would have to call the activity person who documented the activity in order to know what the activity actually was and how long it lasted. The AD left to make a phone call to the 2/19/15, activity person. After the call, the AD stated she was informed R10 had participated in a music activity on television but could not tell what program it was, what time the activity occurred or if R10 enjoyed the activity nor how long the activity lasted but stated there was some music on the television. The AD also	F 248		

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F 248	Continued From page 4 confirmed R10 was not assisted to the church service nor the group birthday party held on 2/19/15. The AD verified both activities were identified as activities of interest for R10 and stated R10 should have been asked to join and assisted to the activities. The AD also stated the activity charting system had changed in the past year and it was now hard to tell what specific activities residents actually attended, how long the activities lasted and if the resident enjoyed the activity. The AD stated 1:1 activities could last anywhere from 2-15 minutes and could range from a conversation in the hallway about a family member or simply turning on the television for a resident all of which would be documented as a 1:1 activity. The AD confirmed the charting system did not give an accurate reflection of how often and what activity R10 had actually participated in. an activy policy and procedure was requested and not provided.	F 248		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are	F 279		3/25/15

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F 279	Continued From page 5 to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions to monitor side effects of anticoagulation medication use for 1 of 1 resident (R22) reviewed on Coumadin (an anticoagulation medication used to eliminate or reduce the risk of blood clots). In addition, the facility failed to develop diabetic management interventions for 1 of 1 resident (R22) who was diabetic. Findings include: R22's Diagnosis Report dated 12/29/14, identified R22's diagnoses as atrial fibrillation (irregular heart rate), hypertension (high blood pressure), congestive heart failure (decrease in heart failure to pump blood), diabetes and a heart valve replacement. R22's admission Minimum Data Set (MDS) dated 1/16/15, indicated R22 received insulin and anticoagulant therapy.	F 279	1. R22 Care Plan has been reviewed and updated to reflect current diagnosis of DM and Atrial Fibrillation and Coumadin use. Interventions and monitoring have been added to Care Plan Nurses educated on 3/11/15 regarding Care Plan Interventions, Updates and Development. CNA□s educated on 3/11/15 regarding viewing Care Plan interventions. 2. All resident Care Plans have been reviewed and updated as appropriate with current unstable diagnosis per Care Plan Policy and Procedure. 3. Upon admission of new residents comprehensive review will be completed With CP focuses and Interventions to reflect current unstable diagnosis and interventions per CP Policy and Procedure. With change in any current resident condition CP will be updated to reflect unstable diagnosis. All Care Plans will be reviewed and updated as appropriate with quarterly review and completion of MDS and prn with changes. 4. DNS or designee will complete audits on Care Plans on 3 residents per week x4 weeks then q2 weeks x4 , then random	

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F 279	Continued From page 6 R22's Order Summary Report directed staff to: · Conduct blood glucose checks twice a day · Administer Coumadin 2.5 milligrams (mg) every Sunday, Tuesday, Wednesday, Friday · Administer Coumadin 5 mg every Monday, Thursday, and Saturday · Administer 15 units of Novolog 70/30 insulin twice a day R22's care plan dated 12/29/14, failed to identify R22's diagnosis of atrial fibrillation and corresponding interventions which directed staff to observe for side effects of anticoagulation therapy usage, such as excessive bleeding, bruising and international normalized ration monitoring (INR- lab work to identify blood clotting levels). In addition, the care plan failed to identify R22's diagnosis of diabetes and the corresponding interventions which directed staff to observe signs and symptoms of hyperglycemic (high blood glucose levels), hypoglycemic (low blood glucose levels), blood glucose monitoring and administration of insulin etc. On 2/19/15, at 12:14 p.m. the director of nursing (DON) confirmed R22 was on Coumadin for atrial fibrillation and was a diabetic. The DON verified R22's care plan lacked focus areas and interventions with regards to diabetes and anticoagulation management. The DON confirmed it would be appropriate to have included on R22's care plan the diagnosis of atrial fibrillation and the side effect monitoring for anticoagulation therapy, in addition the care plan could have been more specific with regards to R22's diabetes management.	F 279	audits. All findings will be reviewed by QA committee with action taken as needed. 5. Completion date 3/25/15	

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F 279	Continued From page 7 The Care Plan policy dated 9/2012, indicated each resident would have an individualized comprehensive care plan. Through the use of departmental assessments and physician orders, any problems, needs and concerns would be identified and addressed. The care plan would ensure that the resident received appropriate care and services.	F 279		
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services in accordance with the resident's written plan of care for 4 of 4 residents (R21, R7, R49, R33) in the sample who required assistance with range of motion services and 1 of 1 resident (R21) who required assistance with ambulation. In addition, the facility failed to ensure activity's had been offered according to the residents care planned need for 1 of 3 residents (R10) reviewed for activities. Findings include: R21 did not receive assistance with ambulation	F 282	1. R 7, 21, 33 and 49 have had evaluations by skilled therapy and treatment as ordered. Plan of Care reviewed and after completion of skilled therapy will have updated Restorative Nursing and/or Functional Maintenance Program Implemented. R21 ambulation is being completed with therapy at this time along with Restorative LPN and CNA□s as she allows. CP has been updated to reflect resident wishes regarding ambulation. R10 Activity preferences and ability to participate in activities has been reviewed and updated in Care Plan. Activity Staff educated on following POC on 3-10-15 and Nursing Staff educated on 3-11-15.	3/25/15

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F 282	Continued From page 8 and range of motion services according to the care plan. R21's care plan dated 5/12/15, directed the staff to provide R21 with nursing rehabilitation services 2-3 times a week. The plan included to following: - ambulation as tolerated - Seated over head bounce passes x 20 - 4 minutes of over head pulleys - red theraband (elastic exercise strap) exercised for the shoulder and elbow stretches x 20 repetitions. - ankle lifts with a three pound weight - hamstring curls with a red theraband - ball squeezes and hip abduction with minimal resistance or red theraband - sit to stand exercises as tolerated. - encourage kegals Review of R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had received ROM 6 of 15 opportunities. R21 had last received assistance with ROM on 10/16/14. The documentation did not include R21's ambulation program. On 2/18/15, at 3:00 p.m. R21 was observed to stand and transfer to a commode with assistance of one staff member. R21 did not display ROM limitations in her lower extremities. On 2/19/15, at 12:00 p.m. R21 was observed to	F 282	2. LPN is filling Restorative Position and completing restorative services for all residents with a Restorative and/ or Functional Maintenance Program per Plan of Care. All current residents with Restorative/ Functional Maintenance program are currently being reviewed and updates or therapy referrals as appropriate. 3. All staff responsible for resident care were educated on Care Plan Policy and Procedure including routine daily practice, development, implementation and access to Care Plans on 3-11-15. All nursing staff educated on 3-11-15 regarding following plan of care to ensure the residents receive appropriate care and services. . With any turnover in staffing with restorative position the position will be posted internally, externally through online posting, newspaper, radio, Facebook as appropriate. Temporary position will be covered by existing staff until filled. Therapy will be involved with any noted changes, decline or inability to tolerate restorative FMP. Any issues will be brought up with QA committee. 4. DNS or designee will complete audits weekly x4 weeks, then q2 weeks x4 , then random audits to follow to ensure Restorative/Functional Maintenance Programs are being followed per Plan of Care. Activities will be completing audits to ensure activities are being offered and encouraged per resident preferences 5 days /week x2 weeks then 1x/week x1	

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F 282	Continued From page 9 feed herself the noon meal. R21 was able to use utensils without problems. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A and NA-B were observed to assist R21 to ambulate 36 feet in the corridor. On 2/20/14, at 9:00 a.m. registered nurse (RN)-A stated the facility did not have a restorative NA to provide the program services and confirmed she was aware the restorative programs had not been completed. She verified R21's care plan had not been followed. R7 had not received restorative nursing services as directed by her care plan. R7's care plan dated 3/20/14, identified restorative interventions due to R7's limited physical mobility related to arthritis and her limited ROM. R7's care plan directed staff to conduct nursing rehab three times a week which included the following exercises: · Upper extremity functional maintenance program: upper extremity bike with resistance; overhead pulley x 3 minutes; number 2 dowel extension: elbow and shoulder 1 x 30; pick up cones off of the floor x1 while seated. · While seated in the wheelchair: hip flexion, marching; heel/toe raises x 10 each side; supine: hamstring stretch and calf stretch 2 x 30, quad sets, hamstring sets and heel slides x 10 each.	F 282	month, then q2 weeks x1 month. All findings will be reported to QA for further recommendations. 5. Completion date 3/25/15	

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F 282	Continued From page 10 On 2/18/15, at 1:00 p.m. R7 was observed propelling herself in her wheelchair down the hallway into her room where she remained seated in her wheelchair. On 2/18/15, at 2:45 p.m. RN-A stated the facility currently did not have anyone providing restorative nursing services. RN-A confirmed R7 had not received her restorative nursing services as directed by her care plan. On 2/19/15, at 12:32 p.m. the director of nursing (DON) verified 10/16/14, was the last day R7 had received restorative therapy. R49 had not received restorative nursing services as directed by his care plan. R49's care plan dated 10/26/14, identified restorative interventions due to R49's performance deficit and limited physical mobility. R49's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises: · If seated: active range of motion (AROM) with hip flexion, hamstring curls with yellow t-band (exercise resistant band) 2 x 10 on right; AROM bilateral abduction and adduction 2 x 10, hamstring stretch and heel cord stretch bilaterally. If laying down: AROM on right hip and knee flexion and stretch. Abduction and adduction on left; passive range of motion (PROM): hip and knee flexion and stretch, abduction and adduction	F 282		

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F 282	Continued From page 11 2 x 20. · PROM right upper extremity, shoulder, elbow wrist, fingers, all planes 2 x 10 each. Encourage movement of thumb and pointer finger as tolerated. Yellow t-band extension left upper extremity 2 x 10 each elbow flexion, extension, and horizontal abduction/adduction. Ball toss to left upper extremity, have him hit it back to you 2 x 10 beach ball. Neck stretches, have him look up and hold for several second seconds 1 x 10, do this to each side. On 2/18/15, at 2:09 p.m. R49 was observed being transferred with a mechanical lift from his wheelchair to his bed by NA-C and licensed practical nurse (LPN)-D. R49 required total assistance with transfer. On 2/18/15, at 3:35 p.m. RN-A confirmed R49 had not received his restorative nursing services as directed by his care plan. In addition, RN-A verified 10/16/14, was the last day the facility had someone providing restorative nursing services. On 2/19/15, at 12:22 p.m. the DON confirmed the facility did not have a formalized restorative nursing program. R33 was not provided restorative nursing services as directed by her current care plan. R33's diagnoses as indicated on the Diagnosis Report, included chronic airway obstruction,	F 282		

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F 282	Continued From page 12	F 282		

generalized osteoarthrosis, congestive heart failure, bursitis disorders, generalized pain and depressive disorder.

R33's quarterly minimum data (MDS) set dated 10/25/14, indicated R33 had severe cognitive impairment and required extensive assist with bed mobility, transferring toileting, dressing and personal hygiene. In addition, R33 had range of motion (ROM) impairment on both sides for upper and lower extremities.

R33's care plan dated 2/19/15, identified restorative interventions due to performance deficit/limited physical mobility. R33's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises:
· Overhead pulley X 3 minutes Yellow t-band all planes 20 each. Assist to stand
· Bilateral stretch all directions including hamstring stretch, ham curls and sit to stand 1-2 minutes each. Sit to stand in parallel bars and work on standing tolerance
· Kegals for stress incontinence
· Seated manually resisted abduction and adduction stand in stand aid and work on weight shifting for 5 to 10 minutes.

On 2/20/15, at 10:05 a.m., NA-C verified that he had not provided any type of restorative nursing exercises to any resident.

On 2/20/15, at 10:10 a.m. LPN-B verified R33 had not received restorative nursing services for several months.

On 2/20/15, at 10:36 a.m. RN-A confirmed R33 had not received her restorative nursing services as directed by her care plan. RN-A verified

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F 282	Continued From page 13 10/14/14, was the last day R33 received any type of restorative services. RN-A stated the facility had not provided restorative services to the residents for the past several months. On 2/20/15, at 11:14 a.m. The DON verified R33 had not received restorative services since 10/14/14. The DON stated R33 should have been provided the services as directed by the care plan. The Restorative Nursing Care policy dated 6/2012, indicated the goal of restorative nursing care was to assure the maximum possible independence for each resident was maintained and declines were prevented. Each resident would receive restorative nursing care to the extent possible, and based on their individual strengths, needs and problems as defined by the nursing assessments. In addition, the restorative care would be outlined in the resident's care plan. R10 was not assisted to participate in acitivies as directed by the care plan. R10's diagnosis report dated 2/20/15, indicated R10 was diagnosed with Alzheimer's disease. R10's care plan dated as last revised on 1/13/15, indicated R10 was dependent on staff for activities, cognitive stimulation and social interaction. The care plan directed staff to provide R10 1:1 bedside/in-room activities if unable to attend out of room events as well as preferred activities such as conversation, music, prefers to stay in room, naps, children, outdoor and spiritual events. The care plan had not identified how	F 282		

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F 282	Continued From page 14 often 1:1 activities were to be provided to R10 who preferred to stay in her room nor the frequency of the directive to encourage ongoing family involvement, invite residents and family to attend special events, activities and meals. On 2/17/15, from 4:45 p.m. until 7:30 p.m. R10 was assisted with eating the evening meal and assisted to bed at 7:23 p.m. R10 was not involved with any activities. On 2/18/15, at 9:30 a.m. R10 was observed seated in her room. No television or radio on. At 11:36 a.m. R10 was observed seated in the common corridor waiting to go into the dinning room for the noon meal. On 2/19/2015, at 8:44 a.m. R10 was observed in the dining room, eating breakfast. On 2/19/2015, at 9:34 a.m. R10 was observed seated in front of the television with other residents while the morning news show was on. R10 had her eyes closed and did not appear to be engaged in watching the television. On 2/19/2015, at 11:03 a.m. Church service was held and R10 was not assisted to the service / activity. On 2/19/2015, at 1:00 p.m. R10 was observed seated in the common lounge area just watching the people go by.	F 282		

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F 282	Continued From page 15 On 2/19/14, at 2:00 p.m. a monthly resident birthday party was held. However, R10 was not asked nor assisted to the birthday party / activity. On 2/20/15, at 10:18 a.m. the activity director (AD) was asked what activities R10 had participated in on 2/19/15. The AD confirmed the 2/19/15, activity documentation and stated the first activity which took place at 1:03 p.m. was an educational / cognitive activity. When the surveyor asked what the actual activity was and if R10 had participated or enjoyed the activity, the AD stated she could not tell by the documentation exactly what the activity actually was and how long the activity lasted. The AD confirmed R10 was not assisted to the church service nor to the group birthday party held on 2/19/15, and should have been. The Care Plan policy dated 9/2012, indicated the care plan would emphasize the care and development of the whole person ensuring that the resident received appropriate care and services.	F 282		
F 311 SS=D	483.25(a)(2) TREATMENT/SERVICES TO IMPROVE/MAINTAIN ADLS A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section. This REQUIREMENT is not met as evidenced	F 311		3/25/15

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F 311	Continued From page 16 by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve or maintain the resident's ability to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing rehabilitation ambulation services. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R21 was diagnosed with dementia and anxiety, had severe cognitive impairment and required extensive assistance with ambulation in her room and did not ambulate in the corridor. The assessment also indicated R21 displayed physical limitations on one side of her lower extremities. R21's care plan dated 5/12/15, directed staff to assist R21 to ambulate with a two wheeled walker 2-3 times a week as tolerated. R21's Restorative Care Program established 10/3/12, by the physical therapist directed staff to ambulate R21 with a two wheeled walker as R21 tolerated. During the survey conducted on 2/17/15, from 12:00 p.m. to 8:00 p.m., on 2/18/15, from 8:00 a.m. to 4:30 p.m. and on 2/19/15, from 7:00 a.m. to 3:30 p.m. R21 was observed to utilize a wheelchair for mobility.	F 311	1. R21 CP reviewed, updated to reflect resident current abilities and preferences regarding ambulation. R21 currently is working with skilled therapy services. CNA□s / Restorative ambulating with resident as she allows. All nursing staff educated on 3-11-15 regarding following plan of care to ensure the residents receive appropriate care and services 2. LPN is filling Restorative Position and completing restorative services for all residents with a Restorative and/ or Functional Maintenance Program per Plan of Care. All current residents with Restorative/ Functional Maintenance program are currently being reviewed and updates or therapy referrals as appropriate. 3. All nursing staff educated on 3-11-15 regarding following plan of care to ensure the residents receive appropriate care and services. All staff responsible for resident care educated on Care Plan Policy and Procedure including routine daily practice, development, implementation and access to Care Plans. With any turnover in staffing with restorative position the position will be posted internally, externally through online posting, newspaper, radio, Facebook as appropriate. Temporary position will be covered by existing staff until filled. Therapy will be involved with any noted changes, decline or inability to tolerate restorative FMP. Any issues will be brought up with QA committee. 4. DNS or designee will complete audits weekly x4 weeks, then q2 weeks x4, then	

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F 311	Continued From page 17 On 2/18/15, at 3:00 p.m. R21 was observed to stand and pivot-transfer to a commode with assistance of one staff member. R21 did not walk during this observation. R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had not received assistance with ambulation services. R21's clinical record did not contain any further documentation related to ambulation services. The last entry related to ambulation was documented on 10/16/14. On 2/19/15, at 1:00 p.m. family member (FM)-A stated she could not recall the last time she had seen R21 ambulate. She stated R21 had her own walker but she had not seen the walker in her room for months. FM-A stated she was not sure if R21 had the ability to ambulate. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A was asked to assist R21 to ambulate. NA-A looked in R21's room and was unable to locate her walker. NA-A went to the therapy room and located a walker. NA-A and NA-B were observed to ambulate R21 36 feet in the corridor. At this same time, NA-A stated the facility usually had enough staff to provide personal cares to the residents, however, the facility did not have a restorative NA to provide restorative services. She stated the facility had not had a restorative NA for the past 4 months. On 2/19/15, at 1:30 p.m. NA-B stated the facility	F 311	random audits to follow to ensure Restorative Programs are being followed per POC. All findings will be reported to QA for further recommendations 5. Completion date 3/25/15	

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F 311	Continued From page 18 had been short staff members therefore, the residents had not received assistance with restorative nursing because they did not have staff members to provide it. On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistants for the past several months. She stated the facility did not have the staff to provide restorative nursing. On 2/19/15, at 2:00 p.m. NA-C stated the nursing assistants did not have time to provide restorative nursing services. On 2/19/15, at 2:00 p.m. LPN-B stated the facility had staffing issues. She stated the staff were doing the best they could, but they did not have time to perform the restorative programs for the residents. On 2/20/15, at 9:00 a.m. registered nurse (RN)-A stated R21's ability to ambulate fluctuated daily related to the amount of back pain she was having. She confirmed R21's clinical record did not direct the staff as to how far R21 was to ambulate. She stated R21 had not been routinely offered assistance to ambulate because the facility did not currently have a restorative NA. She stated the facility use to have a restorative NA who was in charge of completing the restorative nursing program, however, in October of 2014, the restorative NA had left the facility. RN-A stated the facility had hired another NA to complete the restorative programs, however, she	F 311		

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F 311	Continued From page 19 had not been allowed to provide the services because she was needed to provide direct care to the residents instead. She stated she was aware none of the restorative programs had been completed as directed and had reported the concern to the director of nursing (DON). RN-A verified R21's care plan had not been followed to ensure ambulation services were provided to R21. The Care Plan policy dated 9/2012, indicated the care plan would emphasize the care and development of the whole person ensuring that the resident received appropriate care and services.	F 311		
F 318 SS=E	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to maintain or prevent decrease in range of motion (ROM) ability for 4 of 4 residents (R21, R7, R49, R33) in the sample who had limitations in range of motion.	F 318	1. R 7, 21, 33 and 49 have had evaluations by skilled therapy and treatment as ordered. Plan of Care reviewed and after completion of skilled therapy will have updated Restorative Nursing Program Implemented. 2. LPN is filling Restorative Position and completing restorative services for all	3/25/15

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F 318	Continued From page 20 Findings include: R21 did not ROM services as directed by the care plan. R21's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R21 was diagnosed with dementia and anxiety, had severe cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, grooming and had unilateral lower extremity physical limitations. R21's care plan dated 5/12/15, directed staff to provide R21 with nursing rehabilitation 2-3 times a week. The plan included: - Seated over head bounce passes x 20 - 4 minutes of over head pulleys - red theraband (elastic exercise strap) exercised for the shoulder and elbow stretches x 20 repetitions. - encourage to walk to elevated with walker -ankle lifts with a three pound weight - hamstring curls with a red theraband - ball squeezes and hip abduction with minimal resistance or red theraband - sit to stand exercises as tolerated. - encourage kegals R21's Restorative Care Program established on 10/3/12, by the physical therapist directed staff to encourage R21 to participate in lower extremity strengthening exercises including marching exercises with a three pound weights, ankle	F 318	residents with a restorative/functional maintenance program per Plan of Care. All current residents with Restorative/ Functional Maintenance program are currently being reviewed and updates or therapy referrals as appropriate. 3. Nursing Staff educated on 3-11-15 regarding Care Plan Policy and Procedure and following plan of care to ensure the residents receive appropriate care and services including routine daily practice, development, implementation and access to Care Plans. With any turnover in staffing with restorative position the position will be posted internally, externally through online posting, newspaper, radio, Facebook as appropriate. Temporary position will be covered by existing staff until filled. Therapy will be involved with any noted changes, decline or inability to tolerate restorative FMP. Any issues will be brought up with QA committee. 4. DNS or designee will complete audits weekly x4 weeks, then q2 weeks x4, then random audits to follow to ensure Restorative Programs are being followed per POC. All findings will be reported to QA for further recommendations. 5. Completion date 3/25/15	

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F 318	Continued From page 21 pumps, hamstring curls with red theraband, ball squeezes and hip abduction with either manual resistance or red theraband bilaterally x 15 repetitions and sit to stand exercises as R21 tolerated. R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had received ROM 6 of 15 opportunities. R21 had last received assistance with ROM on 10/16/14. R21's clinical record did not contain any further documentation related to the restorative nursing program services. On 2/18/15, at 3:00 p.m. R21 was observed to stand and transfer to a commode with assistance of one staff member. R21 did not display ROM limitations in her lower extremities. On 2/19/15, at 12:00 p.m. R21 was observed to feed herself the noon meal. R21 was able to use utensils without problems. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A stated the facility usually had enough staff to provide personal cares to the residents, however, did not have a restorative NA to provide assistance with restorative services. NA-A stated the facility had not had a restorative NA for the past 4 months.	F 318		

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F 318	Continued From page 22 On 2/19/15, at 1:30 p.m. NA-B stated the facility had been short staff members. She stated the residents did not receive assistance with restorative nursing because they did not have staff members to provide it. On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistance for the past several months and did not have the staff to provide restorative services. On 2/19/15, at 2:00 p.m. NA-C stated the nursing assistants did not have time to provide restorative nursing services. AT the same time, LPN-B stated the facility had staffing issues and the NAs were doing the best they could, but did not have time to perform the restorative programs for the residents. On 2/20/14, at 9:00 a.m. registered nurse (RN)-A stated the facility use to have a NA who was in charge of completing the restorative nursing program, however, in October of 2014, the restorative NA had left the facility. RN-A stated the facility had hired another NA to complete the restorative programs, however, she had not been allowed to provide the services because she was needed to provide direct care to the residents instead. RN-A stated she was aware that none of the restorative programs had been completed as directed and had reported the concern to the director of nursing (DON). RN-A verified R21's care plan had not been followed to ensure restorative nursing services were provided.	F 318		

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F 318	Continued From page 23 On 2/20/14, at 9:15 a.m. RN-A was observed to cue R21 to raise her arms. R21 was able to raise her arms above her head, extended her arms outward and completed a full circle with her shoulders. R21 was not observed to display any type of ROM limitations in her upper extremities. R7 had not received restorative nursing services as directed by her current care plan. R7's diagnoses, as indicated on the Diagnosis Report, included shortness of breath, cataracts, anemia, Alzheimer's, generalized pain, congestive heart failure (decrease in heart function to pump blood), depression and arthritis. R7's quarterly MDS dated 11/26/14, indicated R7 had moderate cognitive impairment and required extensive assist with bed mobility, transferring, locomotion on and off the unit, toileting and personal hygiene. In addition, R7 had ROM impairment on her lower extremities (hip, knee, ankle, foot) on the one side. R7's care plan dated 3/20/14, identified restorative interventions due to R7's limited physical mobility related to arthritis and her limited ROM. R7's care plan directed staff to conduct nursing rehab three times a week which included the following exercises: · Upper extremity functional maintenance program: upper extremity bike with resistance; overhead pulley x 3 minutes; number 2 dowel	F 318		

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F 318	Continued From page 24 extension: elbow and shoulder 1 x 30; pick up cones off of the floor x 1 while seated. · While seated in the wheelchair: hip flexion, marching; heel/toe raises x 10 each side; supine: hamstring stretch and calf stretch 2 x 30, quad sets, hamstring sets and heel slides x 10 each. On 2/18/15, at 2:45 p.m. RN-A stated the facility currently did not have anyone providing restorative nursing services. RN-A thought it had been about two months that the facility had gone without someone in this position. RN-A confirmed R7 had not received her restorative nursing services as directed on her care plan. On 2/18/15, at 3:00 p.m. the physical therapy aide (PTA)-A stated she was aware the facility did not have a current restorative nursing program in place. PTA-A stated the therapy department was frustrated because when they no longer could see a resident, a restorative program was set up for the resident and we know they are not receiving what is needed. On 2/18/15, at 1:00 p.m. R7 was observed propelling herself in her wheelchair down the hallway into her room where she remained seated in her wheelchair. On 2/19/15, at 12:32 p.m. the DON verified 10/16/14, was the last day R7 had received restorative therapy. On 2/20/15, at 9:32 a.m. occupational therapist	F 318		

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F 318	Continued From page 25 (OT)-A was observed conducting an assessment and evaluation on R7. OT-A stated R7 had full extension of her upper extremities. OT-A assisted R7 into the bathroom. R7 was able to propel herself in her wheelchair into the bathroom and with a gait belt around R7's waist; R7 stood and completed the transfer from the wheelchair to the toilet with minimal assistance. OT-A stated on review of R7's baseline and where R7 was today, she did not see a decline in her ability with transfers and upper body strength. However, OT-A thought it would be appropriate for therapy to work with R7, even just for a short period of time. R7's occupational therapy plan of care dated 2/20/15, indicated R7 had not received skilled occupational therapy services since 5/4/2012. The occupational therapist stated R7 would benefit from continued work with breathing and compensatory techniques to improve her energy levels. In addition, the resident showed potential for further gains with upper extremity strength and transfers. R49 had not received restorative nursing services as directed by his current care plan. R49's diagnosis, as indicated on the Diagnosis Report, included cerebrovascular disease (stroke), congestive heart failure, aphasia (partial or total loss of ability to communicate), atrial fibrillation (irregular heart rate), anxiety and arthritis.	F 318		

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R49's quarterly MDS dated 12/9/2014, indicated R49 had severe cognitive impairment and required extensive assist with bed mobility, transferring, dressing, toileting and personal hygiene. In addition, R49 had ROM impairment on one side for upper and lower extremities.

R49's care plan dated 10/26/14, identified restorative interventions due to R49's performance deficit and limited physical mobility. R49's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises:

· If seated: active range of motion (AROM) with hip flexion, hamstring curls with yellow t-band (exercise resistant band) 2 x 10 on right; AROM bilateral abduction and adduction 2 x 10, hamstring stretch and heel cord stretch bilaterally, If laying down: AROM on right hip and knee flexion and stretch. Abduction and adduction on left; passive range of motion (PROM): hip and knee flexion and stretch, abduction and adduction 2 x 20.
· PROM right upper extremity, shoulder, elbow wrist, fingers, all planes 2 x 10 each. Encourage movement of thumb and pointer finger as tolerated. Yellow t-band extension left upper extremity 2 x 10 each elbow flexion, extension, and horizontal abduction/adduction. Ball toss to left upper extremity, have him hit it back to you 2 x 10 beach ball. Neck stretches, have him look up and hold for several second seconds 1 x 10, do this to each side.

R49's Physical Therapy (PT) - Therapist Progress

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F 318	Continued From page 27 and Discharge Summary dated 9/30/14, indicated R49 had participated in PT from 9/5/14 - 9/30/14. PT had worked with R49 and attempted to increase his lower extremity strength bilaterally. In addition, they worked on decreasing the amount of assistance he required with transfers which resulted in little or no gain. R49 was discharged from PT services and placed on a functional maintenance program. R49's Restorative Care Program dated 10/10/14, provided the direction which was reflected on R49's care plan with regards to his functional maintenance program as recommended by therapy. On 2/18/15, at 2:09 p.m. R49 was observed being transferred with a mechanical lift from his wheelchair to his bed by NA-C and licensed practical nurse (LPN)-D. R49 required total assistance with transfer. On 2/18/15, at 3:35 p.m. RN-A confirmed R49 had not received his restorative nursing services as directed by his care plan. In addition, RN-A verified 10/16/14, was the last day the facility had someone providing restorative nursing services. On 2/19/15, at 11:15 a.m. NA-C confirmed he had not done any restorative nursing exercises on the residents. On 2/19/15, at 11:20 a.m. NA-B confirmed she had not done any restorative nursing exercises	F 318		

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F 318	Continued From page 28 with the residents. On 2/19/15, at 11:33 a.m. NA-A confirmed sometimes she would do exercises with the residents; however she did not document these. NA-A stated the facility used to have a restorative aide who did the exercises with the residents. On 2/19/15, at 11:40 a.m. NA-F confirmed she had not done any restorative nursing exercises with the residents. On 2/19/15, at 12:22 p.m. the DON confirmed the facility did not have a formalized restorative nursing program. On 2/20/15, at 9:32 a.m. PT-A conducted an assessment and evaluation on R49. PT-A concluded that through her partial evaluation which she conducted today and her review of R49's past evaluation she had not seen a decline in R49's ROM. R33 had not received restorative nursing services as directed by her current care plan. R33's diagnosis as indicated on the Diagnosis Report, included chronic airway obstruction, generalized osteoarthrosis, congestive heart failure, bursitis disorders generalized pain and depressive disorder. R33's quarterly MDS dated 10/25/14, indicated R33 had severe cognitive impairment and	F 318		

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required extensive assist with bed mobility, transferring, toileting, dressing and personal hygiene. In addition, R33 had ROM impairment on both sides of upper and lower extremities.

R33's care plan dated 2/19/15, identified restorative interventions due to performance deficit/limited physical mobility. R33's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises:

· Overhead pulley X 3 minutes Yellow t-band all planes 20 each. Assist to stand
· Bilateral stretch all directions including hamstring stretch, ham curls and sit to stand 1-2 minutes each. Sit to stand in parallel bars and work on standing tolerance
· Kegals for stress incontinence
· Seated manually resisted abduction and adduction stand in stand aid and work on weight shifting for 5 to 10 minutes.

R33's Physical Therapy (PT)- Therapist Progress and Discharge Summary dated 9/15/12, indicated R33 had participated in therapy from 8/9/2012 - 9/7/12. PT had worked with R33 and had gains in her lower extremity ROM and improved transfer status. PT provided gait services which improved R33's abilities in all functional mobility. R33 was discharged from PT services and placed on a restorative service program.

R33's Restorative Care Program dated 9/10/12, provided goals recommended by therapy for restorative services program to maintain ROM, maintain strength for lower extremities bilaterally, and maintain standing tolerance/endurance. Approaches and recommendations for implementation of the goals are identified on R33's care plan.

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F 318	Continued From page 30 On 2/20/15, at 10:05 a.m., NA-C verified that he had not provided any restorative nursing exercises to any resident. On 2/20/15, at 10:10 a.m. LPN-B stated R33 had not received restorative services for the past several months. On 2/20/15, at 10:21 a.m. during observation of R33'S physical therapy assessment, PTA-A verified R33's restorative services recommendations following discharge from PT was 9/10/12. PTA-A confirmed it was her expectation the facility would provide the services. PTA-A completed the physical assessment following the recommended goals and verified there was no decline in R33's physical mobility. On 2/20/15, at 10:36 a.m. RN-A confirmed R33 had not received restorative nursing services as directed by her care plan. RN-A verified 10/14/14, was the last day R33 received restorative services. RN-A stated the facility had not provided restorative services for the past several months. On 2/20/15, at 11:14 a.m. the DON verified 10/14/14, was the last day R33 received restorative nursing services and should have as directed by the care plan. The Restorative Nursing Care policy dated 6/2012, indicated the goal of restorative nursing care was to assure the maximum possible independence for each resident was maintained and declines were prevented. Each resident would receive restorative nursing care to the	F 318		

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F 318	Continued From page 31 extent possible, and based on their individual strengths, needs and problems as defined by the nursing assessments. In addition, the restorative care would be outlined in the resident's care plan.	F 318		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there was adequate indication for the use of Seroquel	F 329	1. R48 seen by MD on NH Rounds 3-5-15. Reduction of Seroquel started 3-5-15 with potential for DC as appropriate.	3/25/15

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F 329	Continued From page 32 (anti-psychotic) medication for 1 of 5 residents (R48) in the sample reviewed for unnecessary medications. Findings include: R48's Diagnosis Report dated 2/20/15, indicated R48 was diagnosed with memory loss, generalized pain, dementia with behavioral disturbances, generalized anxiety disorder and hearing loss. R48's admission Minimum Data Set (MDS) dated 9/1/14, identified R48's lifetime occupation was a LPN and R48 had moderate difficulty with hearing, was able to clearly make self understood, had severely impaired cognition, and displayed patterns of disorganized thinking (disorganized or illogical flow of conversation rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable speech switching from one idea to the next rapidly). The admission MDS also identified R48 had delusions, was independent with ambulation and transfer ability and did not have any balance deficits. R48's care plan last revised 12/6/14, revealed the following: R48 is on Seroquel related to attempting to elope, attempting to toilet or get other resident up, storing garbage in drawers. Reduction attempted in November 2014. The interventions included the following: "BLACK BOX WARNINGS: #1 Observe for increased mortality in elderly patients with dementia-related	F 329	Mood/behavior monitoring being completed currently. Diagnosis was updated per MD to indicate current diagnosis of Psychosis and Delusions after MD reviewed chart and evaluated resident. Behavioral Interventions updated in Care Plan to reflect current behaviors and interventions to reduce behaviors without pharmacological intervention. Pharmacist will review and make recommendation in regards to alternate behavioral interventions/medications. 2. All residents with antipsychotic medications have been reviewed and will again be reviewed by Pharmacist. Care Plans have been reviewed and updated regarding behavioral interventions and updated as appropriate. 3. Prior to start of Antipsychotic medications resident will be monitored for and Care Plans updated to reflect current behavioral interventions to decrease behaviors nonpharmacologically. MD will report appropriate diagnosis with use of needed medications. Pharm D will review monthly with recommendations as appropriate. Reductions will be completed as appropriate to meet lowest dose to maintain function. Facility is in the process of procuring Mental Health MD to complete NH Rounds in facility. Reviewed quarterly with MDS and prn with changes. Nursing Staff educated 3-11-15 regarding behavioral interventions, use of Psychotropic medications and following Psychotropic Medication Policy and Procedure. All findings will be reported to QA. 4. DNS or designee will complete audits	

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F 329	Continued From page 33 psychosis, clinical worsening of depression and suicide risk. Potential adverse effects include agitation, anxiety, increased cholesterol, constipation, dizziness, drowsiness. The resident has a behavior symptom related to poor memory, wanders, attempts elopements, attempts toileting other residents goes in at night and awakes other residents for cares. The interventions included: Intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to an alternate location, provide opportunity for positive interaction and attention. Minimize potential for residents disruptive behaviors, elopement attempts by offering tasks which divert attention such as scrabble games puzzles and visiting with other ladies. Praise any indication of residents progress/ improvement in behavior. Resident prefers diversional activities as listed above puzzles, scrabble. The care plan identified the following behaviors: -BEHAVIOR #1 elopement attempts: likes scrabble, puzzles with other ladies. Target behaviors for PRN Xanax. -BEHAVIOR #2 Storing garbage in dresser drawers. Check dresser drawers once every shift for garbage or food. -BEHAVIOR #4 awaking other residents attempting to toilet/get up at night. Check resident every 30 minutes. Offer to take resident on a walk outside. Redirect. R48's Social Services section of the care plan included the following: The resident has a behavior symptom related to poor memory, wanders, attempts elopement, attempts toileting	F 329	on all resident with Antipsychotic medications q2 weeks x4, then monthly review per Pharm D. 5. Completion date 3/25/15	

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F 329	Continued From page 34 other residents goes in at night and awakes other residents for cares. The care plan is virtually the same as above where it lists the same problems and interventions there is nothing new in this section of the care plan just a repeat of the aforementioned problem and intervention. The resident has potential for elopement related to dementia, less than 5 minute recall. Interventions included: check resident every 30 minutes. R48's physician progress notes dated 11/10/14, indicated Seroquel was started because R48 had behaviors that included wanting to assist in the care of other residents in the facility as well as help the nurses in the facility care for the residents. The physician progress note indicated R48 had no hallucinations or delusions. The next physician progress note provided was dated 12/18/14, which identified that R48 was prescribed the antipsychotic medication for behaviors that included: "...continues to have some behaviors where she tends to interrupt the care of the patient, like transferring them, trying to feed them, entering into other residents' rooms, etc." The physician wrote "Seroquel seems to be helping." but does not identify how often the behaviors occurred, non-pharmacological interventions attempted and if those non-pharmacological interventions were successful. R48's nursing progress notes (NPN) dated 11/17/14, indicated Seroquel was discontinued and the NPN dated 12/4/14, identified the Seroquel had been restarted, however there was no physician progress note that explained the rationale for stopping the medication on 11/17/14,	F 329		

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F 329	Continued From page 35 nor for restarting the medication on 12/4/14. Review of R48's physician orders revealed that on 12/4/14, Seroquel 25 milligrams (mg) (an antipsychotic medication) was restarted for dementia with behaviors. Further review of R48's medical record revealed that monthly summaries of behavior were completed for the day and night shift from 9/1/14-1/24/15, and included the following: -Monthly nursing documentation dated 9/16/14, identified R48 had behavior symptoms that included delusions (misconceptions or beliefs that are firmly held, contrary to reality.). The comment section of the report identified "res becomes restless at times and walks hallways rather quickly will settle down after gets ready for bed or gets distracted talking with other ladies or an activity. Seems to be worse in evening. The documentation had not identified how often this behavior was occurring nor what type of pharmacological and non-pharmacological interventions were attempted to remove or relieve these mood symptoms and if they were successful. -Night shift monthly nursing documentation dated 9/17/14, identified R48 had mood and behavior symptoms exhibited during the night shift. The documentation had not identified what the behaviors were or how frequently they occurred. The boxes that identified non-pharmacological interventions included "phone calls to daughter, puzzles, reading materials and TV programs."	F 329		

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F 329	Continued From page 36 Pharmacological interventions were "PRN Xanax available." Under the section for sleep patterns it was identified that R48 had "Issues with roommate." Under the section that was identified as "Specify:" the following was written: "Anxiety and confusion." -Monthly nursing documentation dated 11/24/14, identified R48 had behavior symptoms that included delusions. The comment section of the report identified "becomes very restless in the evening wanting to push other residents, going into other residents rooms wanting to help walking up and down hallways...going to the kitchen wanting to help,,, becomes agitated at times when told she is not to help either residents toilet transfer states this is her house an she can do what she wants here,,,needs redirection that is often not successful related to poor and short term memory. The documentation had not identified how often this behavior was occurring and what type of pharmacological and non-pharmacological interventions were attempted and if they were successful. Also noted "Some decrease in behaviors noted with start of Seroquel. Will cont to monitor. Night shift monthly documentation dated 11/17/14, identified R48 had mood and behavior symptoms exhibited during the night shift. The documentation had not identified what the behaviors were or how frequently they had occurred. The boxes on the monthly nursing documentation form that identified non-pharmacological interventions included "Redirect to bedroom, offer activity" and pharmacological interventions were identified as: "PRN Xanax, scheduled HS Seroquel."	F 329		

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-Review of the monthly nursing documentation dated 12/24/14, identified again no behavior symptom. Night shift monthly documentation dated 12/18/14, identified that R48 had mood and behavior symptoms exhibited during the night but had not identified what the behaviors were or how frequently they had occurred and the boxes that identified non-pharmacological interventions and pharmacological interventions were left blank. Further documentation identified R48 appeared to rest comfortably through the night. No further behavior documentation noted.

-Review of the monthly nursing documentation dated as completed on 1/24/15, revealed R48 had no behavioral or mood symptoms. The documentation identified R48 got very anxious and paced up and down the hallways, unable to redirect most of the time. New medications included Seroquel started on 12/18/14. Night shift monthly nursing documentation completed 1/18/15, identified R48 had mood and behavior symptoms exhibited during the night but had not identified what the behaviors were or how frequently they had occurred and the boxes that identified non-pharmacological interventions and pharmacological interventions were left blank. Further documentation identified R48 appeared to rest comfortably through the night.

The monthly pharmacist drug regimen review reports were reviewed from 9/1/14-2/1/15, and the following was identified:

-On 11/17/14, the pharmacist recommendations included: "Please update care plan to reflect non pharm interventions to try, consider discontinuing

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F 329	Continued From page 38 the Seroquel after the non- pharm interventions in place. If medication is needed, consider trazodone 12.5 mg BID instead of Seroquel. Please document non pharm interventions which failed and perform qualitative and quantitative analysis at least quarterly of this information to determine triggers of the behaviors and re-assess/update care plan as needed." There was no indication that this pharmacy recommendation had been acted on in its entirety. The Seroquel had been discontinued on 11/17/14, however trazodone had not been started in it's place, and qualitative and quantitative analysis of R48's behavior had not been completed. -On 12/15/14, the pharmacist made the following recommendations for all facility residents': "Discussed need to care plan non pharm interventions and target behaviors for psychotropics with DON and staff. They are aware. Utilize antipsychotic when all other reasons for behaviors are ruled out. Be sure documenting interventions failed and perform analysis of behaviors at least quarterly for patterns, # of times, other pertinent information around the behaviors. Update care plan as needed.- continues from Nov." On 2/18/2015 11:20 a.m. R48 was observed seated in the common lounge area nicely dressed holding her purse. R48 told the surveyor that she was getting ready to go home and that her house was a few blocks away from here and that she was just working here filling in. R48 stated she still had a car in the garage at home and was planning on taking it for a drive into the country	F 329		

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	245523	A. BUILDING _____ B. WING _____	02/20/2015

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F 329	Continued From page 39 later today. R48 stated she was working here in the nursing home now only part time as she was retired. R48 stated that she was a licensed practical nurse (LPN) and liked visiting with the residents and helping them as much as she could. On 2/19/2015, at 1:20 p.m. the pharmacist stated she had verbally expressed her concerns with starting antipsychotic medication for R48 without first doing a complete assessment of the behavior then identifying and exhausting all non-pharmacological interventions. The pharmacist stated that the indications for using the antipsychotic medication for R48 included elopement attempts and attempting to care for other residents in the facility (the pharmacist also stated that R48 had been a former employee of the facility working as a licensed practical nurse for over 40 years). The pharmacist confirmed R48 did not have an adequate indication for the use of the antipsychotic medication Seroquel and stated she had also explained this to the director of nursing (DON). The pharmacist revealed she had explained to the facility staff that using antipsychotic medication without an adequate indication for its use could be a chemical restraint and the facility would need to assess R48's behavior and develop non-pharmacological interventions and determine that all of them had failed including the use of more appropriate pharmacological medications before using antipsychotic medication for R48 and stated that she had included the aforementioned information in her monthly drug regimen review for R48. On 2/19/15, at 2:30 p.m. nursing assistant (NA)-F	F 329		

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F 329	Continued From page 40 stated R48's behavior was not a huge problem and R48 was easily redirected if she started helping residents too much. NA-F stated it was hard for R48 to remember that she was not working here in the nursing home anymore. NA-F stated R48 was usually redirected easily by giving her a cup of coffee or setting her out in the common lounge area where other residents hang out so that she could converse with them. On 2/20/15 at 9:33 a.m. the DON stated R48 had been an employee of the nursing home for over 40 years. The DON stated R48 was receiving Seroquel for indications which included elopement from the facility and attempting to assist other residents. The DON stated she could not provide a comprehensive assessment of R48's behaviors and provide all non-pharmacological interventions attempted and those that had failed to deter R48's behavior. The DON confirmed R48 had never successfully eloped from the facility and using antipsychotic medication to deter elopement and assisting other residents was not an adequate indication for the use of antipsychotic medication including Seroquel. On 2/20/2015, at 10:17 a.m. licensed practical nurse (LPN)-C stated R48 had behaviors in the evening that included trying to help other residents. LPN-C stated R48 would never harm anyone, and didn't really think of R48's actions as a behavior...and R48 would never hurt anyone. LPN-C also stated R48 liked to be around other people and there were no residents in danger as a result of R48 trying to be helpful. LPN-C stated	F 329		

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F 329	Continued From page 41 R48 was easy to redirect by asking her to have a cup of coffee or getting her involved in reading to other residents. An antipsychotic use policy was requested and not provided.	F 329		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff was available to meet the	F 353	R 7, 21, 33 and 49 have had evaluations by skilled therapy and treatment as ordered. Plan of Care reviewed and after	3/25/15

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F 353	Continued From page 42 residents' needs for nursing care related to restorative services in a manner which promoted physical, mental and psychosocial well-being, thus enhancing each residents' quality of life. This practice had the potential to affect all 38 residents residing in the facility. Findings include: The facility failed to provide services in accordance with the resident's written care plan for 4 of 4 residents (R21, R7, R49, R33) in the sample who required assistance with range of motion (ROM) services and 1 of 1 resident (R21) who required assistance with ambulation services. See F282. The facility failed to provide ambulation services in order to improve or maintain the resident's ability to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing restorative rehabilitation services. See F311. The facility failed to provide range of motion services in order to maintain and/or prevent further decrease in ROM for 4 of 4 residents (R21, R7, R49, R33) in the sample who had limitations in range of motion. See F318. Review of the nurse staffing for the past six weeks, (1/1/15 - 2/20/15) revealed the facility had not had a restorative aide assigned during the review period.	F 353	completion of skilled therapy will have updated Restorative Nursing Program Implemented. LPN is working restorative position to meet Care Plan needs 2. LPN is filling Restorative Position and completing all restorative/functional maintenance programs following Plans of Care. All current residents with Restorative/ Functional Maintenance program are currently being reviewed and updates or therapy referrals as appropriate. 3. With any turnover in the restorative position the center will post the position internally, externally through online posting, newspaper, radio, Facebook as appropriate. Temporary position will be covered by existing staff until filled. Education completed on 3-11-15 with all Nursing staff regarding following Plans of Care, Care Plan Policy and Procedure, development, implementation and access to Care Plans. 4. DNS or designee will complete audits weekly x4 weeks, then q2 weeks x4, then random audits to follow to ensure Restorative Programs are being followed per POC. All findings will be reported to QA for further recommendations. 5. Completion date 3/25/15	

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F 353	Continued From page 43 On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A stated the facility usually had enough staff to provide personal cares to the residents, however, did not have a restorative NA to provide assistance with restorative services. NA-A stated the facility had not had a restorative NA for the past 4 months. On 2/19/15, at 1:30 p.m. NA-B stated the facility had been short staff members. She stated the residents had not received assistance with restorative nursing because they did not have staff members to provide it. On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistants for the past several months and they had not had the staff to provide restorative nursing services. On 2/19/15, at 2:00 p.m. NA-C stated the NAs did not have time to provide restorative nursing services. On 2/19/15, at 2:00 p.m. LPN-B stated the facility had staffing issues. She stated the staff were doing the best they could but did not have time to perform the restorative programs for the residents. On 2/20/15, at 8:45 a.m. registered nurse (RN)-A stated she was in charge of the restorative nursing program. She explained the restorative	F 353		

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F 353	Continued From page 44 NA had left the facility in the middle of October 2014. Since that time, a NA was hired internally to complete the restorative programs, however, the NA was needed to provide direct care to the residents therefore had not been able to complete the training required to provide the restorative services. RN-A stated the facility had recently had two interim directors or nursing that had been made aware of the concern, however, they were unable to hire enough staff members to ensure the restorative NA was able to complete the programs. She confirmed the facility did not have sufficient nursing assistants to complete the restorative programs as directed. On 2/20/15, at 9:00 a.m. the director of nurses stated the facility was to have a specified NA to provide restorative nursing either four days a week for a five hour shift, or 2 full 8 hour shifts per week. She stated she had been informed the facility did not have a restorative NA when she started the DON position on 2/17/15. She stated she was told the facility had been unable to fill the restorative position and was aware the restorative nursing programs were not being completed but added the restorative program would become a facility priority. On 2/20/14, at 10:00 am. NA-E stated the restorative NA was to responsible to provide the services however stated the they had not been provided for a long time. On 2/20/15, at 11:05 a.m. the administrator confirmed he was aware the restorative nursing	F 353		

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F 353	Continued From page 45 programs had not been completed due to a lack of nursing assistants. The Nursing Services Staff policy dated 9/2012, directed the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, spiritual, mental and psychosocial well-being of each resident, as determined by the resident assessment and individual plans of care.	F 353		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441		3/25/15

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F 441	Continued From page 46 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the glucometers (devices utilized for monitoring blood sugars) were appropriately disinfected after each resident use. This had the potential to affect 3 of 3 residents (R14, R22, R54) who used a community glucometer. Findings include: On 2/17/15, at 4:31 p.m. registered nurse (RN)-B was observed to conduct a blood glucose check on R14. Immediately following R14's blood glucose check, RN-B was observed to wipe off the glucometer with an alcohol prep wipe which contained 70% isopropyl alcohol. RN-B confirmed R14, R22, and R54, all utilized this glucometer and that she routinely disinfected the glucometer by wiping it down with an alcohol prep wipe after each resident use. On 2/18/15, at 8:37 a.m. the licensed practical nurse (LPN)-B confirmed the two glucometers currently stored in the first floor treatment cart	F 441	1. On 2-19-15 R 14, 22, 54 received individual glucometers. Glucometers were cleaned and disinfected per manufacturer□s guidelines and Policy and Procedure. Nursing Staff were immediately educated on proper cleaning and disinfecting. 2. All residents who require blood glucose monitoring have individual glucometers that are stored in their rooms. Upon admission if needed resident will receive personal glucometer. Education was completed with all nursing staff regarding correct procedure for cleaning and disinfecting glucometers on 3-11-15. 3. Policy and Procedure, manufacturers recommendation reviewed for Cleaning and disinfecting glucometers at 3-11-15 nursing staff meeting 4. DNS or designee will complete Random audits x3 months to ensure individual glucometers are being used and disinfecting log is being completed.	

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F 441	Continued From page 47 were utilized by R14, R22, and R54. LPN-B stated she disinfected the glucometers after each resident use by wiping them down with an alcohol wipe. On 2/19/15, at 12:04 p.m. the director of nursing (DON) verified the residents on the first floor did not have their own designated glucometer. The DON stated the glucometers should be cleaned after each use and she believed the alcohol prep wipe was an appropriate disinfecting wipe, however, the staff should follow the facility policy and manufacture guidelines. The Cleaning and Disinfecting Blood Glucose Meters policy dated 11/2014, directed staff to properly disinfect the glucometer after each resident use with 1:10 bleach to water solution or an acceptable germicidal disposable wipe. The Assure Platinum glucometer manufacture instructions directed staff to clean and disinfect the glucometer between each resident, using an EPA (Environmental Protection Agency) registered disinfectant detergent or germicide wipe.	F 441	Findings reported to QA. 5. Completion date 3-25-15	
F 520 SS=F	483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance	F 520		3/25/15

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F 520	Continued From page 48 committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility did not ensure the Quality Assessment and Assurance (QA&A) committee developed and implemented appropriate plans of action to correct identified quality deficiencies related the lack of restorative nursing services. This had the potential to affect all 34 residents who resided in the facility. Findings include: The facility failed to provide services in accordance with the resident's written plan of care for 4 of 4 residents (R21, R7, R49, R33) in the sample who required assistance with range of motion services and 1 of 1 resident (R21) who required assistance with ambulation services. See F282.	F 520	1.Plan developed for restorative nursing program at 3-5-15 QA Meeting to identify concerns and develop corrective action. QAPI Committee determined that restorative position cannot be pulled and must be maintained throughout any staffing issues. Committee developed immediate action plan that casual LPN will be providing the program for the immediate and foreseeable future (with RN oversight with referrals to therapies as needed). Also, CNA already on staff will be trained for the position. 2. QA will continue to meet monthly and prn for updates to existing action plans and Performance Improvement Projects, review, and initiate action plans for any new or potential concerns. 1:1 training provided for QAPI coordinator on available QAPI tools, processes, and	

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F 520	Continued From page 49 The facility failed to provide the necessary treatment and services to improve and maintain the resident's abilities to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing rehabilitation. See F311. The facility failed to provide range of motion services to prevent further decrease in range of motion (ROM) for 4 of 4 residents (R21, R7, R49, R33) in the sample who had limitations in range of motion. See F318. The facility failed to ensure that sufficient qualified nursing staff was available to meet the residents' needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 38 residents residing in the facility. See F353. On 2/20/15, at 1:40 p.m. registered nurse (RN)-A/QA&A coordinator stated the QA&A committee had identified and discussed the concern of the lack of nursing assistants at the quarterly QA&A meetings. She stated the committee had attempted to be proactive in hiring more staff members, but their efforts had not generated a solution. She stated the QA&A committee had not specifically discussed the concern of lack of staffing in relationship to the lack of restorative nursing programs. RN-A confirmed the QA&A committee had not developed a formal action plan to ensure the	F 520	plans. Also discussion to ensure that correct issues are brought to the QAPI committee carried out on 3-5-15 and 3-13 -15. 3. In the event the restorative position was vacated it will be posted internally, externally via online, newspapers, radio, Facebook as appropriate. During the transition, if there are no restorative aides available, Activities will provide a 2-3xper week stretching and ROM program to ensure no declines are noted, this program is already operating. Therapy department was involved in discussion with this decision and they did feel this intervention was appropriate to help reduce declines if able. Nursing Staff educated on 3-11-15, all other departments to be educated 3-23-15 regarding QA committee and purpose, how to report concerns, be made aware of updates with other departments to follow as they have their meetings. Also, posters placed on QAPI coordinators door with current projects, purpose, and plans . 4. Admin or representative will audit monthly x3 to ensure QA coordinator/committee have identified problems and initiated appropriate plan or process to correct. Audit findings will be reviewed at QAPI meetings. Restorative will be added to the QAPI agenda and with audits addressed monthly. 5. Completion date 3-25-15	

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F 520	Continued From page 50 residents received their restorative programs as directed. On 2/20/15, at 11:05 a.m. the facility administrator confirmed he was aware the restorative nursing programs had not been completed due to a lack of nursing assistants. The Quality Improvement procedure dated 3/2012, under Procedure bullet number 7 read: "Action plans will be implemented to address identified issues and will be evaluated for effectiveness on a regular basis."	F 520		

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GOOD SAMARITAN SOCIETY - CLEARBROOK	**305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on March 13, 2014. At the time of this survey Good Samaritan Society Clearbrook was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101

Or by e-mail to:

EPOC

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/13/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING **01 - 1953 BUILDING WITH ADDITIONS** B. WING _____	**02/19/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 Marian.Whitney@state.mn.us or Angela.Kappenman@state.mn.us	K 000		

THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION:

1. A description of what has been, or will be, done to correct the deficiency.

2. The actual, or proposed, completion date.

3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency

The Good Samaritan Society Clearbrook is a one story building with a full basement. The main building was built in 1953 and has a wood roof system making this building a Type V (000). The facility has additions built in 1962 and 1966, one to the south and one to the east of the original building, which are one story buildings with basements and are Type II (111) construction. These additions are separated with 2- hour fire barriers. In 1999 a basement laundry addition was added to the west of the north wing and was determined to be Type II(111) construction. The basement level is call 1st floor and the 1st story is called 2nd floor.

The facility is completely protected by an automatic sprinkler system and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification.

The facility has a capacity of 43 beds and had a

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K 000	Continued From page 2 census of 36 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 029 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 This STANDARD is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection from 1 of several hazardous areas located throughout the facility in accordance with NFPA Life Safety Code 101 (2000 edition) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect the exiting capabilities for residents, staff and visitors. Findings include: On facility tour between 11:30 AM and 1:30 PM	K 029	1. The inner wood ply on door to Elevator Equipment room detached from the main supporting structure- no internal door material was lost or damaged. The outer ply was securely reglued and bolted back into place. 2. Maintenance staff will be checking this weekly for separation issues and if any noted concerns a new door will be purchased and installed. 3. Maintenance staff will have ongoing monitoring of doors to prevent future occurrences with repairs/replacement as appropriate. Maintenance staff educated on 3-10-15 regarding monitoring doors, maintenance concerns. 4. Weekly audits will be recorded x 8	3/25/15

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K 029	Continued From page 3 on 02/19/2015, observation revealed, that the fire rated door to the elevator equipment room was found to be damaged and splitting exposing the interior of the door. This deficient practice was verified by the Maintenance Supervisor.	K 029	weeks and findings reported to QA. 5. Completion date 3-25-15	

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered
March 5, 2015

Mr. Gordon Hormann, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, Minnesota 56634

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5523023

Dear Mr. Hormann:

The above facility was surveyed on February 17, 2015 through February 20, 2015 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, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman at (218) 308-2104) or email: lyla.burkman@state.mn.us.

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

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00078	A. BUILDING: _____ B. WING _____	02/20/2015

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On February 17th, 18th, 19th and 20th 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review the facility did not ensure the Quality Assessment and Assurance (QA&A) committee developed and implemented appropriate plans of action to correct identified quality deficiencies related the lack of restorative nursing services. This had the potential to affect all 34 residents who resided in the facility. Findings include:	2 255	corrected	3/25/15

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2 255	Continued From page 3 The facility failed to provide services in accordance with the resident's written plan of care for 4 of 4 residents (R21, R7, R49, R33) in the sample who required assistance with range of motion services and 1 of 1 resident (R21) who required assistance with ambulation services. See F282. The facility failed to provide the necessary treatment and services to improve and maintain the resident's abilities to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing rehabilitation. See F311. The facility failed to provide range of motion services to prevent further decrease in range of motion (ROM) for 4 of 4 residents (R21, R7, R49, R33) in the sample who had limitations in range of motion. See F318. The facility failed to ensure that sufficient qualified nursing staff was available to meet the residents' needs for nursing care in a manner which promoted each resident's physical, mental and psychosocial well-being, thus enhancing their quality of life. This practice had the potential to affect all 38 residents residing in the facility. See F353. On 2/20/15, at 1:40 p.m. registered nurse (RN)-A/QA&A coordinator stated the QA&A committee had identified and discussed the concern of the lack of nursing assistants at the quarterly QA&A meetings. She stated the	2 255		

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2 255	Continued From page 4 committee had attempted to be proactive in hiring more staff members, but their efforts had not generated a solution. She stated the QA&A committee had not specifically discussed the concern of lack of staffing in relationship to the lack of restorative nursing programs. RN-A confirmed the QA&A committee had not developed a formal action plan to ensure the residents received their restorative programs as directed. On 2/20/15, at 11:05 a.m. the facility administrator confirmed he was aware the restorative nursing programs had not been completed due to a lack of nursing assistants. The Quality Improvement procedure dated 3/2012, under Procedure bullet number 7 read: "Action plans will be implemented to address identified issues and will be evaluated for effectiveness on a regular basis." SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies related to the appropriate functions of the QA committee and related to identified concerns and the development and implementaytion of an action plan. The administrator of designee could develop and auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 255		

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2 302	Continued From page 5	2 302		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure consumers were provided in a written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the	2 302	corrected	3/25/15

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2 302	Continued From page 6 training. This had the potential to affect all 36 residents residing in the facility and resident representatives/families. Findings Include: On 2/19/15, at 8:43 a.m. the director of nursing (DON) stated the facility did not have any consumer education regarding their dementia/Alzheimer's staff training program. The DON verified there was not policy regarding consumer education for the dementia/Alzheimer training. On 2/19/15, at 8:50 a.m. the social service designee (SSD) provided the Social Work Admissions Checklist form revised 12/14, and verified there was nothing related to the provision of the required education on it and stated she had never seen it identified before. SUGGESTED METHOD OF CORRECTION: The administrator or designee could add/provide information describing the staff training program, categories of employees trained and the frequency of the training for consumers in written or electronic form. The administrator or designee could develop an auditing system to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 302		

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2 560	Continued From page 7	2 560		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop care plan interventions to monitor side effects of anticoagulation medication use for 1 of 1 resident (R22) reviewed on Coumadin (an anticoagulation medication used to eliminate or reduce the risk of blood clots). In addition, the facility failed to develop diabetic management interventions for 1 of 1 resident (R22) who was diabetic. Findings include: R22's Diagnosis Report dated 12/29/14, identified R22's diagnoses as atrial fibrillation (irregular heart rate), hypertension (high blood pressure), congestive heart failure (decrease in heart failure to pump blood), diabetes and a heart valve replacement. R22's admission Minimum Data Set (MDS) dated	2 560	corrected	3/25/15

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2 560	Continued From page 8 1/16/15, indicated R22 received insulin and anticoagulant therapy. R22's Order Summary Report directed staff to: · Conduct blood glucose checks twice a day · Administer Coumadin 2.5 milligrams (mg) every Sunday, Tuesday, Wednesday, Friday · Administer Coumadin 5 mg every Monday, Thursday, and Saturday · Administer 15 units of Novolog 70/30 insulin twice a day R22's care plan dated 12/29/14, failed to identify R22's diagnosis of atrial fibrillation and corresponding interventions which directed staff to observe for side effects of anticoagulation therapy usage, such as excessive bleeding, bruising and international normalized ration monitoring (INR- lab work to identify blood clotting levels). In addition, the care plan failed to identify R22's diagnosis of diabetes and the corresponding interventions which directed staff to observe signs and symptoms of hyperglycemic (high blood glucose levels), hypoglycemic (low blood glucose levels), blood glucose monitoring and administration of insulin etc. On 2/19/15, at 12:14 p.m. the director of nursing (DON) confirmed R22 was on Coumadin for atrial fibrillation and was a diabetic. The DON verified R22's care plan lacked focus areas and interventions with regards to diabetes and anticoagulation management. The DON confirmed it would be appropriate to have included on R22's care plan the diagnosis of atrial fibrillation and the side effect monitoring for anticoagulation therapy, in addition the care plan	2 560		

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2 560	Continued From page 9 could have been more specific with regards to R22's diabetes management. The Care Plan policy dated 9/2012, indicated each resident would have an individualized comprehensive care plan. Through the use of departmental assessments and physician orders, any problems, needs and concerns would be identified and addressed. The care plan would ensure that the resident received appropriate care and services. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the development of comprehensive care plans. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document	2 565	corrected	3/25/15

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2 565	Continued From page 10	2 565		

review, the facility failed to provide services in accordance with the resident's written plan of care for 4 of 4 residents (R21, R7, R49, R33) in the sample who required assistance with range of motion services and 1 of 1 resident (R21) who required assistance with ambulation. In addition, the facility failed to ensure activity's had been offered according to the residents care planned need for 1 of 3 residents (R10) reviewed for activities.

Findings include:

R21 did not receive assistance with ambulation and range of motion services according to the care plan.

R21's care plan dated 5/12/15, directed the staff to provide R21 with nursing rehabilitation services 2-3 times a week. The plan included to following:

- ambulation as tolerated
- Seated over head bounce passes x 20
- 4 minutes of over head pulleys
- red theraband (elastic exercise strap) exercised for the shoulder and elbow stretches x 20 repetitions.
- ankle lifts with a three pound weight
- hamstring curls with a red theraband
- ball squeezes and hip abduction with minimal resistance or red theraband
- sit to stand exercises as tolerated.
- encourage kegals

Review of R21's October 2014, Follow Up

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2 565	Continued From page 11 Question Report (restorative nursing documentation) indicated R21 had received ROM 6 of 15 opportunities. R21 had last received assistance with ROM on 10/16/14. The documentation did not include R21's ambulation program. On 2/18/15, at 3:00 p.m. R21 was observed to stand and transfer to a commode with assistance of one staff member. R21 did not display ROM limitations in her lower extremities. On 2/19/15, at 12:00 p.m. R21 was observed to feed herself the noon meal. R21 was able to use utensils without problems. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A and NA-B were observed to assist R21 to ambulate 36 feet in the corridor. On 2/20/14, at 9:00 a.m. registered nurse (RN)-A stated the facility did not have a restorative NA to provide the program services and confirmed she was aware the restorative programs had not been completed. She verified R21's care plan had not been followed. R7 had not received restorative nursing services as directed by her care plan. R7's care plan dated 3/20/14, identified restorative interventions due to R7's limited physical mobility related to arthritis and her limited ROM. R7's care plan directed staff to conduct	2 565		

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2 565	Continued From page 12 nursing rehab three times a week which included the following exercises: · Upper extremity functional maintenance program: upper extremity bike with resistance; overhead pulley x 3 minutes; number 2 dowel extension: elbow and shoulder 1 x 30; pick up cones off of the floor x1 while seated. · While seated in the wheelchair: hip flexion, marching; heel/toe raises x 10 each side; supine: hamstring stretch and calf stretch 2 x 30, quad sets, hamstring sets and heel slides x 10 each. On 2/18/15, at 1:00 p.m. R7 was observed propelling herself in her wheelchair down the hallway into her room where she remained seated in her wheelchair. On 2/18/15, at 2:45 p.m. RN-A stated the facility currently did not have anyone providing restorative nursing services. RN-A confirmed R7 had not received her restorative nursing services as directed by her care plan. On 2/19/15, at 12:32 p.m. the director of nursing (DON) verified 10/16/14, was the last day R7 had received restorative therapy. R49 had not received restorative nursing services as directed by his care plan. R49's care plan dated 10/26/14, identified restorative interventions due to R49's performance deficit and limited physical mobility.	2 565		

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2 565	Continued From page 13 R49's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises: · If seated: active range of motion (AROM) with hip flexion, hamstring curls with yellow t-band (exercise resistant band) 2 x 10 on right; AROM bilateral abduction and adduction 2 x 10, hamstring stretch and heel cord stretch bilaterally. If laying down: AROM on right hip and knee flexion and stretch. Abduction and adduction on left; passive range of motion (PROM): hip and knee flexion and stretch, abduction and adduction 2 x 20. · PROM right upper extremity, shoulder, elbow wrist, fingers, all planes 2 x 10 each. Encourage movement of thumb and pointer finger as tolerated. Yellow t-band extension left upper extremity 2 x 10 each elbow flexion, extension, and horizontal abduction/adduction. Ball toss to left upper extremity, have him hit it back to you 2 x 10 beach ball. Neck stretches, have him look up and hold for several second seconds 1 x 10, do this to each side. On 2/18/15, at 2:09 p.m. R49 was observed being transferred with a mechanical lift from his wheelchair to his bed by NA-C and licensed practical nurse (LPN)-D. R49 required total assistance with transfer. On 2/18/15, at 3:35 p.m. RN-A confirmed R49 had not received his restorative nursing services as directed by his care plan. In addition, RN-A verified 10/16/14, was the last day the facility had someone providing restorative nursing services.	2 565		

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2 565	Continued From page 14 On 2/19/15, at 12:22 p.m. the DON confirmed the facility did not have a formalized restorative nursing program. R33 was not provided restorative nursing services as directed by her current care plan. R33's diagnoses as indicated on the Diagnosis Report, included chronic airway obstruction, generalized osteoarthrosis, congestive heart failure, bursitis disorders, generalized pain and depressive disorder. R33's quarterly minimum data (MDS) set dated 10/25/14, indicated R33 had severe cognitive impairment and required extensive assist with bed mobility, transferring toileting, dressing and personal hygiene. In addition, R33 had range of motion (ROM) impairment on both sides for upper and lower extremities. R33's care plan dated 2/19/15, identified restorative interventions due to performance deficit/limited physical mobility. R33's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises: · Overhead pulley X 3 minutes Yellow t-band all planes 20 each. Assist to stand · Bilateral stretch all directions including hamstring stretch, ham curls and sit to stand 1-2 minutes each. Sit to stand in parallel bars and work on standing tolerance · Kegals for stress incontinence · Seated manually resisted abduction and adduction stand in stand aid and work on weight shifting for 5 to 10 minutes. On 2/20/15, at 10:05 a.m., NA-C verified that he	2 565		

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2 565	Continued From page 15 had not provided any type of restorative nursing exercises to any resident. On 2/20/15, at 10:10 a.m. LPN-B verified R33 had not received restorative nursing services for several months. On 2/20/15, at 10:36 a.m. RN-A confirmed R33 had not received her restorative nursing services as directed by her care plan. RN-A verified 10/14/14, was the last day R33 received any type of restorative services. RN-A stated the facility had not provided restorative services to the residents for the past several months. On 2/20/15, at 11:14 a.m. The DON verified R33 had not received restorative services since 10/14/14. The DON stated R33 should have been provided the services as directed by the care plan. The Restorative Nursing Care policy dated 6/2012, indicated the goal of restorative nursing care was to assure the maximum possible independence for each resident was maintained and declines were prevented. Each resident would receive restorative nursing care to the extent possible, and based on their individual strengths, needs and problems as defined by the nursing assessments. In addition, the restorative care would be outlined in the resident's care plan. R10 was not assisted to participate in acitivies as directed by the care plan. R10's diagnosis report dated 2/20/15, indicated R10 was diagnosed with Alzheimer's disease.	2 565		

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2 565	Continued From page 16	2 565		

R10's care plan dated as last revised on 1/13/15, indicated R10 was dependent on staff for activities, cognitive stimulation and social interaction. The care plan directed staff to provide R10 1:1 bedside/in-room activities if unable to attend out of room events as well as preferred activities such as conversation, music, prefers to stay in room, naps, children, outdoor and spiritual events. The care plan had not identified how often 1:1 activities were to be provided to R10 who preferred to stay in her room nor the frequency of the directive to encourage ongoing family involvement, invite residents and family to attend special events, activities and meals.

On 2/17/15, from 4:45 p.m. until 7:30 p.m. R10 was assisted with eating the evening meal and assisted to bed at 7:23 p.m. R10 was not involved with any activities.

On 2/18/15, at 9:30 a.m. R10 was observed seated in her room. No television or radio on. At 11:36 a.m. R10 was observed seated in the common corridor waiting to go into the dinning room for the noon meal.

On 2/19/2015, at 8:44 a.m. R10 was observed in the dining room, eating breakfast.

On 2/19/2015, at 9:34 a.m. R10 was observed seated in front of the television with other residents while the morning news show was on. R10 had her eyes closed and did not appear to be engaged in watching the television.

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2 565	Continued From page 17 On 2/19/2015, at 11:03 a.m. Church service was held and R10 was not assisted to the service / activity. On 2/19/2015, at 1:00 p.m. R10 was observed seated in the common lounge area just watching the people go by. On 2/19/14, at 2:00 p.m. a monthly resident birthday party was held. However, R10 was not asked nor assisted to the birthday party / activity. On 2/20/15, at 10:18 a.m. the activity director (AD) was asked what activities R10 had participated in on 2/19/15. The AD confirmed the 2/19/15, activity documentation and stated the first activity which took place at 1:03 p.m. was an educational / cognitive activity. When the surveyor asked what the actual activity was and if R10 had participated or enjoyed the activity, the AD stated she could not tell by the documentation exactly what the activity actually was and how long the activity lasted. The AD confirmed R10 was not assisted to the church service nor to the group birthday party held on 2/19/15, and should have been. The Care Plan policy dated 9/2012, indicated the care plan would emphasize the care and development of the whole person ensuring that the resident received appropriate care and services.	2 565		

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2 565	Continued From page 18 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee (s)could review and revise policies and procedures related to ensuring the care plan for each individual resident is followed. The director of nursing or designee (s) could develop a system to educate staff and develop a monitoring system to ensure staff are providing care as directed by the written plan of care. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 565		
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient qualified nursing staff was available to meet the residents' needs for nursing care related to restorative services in a manner which promoted	2 800	corrected	3/25/15

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2 800	Continued From page 19 physical, mental and psychosocial well-being, thus enhancing each residents' quality of life. This practice had the potential to affect all 38 residents residing in the facility. Findings include: The facility failed to provide services in accordance with the resident's written care plan for 4 of 4 residents (R21, R7, R49, R33) in the sample who required assistance with range of motion (ROM) services and 1 of 1 resident (R21) who required assistance with ambulation services. See F282. The facility failed to provide ambulation services in order to improve or maintain the resident's ability to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing restorative rehabilitation services. See F311. The facility failed to provide range of motion services in order to maintain and/or prevent further decrease in ROM for 4 of 4 residents (R21, R7, R49, R33) in the sample who had limitations in range of motion. See F318. Review of the nurse staffing for the past six weeks, (1/1/15 - 2/20/15) revealed the facility had not had a restorative aide assigned during the review period. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A stated the facility usually had enough staff to	2 800		

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2 800	Continued From page 20	2 800		

provide personal cares to the residents, however, did not have a restorative NA to provide assistance with restorative services. NA-A stated the facility had not had a restorative NA for the past 4 months.

On 2/19/15, at 1:30 p.m. NA-B stated the facility had been short staff members. She stated the residents had not received assistance with restorative nursing because they did not have staff members to provide it.

On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistants for the past several months and they had not had the staff to provide restorative nursing services.

On 2/19/15, at 2:00 p.m. NA-C stated the NAs did not have time to provide restorative nursing services.

On 2/19/15, at 2:00 p.m. LPN-B stated the facility had staffing issues. She stated the staff were doing the best they could but did not have time to perform the restorative programs for the residents.

On 2/20/15, at 8:45 a.m. registered nurse (RN)-A stated she was in charge of the restorative nursing program. She explained the restorative NA had left the facility in the middle of October 2014. Since that time, a NA was hired internally to complete the restorative programs, however, the NA was needed to provide direct care to the

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2 800	Continued From page 21 residents therefore had not been able to complete the training required to provide the restorative services. RN-A stated the facility had recently had two interim directors or nursing that had been made aware of the concern, however, they were unable to hire enough staff members to ensure the restorative NA was able to complete the programs. She confirmed the facility did not have sufficient nursing assistants to complete the restorative programs as directed. On 2/20/15, at 9:00 a.m. the director of nurses stated the facility was to have a specified NA to provide restorative nursing either four days a week for a five hour shift, or 2 full 8 hour shifts per week. She stated she had been informed the facility did not have a restorative NA when she started the DON position on 2/17/15. She stated she was told the facility had been unable to fill the restorative position and was aware the restorative nursing programs were not being completed but added the restorative program would become a facility priority. On 2/20/14, at 10:00 am. NA-E stated the restorative NA was to responsible to provide the services however stated the they had not been provided for a long time. On 2/20/15, at 11:05 a.m. the administrator confirmed he was aware the restorative nursing programs had not been completed due to a lack of nursing assistants. The Nursing Services Staff policy dated 9/2012,	2 800		

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2 800	Continued From page 22 directed the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, spiritual, mental and psychosocial well-being of each resident, as determined by the resident assessment and individual plans of care. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies, review and adjust scheduling needs in order to ensure the residents services are provided. The administrator or designee could develop an auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 800		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion.	2 895		3/25/15

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	00078	A. BUILDING: _____ B. WING _____	02/20/2015

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2 895	Continued From page 23 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion services in order to maintain or prevent decrease in range of motion (ROM) ability for 4 of 4 residents (R21, R7, R49, R33) in the sample who had limitations in range of motion. Findings include: R21 did not ROM services as directed by the care plan. R21's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R21 was diagnosed with dementia and anxiety, had severe cognitive impairment and required extensive assistance with bed mobility, transfers, dressing, grooming and had unilateral lower extremity physical limitations. R21's care plan dated 5/12/15, directed staff to provide R21 with nursing rehabilitation 2-3 times a week. The plan included: - Seated over head bounce passes x 20 - 4 minutes of over head pulleys - red theraband (elastic exercise strap) exercised for the shoulder and elbow stretches x 20 repetitions. - encourage to walk to elevated with walker -ankle lifts with a three pound weight - hamstring curls with a red theraband - ball squeezes and hip abduction with minimal resistance or red theraband	2 895	corrected	

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2 895	Continued From page 24 - sit to stand exercises as tolerated. - encourage kegals R21's Restorative Care Program established on 10/3/12, by the physical therapist directed staff to encourage R21 to participate in lower extremity strengthening exercises including marching exercises with a three pound weights, ankle pumps, hamstring curls with red theraband, ball squeezes and hip abduction with either manual resistance or red theraband bilaterally x 15 repetitions and sit to stand exercises as R21 tolerated. R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had received ROM 6 of 15 opportunities. R21 had last received assistance with ROM on 10/16/14. R21's clinical record did not contain any further documentation related to the restorative nursing program services. On 2/18/15, at 3:00 p.m. R21 was observed to stand and transfer to a commode with assistance of one staff member. R21 did not display ROM limitations in her lower extremities. On 2/19/15, at 12:00 p.m. R21 was observed to feed herself the noon meal. R21 was able to use utensils without problems. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A	2 895		

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2 895	Continued From page 25 stated the facility usually had enough staff to provide personal cares to the residents, however, did not have a restorative NA to provide assistance with restorative services. NA-A stated the facility had not had a restorative NA for the past 4 months. On 2/19/15, at 1:30 p.m. NA-B stated the facility had been short staff members. She stated the residents did not receive assistance with restorative nursing because they did not have staff members to provide it. On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistance for the past several months and did not have the staff to provide restorative services. On 2/19/15, at 2:00 p.m. NA-C stated the nursing assistants did not have time to provide restorative nursing services. AT the same time, LPN-B stated the facility had staffing issues and the NAs were doing the best they could, but did not have time to perform the restorative programs for the residents. On 2/20/14, at 9:00 a.m. registered nurse (RN)-A stated the facility use to have a NA who was in charge of completing the restorative nursing program, however, in October of 2014, the restorative NA had left the facility. RN-A stated the facility had hired another NA to complete the restorative programs, however, she had not been allowed to provide the services because she was needed to provide direct care to the residents	2 895		

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2 895	Continued From page 26 instead. RN-A stated she was aware that none of the restorative programs had been completed as directed and had reported the concern to the director of nursing (DON). RN-A verified R21's care plan had not been followed to ensure restorative nursing services were provided. On 2/20/14, at 9:15 a.m. RN-A was observed to cue R21 to raise her arms. R21 was able to raise her arms above her head, extended her arms outward and completed a full circle with her shoulders. R21 was not observed to display any type of ROM limitations in her upper extremities. R7 had not received restorative nursing services as directed by her current care plan. R7's diagnoses, as indicated on the Diagnosis Report, included shortness of breath, cataracts, anemia, Alzheimer's, generalized pain, congestive heart failure (decrease in heart function to pump blood), depression and arthritis. R7's quarterly MDS dated 11/26/14, indicated R7 had moderate cognitive impairment and required extensive assist with bed mobility, transferring, locomotion on and off the unit, toileting and personal hygiene. In addition, R7 had ROM impairment on her lower extremities (hip, knee, ankle, foot) on the one side. R7's care plan dated 3/20/14, identified restorative interventions due to R7's limited physical mobility related to arthritis and her limited	2 895		

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2 895	Continued From page 27 ROM. R7's care plan directed staff to conduct nursing rehab three times a week which included the following exercises: · Upper extremity functional maintenance program: upper extremity bike with resistance; overhead pulley x 3 minutes; number 2 dowel extension: elbow and shoulder 1 x 30; pick up cones off of the floor x 1 while seated. · While seated in the wheelchair: hip flexion, marching; heel/toe raises x 10 each side; supine: hamstring stretch and calf stretch 2 x 30, quad sets, hamstring sets and heel slides x 10 each. On 2/18/15, at 2:45 p.m. RN-A stated the facility currently did not have anyone providing restorative nursing services. RN-A thought it had been about two months that the facility had gone without someone in this position. RN-A confirmed R7 had not received her restorative nursing services as directed on her care plan. On 2/18/15, at 3:00 p.m. the physical therapy aide (PTA)-A stated she was aware the facility did not have a current restorative nursing program in place. PTA-A stated the therapy department was frustrated because when they no longer could see a resident, a restorative program was set up for the resident and we know they are not receiving what is needed. On 2/18/15, at 1:00 p.m. R7 was observed propelling herself in her wheelchair down the hallway into her room where she remained seated in her wheelchair. On 2/19/15, at 12:32 p.m. the DON verified	2 895		

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2 895	Continued From page 28 10/16/14, was the last day R7 had received restorative therapy. On 2/20/15, at 9:32 a.m. occupational therapist (OT)-A was observed conducting an assessment and evaluation on R7. OT-A stated R7 had full extension of her upper extremities. OT-A assisted R7 into the bathroom. R7 was able to propel herself in her wheelchair into the bathroom and with a gait belt around R7's waist; R7 stood and completed the transfer from the wheelchair to the toilet with minimal assistance. OT-A stated on review of R7's baseline and where R7 was today, she did not see a decline in her ability with transfers and upper body strength. However, OT-A thought it would be appropriate for therapy to work with R7, even just for a short period of time. R7's occupational therapy plan of care dated 2/20/15, indicated R7 had not received skilled occupational therapy services since 5/4/2012. The occupational therapist stated R7 would benefit from continued work with breathing and compensatory techniques to improve her energy levels. In addition, the resident showed potential for further gains with upper extremity strength and transfers. R49 had not received restorative nursing services as directed by his current care plan. R49's diagnosis, as indicated on the Diagnosis Report, included cerebrovascular disease (stroke), congestive heart failure, aphasia (partial	2 895		

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2 895	Continued From page 29 or total loss of ability to communicate), atrial fibrillation (irregular heart rate), anxiety and arthritis. R49's quarterly MDS dated 12/9/2014, indicated R49 had severe cognitive impairment and required extensive assist with bed mobility, transferring, dressing, toileting and personal hygiene. In addition, R49 had ROM impairment on one side for upper and lower extremities. R49's care plan dated 10/26/14, identified restorative interventions due to R49's performance deficit and limited physical mobility. R49's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises: · If seated: active range of motion (AROM) with hip flexion, hamstring curls with yellow t-band (exercise resistant band) 2 x 10 on right; AROM bilateral abduction and adduction 2 x 10, hamstring stretch and heel cord stretch bilaterally, If laying down: AROM on right hip and knee flexion and stretch. Abduction and adduction on left; passive range of motion (PROM): hip and knee flexion and stretch, abduction and adduction 2 x 20. · PROM right upper extremity, shoulder, elbow wrist, fingers, all planes 2 x 10 each. Encourage movement of thumb and pointer finger as tolerated. Yellow t-band extension left upper extremity 2 x 10 each elbow flexion, extension, and horizontal abduction/adduction. Ball toss to left upper extremity, have him hit it back to you 2 x 10 beach ball. Neck stretches, have him look up and hold for several second seconds 1 x 10, do this to each side.	2 895		

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2 895	Continued From page 30 R49's Physical Therapy (PT) - Therapist Progress and Discharge Summary dated 9/30/14, indicated R49 had participated in PT from 9/5/14 - 9/30/14. PT had worked with R49 and attempted to increase his lower extremity strength bilaterally. In addition, they worked on decreasing the amount of assistance he required with transfers which resulted in little or no gain. R49 was discharged from PT services and placed on a functional maintenance program. R49's Restorative Care Program dated 10/10/14, provided the direction which was reflected on R49's care plan with regards to his functional maintenance program as recommended by therapy. On 2/18/15, at 2:09 p.m. R49 was observed being transferred with a mechanical lift from his wheelchair to his bed by NA-C and licensed practical nurse (LPN)-D. R49 required total assistance with transfer. On 2/18/15, at 3:35 p.m. RN-A confirmed R49 had not received his restorative nursing services as directed by his care plan. In addition, RN-A verified 10/16/14, was the last day the facility had someone providing restorative nursing services. On 2/19/15, at 11:15 a.m. NA-C confirmed he had not done any restorative nursing exercises on the residents.	2 895		

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2 895	Continued From page 31 On 2/19/15, at 11:20 a.m. NA-B confirmed she had not done any restorative nursing exercises with the residents. On 2/19/15, at 11:33 a.m. NA-A confirmed sometimes she would do exercises with the residents; however she did not document these. NA-A stated the facility used to have a restorative aide who did the exercises with the residents. On 2/19/15, at 11:40 a.m. NA-F confirmed she had not done any restorative nursing exercises with the residents. On 2/19/15, at 12:22 p.m. the DON confirmed the facility did not have a formalized restorative nursing program. On 2/20/15, at 9:32 a.m. PT-A conducted an assessment and evaluation on R49. PT-A concluded that through her partial evaluation which she conducted today and her review of R49's past evaluation she had not seen a decline in R49's ROM. R33 had not received restorative nursing services as directed by her current care plan. R33's diagnosis as indicated on the Diagnosis Report, included chronic airway obstruction, generalized osteoarthrosis, congestive heart failure, bursitis disorders generalized pain and depressive disorder.	2 895		

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2 895	Continued From page 32 R33's quarterly MDS dated 10/25/14, indicated R33 had severe cognitive impairment and required extensive assist with bed mobility, transferring, toileting, dressing and personal hygiene. In addition, R33 had ROM impairment on both sides of upper and lower extremities. R33's care plan dated 2/19/15, identified restorative interventions due to performance deficit/limited physical mobility. R33's care plan directed staff to conduct nursing rehab 2-3 times a week which included the following exercises: · Overhead pulley X 3 minutes Yellow t-band all planes 20 each. Assist to stand · Bilateral stretch all directions including hamstring stretch, ham curls and sit to stand 1-2 minutes each. Sit to stand in parallel bars and work on standing tolerance · Kegals for stress incontinence · Seated manually resisted abduction and adduction stand in stand aid and work on weight shifting for 5 to 10 minutes. R33's Physical Therapy (PT)- Therapist Progress and Discharge Summary dated 9/15/12, indicated R33 had participated in therapy from 8/9/2012 - 9/7/12. PT had worked with R33 and had gains in her lower extremity ROM and improved transfer status. PT provided gait services which improved R33's abilities in all functional mobility. R33 was discharged from PT services and placed on a restorative service program. R33's Restorative Care Program dated 9/10/12, provided goals recommended by therapy for restorative services program to maintain ROM, maintain strength for lower extremities bilaterally, and maintain standing tolerance/endurance. Approaches and recommendations for implementation of the goals are identified on	2 895		

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2 895	Continued From page 33 R33's care plan. On 2/20/15, at 10:05 a.m., NA-C verified that he had not provided any restorative nursing exercises to any resident. On 2/20/15, at 10:10 a.m. LPN-B stated R33 had not received restorative services for the past several months. On 2/20/15, at 10:21 a.m. during observation of R33'S physical therapy assessment, PTA-A verified R33's restorative services recommendations following discharge from PT was 9/10/12. PTA-A confirmed it was her expectation the facility would provide the services. PTA-A completed the physical assessment following the recommended goals and verified there was no decline in R33's physical mobility. On 2/20/15, at 10:36 a.m. RN-A confirmed R33 had not received restorative nursing services as directed by her care plan. RN-A verified 10/14/14, was the last day R33 received restorative services. RN-A stated the facility had not provided restorative services for the past several months. On 2/20/15, at 11:14 a.m. the DON verified 10/14/14, was the last day R33 received restorative nursing services and should have as directed by the care plan. The Restorative Nursing Care policy dated 6/2012, indicated the goal of restorative nursing care was to assure the maximum possible independence for each resident was maintained and declines were prevented. Each resident would receive restorative nursing care to the	2 895		

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2 895	Continued From page 34 extent possible, and based on their individual strengths, needs and problems as defined by the nursing assessments. In addition, the restorative care would be outlined in the resident's care plan. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the provision of restorative services. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 895		
2 915	MN Rule 4658.0525 Subp. 6 A Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident is given the appropriate treatments and services to maintain or improve abilities in activities of daily living unless deterioration is a normal or characteristic part of the resident's condition. For purposes of this part, activities of daily living includes the resident's ability to: (1) bathe, dress, and groom; (2) transfer and ambulate; (3) use the toilet; (4) eat; and (5) use speech, language, or other functional communication systems; and	2 915		3/25/15

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2 915	Continued From page 35 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide ambulation services in order to improve or maintain the resident's ability to ambulate for 1 of 4 residents (R21) in the sample who were reviewed for nursing rehabilitation ambulation services. Findings include: R21's quarterly Minimum Data Set (MDS) dated 1/27/15, indicated R21 was diagnosed with dementia and anxiety, had severe cognitive impairment and required extensive assistance with ambulation in her room and did not ambulate in the corridor. The assessment also indicated R21 displayed physical limitations on one side of her lower extremities. R21's care plan dated 5/12/15, directed staff to assist R21 to ambulate with a two wheeled walker 2-3 times a week as tolerated. R21's Restorative Care Program established 10/3/12, by the physical therapist directed staff to ambulate R21 with a two wheeled walker as R21 tolerated. During the survey conducted on 2/17/15, from 12:00 p.m. to 8:00 p.m., on 2/18/15, from 8:00 a.m. to 4:30 p.m. and on 2/19/15, from 7:00 a.m.	2 915	corrected	

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2 915	Continued From page 36 to 3:30 p.m. R21 was observed to utilize a wheelchair for mobility. On 2/18/15, at 3:00 p.m. R21 was observed to stand and pivot-transfer to a commode with assistance of one staff member. R21 did not walk during this observation. R21's October 2014, Follow Up Question Report (restorative nursing documentation) indicated R21 had not received assistance with ambulation services. R21's clinical record did not contain any further documentation related to ambulation services. The last entry related to ambulation was documented on 10/16/14. On 2/19/15, at 1:00 p.m. family member (FM)-A stated she could not recall the last time she had seen R21 ambulate. She stated R21 had her own walker but she had not seen the walker in her room for months. FM-A stated she was not sure if R21 had the ability to ambulate. On 2/19/15, at 1:20 p.m. nursing assistant (NA)-A was asked to assist R21 to ambulate. NA-A looked in R21's room and was unable to locate her walker. NA-A went to the therapy room and located a walker. NA-A and NA-B were observed to ambulate R21 36 feet in the corridor. At this same time, NA-A stated the facility usually had enough staff to provide personal cares to the residents, however, the facility did not have a restorative NA to provide restorative services. She stated the facility had not had a restorative NA for the past 4 months.	2 915		

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2 915	Continued From page 37 On 2/19/15, at 1:30 p.m. NA-B stated the facility had been short staff members therefore, the residents had not received assistance with restorative nursing because they did not have staff members to provide it. On 2/19/15, at 1:45 p.m. licensed practical nurse (LPN)-A stated the facility had been short of nursing assistants for the past several months. She stated the facility did not have the staff to provide restorative nursing. On 2/19/15, at 2:00 p.m. NA-C stated the nursing assistants did not have time to provide restorative nursing services. On 2/19/15, at 2:00 p.m. LPN-B stated the facility had staffing issues. She stated the staff were doing the best they could, but they did not have time to perform the restorative programs for the residents. On 2/20/15, at 9:00 a.m. registered nurse (RN)-A stated R21's ability to ambulate fluctuated daily related to the amount of back pain she was having. She confirmed R21's clinical record did not direct the staff as to how far R21 was to ambulate. She stated R21 had not been routinely offered assistance to ambulate because the facility did not currently have a restorative NA. She stated the facility use to have a restorative NA who was in charge of completing the restorative nursing program, however, in October of 2014, the restorative NA had left the facility. RN-A stated the facility had hired another NA to	2 915		

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2 915	Continued From page 38 complete the restorative programs, however, she had not been allowed to provide the services because she was needed to provide direct care to the residents instead. She stated she was aware none of the restorative programs had been completed as directed and had reported the concern to the director of nursing (DON). RN-A verified R21's care plan had not been followed to ensure ambulation services were provided to R21. The Care Plan policy dated 9/2012, indicated the care plan would emphasize the care and development of the whole person ensuring that the resident received appropriate care and services. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related the provision of ambulation services. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	2 915		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.	21375		3/25/15

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21375	Continued From page 39 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the glucometers (devices utilized for monitoring blood sugars) were appropriately disinfected after each resident use. This had the potential to affect 3 of 3 residents (R14, R22, R54) who used a community glucometer. Findings include: On 2/17/15, at 4:31 p.m. registered nurse (RN)-B was observed to conduct a blood glucose check on R14. Immediately following R14's blood glucose check, RN-B was observed to wipe off the glucometer with an alcohol prep wipe which contained 70% isopropyl alcohol. RN-B confirmed R14, R22, and R54, all utilized this glucometer and that she routinely disinfected the glucometer by wiping it down with an alcohol prep wipe after each resident use. On 2/18/15, at 8:37 a.m. the licensed practical nurse (LPN)-B confirmed the two glucometers currently stored in the first floor treatment cart were utilized by R14, R22, and R54. LPN-B stated she disinfected the glucometers after each resident use by wiping them down with an alcohol wipe. On 2/19/15, at 12:04 p.m. the director of nursing (DON) verified the residents on the first floor did not have their own designated glucometer. The DON stated the glucometers should be cleaned after each use and she believed the alcohol prep wipe was an appropriate disinfecting wipe, however, the staff should follow the facility policy and manufacture guidelines.	21375	corrected	

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21375	Continued From page 40 The Cleaning and Disinfecting Blood Glucose Meters policy dated 11/2014, directed staff to properly disinfect the glucometer after each resident use with 1:10 bleach to water solution or an acceptable germicidal disposable wipe. The Assure Platinum glucometer manufacture instructions directed staff to clean and disinfect the glucometer between each resident, using an EPA (Environmental Protection Agency) registered disinfectant detergent or germicide wipe. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures related the appropriate cleaning/disinfecting of the community glucometers and provide staff education. The administrator or designee could develop and auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21375		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be	21435		3/25/15

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21435	Continued From page 41 provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure activity's had been offered according to the assessed need for 1 of 3 residents (R10) reviewed for activities. Findings include: R10's diagnosis report dated 2/20/15, indicated R10 was diagnosed with Alzheimer's disease, osteoarthrosis, dysphagia and depressive disorder. R10's annual Minimum Data Set (MDS) dated 7/4/14, indicated R10 had severely impaired cognition, required extensive assistance of two staff with transfers and locomotion on the unit. The MDS further indicated R10 felt the following activities of interest were very important to her: - listen to music - participating in favorite activities - participate in religious services or practice R10's comprehensive activities assessment completed 7/2/14, indicated R10 enjoyed the following activity interests: Children/youth, Entertainment, poetry, tending garden, 1:1 activities, music activities that involved old time and Christian music, movies, television shows that involved family type interaction such as Little	21435	corrected	

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21435	Continued From page 42 House on the Prairie, beach ball toss, humor and conversing, clergy visits, devotions, worship services and sitting outdoors. R10's care plan dated as last revised on 1/13/15, indicated R10 was dependent on staff for activities, cognitive stimulation and social interaction. The care plan directed staff to provide R10 1:1 bedside/in-room activities if unable to attend out of room events as well as preferred activities such as conversation, music, prefers to stay in room, naps, children, outdoor and spiritual events. The care plan had not identified how often 1:1 activities were to be provided to R10 who preferred to stay in her room nor the frequency of the directive to encourage ongoing family involvement, invite residents and family to attend special events, activities and meals. On 2/17/15, from 4:45 p.m. until 7:30 p.m. R10 was observed being assisted to eat the evening meal and assisted to bed at 7:23 p.m. R10 was not involved with any activities. On 2/18/15, at 9:30 a.m. R10 was observed seated in her room. No television or radio on. At 11:36 a.m. R10 was observed seated in the common corridor waiting to go into the dinning room for the noon meal. On 2/19/2015, at 8:44 a.m. R10 was observed in the dining room, eating breakfast. On 2/19/2015, at 9:34 a.m. R10 was observed seated in front of the television with other	21435		

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21435	Continued From page 43	21435		

residents while the morning news show was on. R10 had her eyes closed and did not appear to be engaged in watching the television.

On 2/19/2015, at 11:03 a.m. Church service was held and R10 was not assisted to the service / activity.

On 2/19/2015, at 1:00 p.m. R10 was observed seated in the common lounge area just watching the people go by.

2/19/14, at 2:00 p.m. a monthly resident birthday party was held. However, R10 was not asked or assisted to join the birthday party / activity.

Review of R10's activity documentation indicated that on 2/19/14, R10 had attended / participated in 2 activities, however it was unclear by the documentation what activities R10 had been provided and if R10 actually participated in the activity or even liked the activity. Further review of the activity participation documentation in February 2015, revealed R10 had participated in 22 1:1 activities and 11 group activities. However, the actual type of activity and the length of the activity was not identified. The documentation included a checkmark by a time and a checkmark that indicated an activity had occurred.

On 2/20/15, at 10:18 a.m. the activity director (AD) was asked what activities R10 had participated in on 2/19/15. The AD confirmed the 2/19/15, activity documentation and stated the first activity which took place at 1:03 p.m. was an

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21435	Continued From page 44 educational / cognitive activity. When the surveyor asked what the actual activity was and if R10 had participated or enjoyed the activity, the AD stated she could not tell by the documentation exactly what the activity actually was nor how long the activity lasted. The AD stated she would have to call the activity person who documented the activity in order to know what the activity actually was and how long it lasted. The AD left to make a phone call to the 2/19/15, activity person. After the call, the AD stated she was informed R10 had participated in a music activity on television but could not tell what program it was, what time the activity occurred or if R10 enjoyed the activity nor how long the activity lasted but stated there was some music on the television. The AD also confirmed R10 was not assisted to the church service nor the group birthday party held on 2/19/15. The AD verified both activities were identified as activities of interest for R10 and stated R10 should have been asked to join and assisted to the activities. The AD also stated the activity charting system had changed in the past year and it was now hard to tell what specific activities residents actually attended, how long the activities lasted and if the resident enjoyed the activity. The AD stated 1:1 activities could last anywhere from 2-15 minutes and could range from a conversation in the hallway about a family member or simply turning on the television for a resident all of which would be documented as a 1:1 activity. The AD confirmed the charting system did not give an accurate reflection of how often and what activity R10 had actually participated in. an activy policy and procedure was requested and not provided.	21435		

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21435	Continued From page 45 SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the provision of activity services. The administrator or designee could develop an auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21435		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change.	21535		3/25/15

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21535	Continued From page 46 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure there was adequate indication for the use of Seroquel (anti-psychotic) medication for 1 of 5 residents (R48) in the sample reviewed for unnecessary medications. Findings include: R48's Diagnosis Report dated 2/20/15, indicated R48 was diagnosed with memory loss, generalized pain, dementia with behavioral disturbances, generalized anxiety disorder and hearing loss. R48's admission Minimum Data Set (MDS) dated 9/1/14, identified R48's lifetime occupation was a LPN and R48 had moderate difficulty with hearing, was able to clearly make self understood, had severely impaired cognition, and displayed patterns of disorganized thinking (disorganized or illogical flow of conversation rambling or irrelevant conversation, unclear or illogical flow of ideas, or unpredictable speech switching from one idea to the next rapidly). The admission MDS also identified R48 had delusions, was independent with ambulation and transfer ability and did not have any balance deficits. R48's care plan last revised 12/6/14, revealed the following: R48 is on Seroquel related to	21535	corrected	

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21535	Continued From page 47 attempting to elope, attempting to toilet or get other resident up, storing garbage in drawers. Reduction attempted in November 2014. The interventions included the following: "BLACK BOX WARNINGS: #1 Observe for increased mortality in elderly patients with dementia-related psychosis, clinical worsening of depression and suicide risk. Potential adverse effects include agitation, anxiety, increased cholesterol, constipation, dizziness, drowsiness. The resident has a behavior symptom related to poor memory, wanders, attempts elopements, attempts toileting other residents goes in at night and awakes other residents for cares. The interventions included: Intervene as necessary to protect the rights and safety of others, approach and speak in a calm manner, divert attention, remove from situation and take to an alternate location, provide opportunity for positive interaction and attention. Minimize potential for residents disruptive behaviors, elopement attempts by offering tasks which divert attention such as scrabble games puzzles and visiting with other ladies. Praise any indication of residents progress/ improvement in behavior. Resident prefers diversional activities as listed above puzzles, scrabble. The care plan identified the following behaviors: -BEHAVIOR #1 elopement attempts: likes scrabble, puzzles with other ladies. Target behaviors for PRN Xanax. -BEHAVIOR #2 Storing garbage in dresser drawers. Check dresser drawers once every shift for garbage or food. -BEHAVIOR #4 awaking other residents attempting to toilet/get up at night. Check resident every 30 minutes. Offer to take resident on a walk outside. Redirect.	21535		

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21535	Continued From page 48 R48's Social Services section of the care plan included the following: The resident has a behavior symptom related to poor memory, wanders, attempts elopement, attempts toileting other residents goes in at night and awakes other residents for cares. The care plan is virtually the same as above where it lists the same problems and interventions there is nothing new in this section of the care plan just a repeat of the aforementioned problem and intervention. The resident has potential for elopement related to dementia, less than 5 minute recall. Interventions included: check resident every 30 minutes. R48's physician progress notes dated 11/10/14, indicated Seroquel was started because R48 had behaviors that included wanting to assist in the care of other residents in the facility as well as help the nurses in the facility care for the residents. The physician progress note indicated R48 had no hallucinations or delusions. The next physician progress note provided was dated 12/18/14, which identified that R48 was prescribed the antipsychotic medication for behaviors that included: "...continues to have some behaviors where she tends to interrupt the care of the patient, like transferring them, trying to feed them, entering into other residents' rooms, etc." The physician wrote "Seroquel seems to be helping." but does not identify how often the behaviors occurred, non-pharmacological interventions attempted and if those non-pharmacological interventions were successful. R48's nursing progress notes (NPN) dated 11/17/14, indicated Seroquel was discontinued	21535		

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21535	Continued From page 49	21535		

and the NPN dated 12/4/14, identified the Seroquel had been restarted, however there was no physician progress note that explained the rationale for stopping the medication on 11/17/14, nor for restarting the medication on 12/4/14.

Review of R48's physician orders revealed that on 12/4/14, Seroquel 25 milligrams (mg) (an antipsychotic medication) was restarted for dementia with behaviors.

Further review of R48's medical record revealed that monthly summaries of behavior were completed for the day and night shift from 9/1/14-1/24/15, and included the following:

-Monthly nursing documentation dated 9/16/14, identified R48 had behavior symptoms that included delusions (misconceptions or beliefs that are firmly held, contrary to reality.). The comment section of the report identified "res becomes restless at times and walks hallways rather quickly will settle down after gets ready for bed or gets distracted talking with other ladies or an activity. Seems to be worse in evening. The documentation had not identified how often this behavior was occurring nor what type of pharmacological and non-pharmacological interventions were attempted to remove or relieve these mood symptoms and if they were successful.

-Night shift monthly nursing documentation dated 9/17/14, identified R48 had mood and behavior symptoms exhibited during the night shift. The documentation had not identified what the behaviors were or how frequently they occurred.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21535	Continued From page 50 The boxes that identified non-pharmacological interventions included "phone calls to daughter, puzzles, reading materials and TV programs." Pharmacological interventions were "PRN Xanax available." Under the section for sleep patterns it was identified that R48 had "Issues with roommate." Under the section that was identified as "Specify:" the following was written: "Anxiety and confusion." -Monthly nursing documentation dated 11/24/14, identified R48 had behavior symptoms that included delusions. The comment section of the report identified "becomes very restless in the evening wanting to push other residents, going into other residents rooms wanting to help walking up and down hallways...going to the kitchen wanting to help,,, becomes agitated at times when told she is not to help either residents toilet transfer states this is her house an she can do what she wants here,,,needs redirection that is often not successful related to poor and short term memory. The documentation had not identified how often this behavior was occurring and what type of pharmacological and non-pharmacological interventions were attempted and if they were successful. Also noted "Some decrease in behaviors noted with start of Seroquel. Will cont to monitor. Night shift monthly documentation dated 11/17/14, identified R48 had mood and behavior symptoms exhibited during the night shift. The documentation had not identified what the behaviors were or how frequently they had occurred. The boxes on the monthly nursing documentation form that identified non-pharmacological interventions included "Redirect to bedroom, offer activity" and pharmacological interventions were identified as: "PRN Xanax, scheduled HS Seroquel."	21535		

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	00078	A. BUILDING: _____ B. WING _____	02/20/2015

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21535	Continued From page 51 -Review of the monthly nursing documentation dated 12/24/14, identified again no behavior symptom. Night shift monthly documentation dated 12/18/14, identified that R48 had mood and behavior symptoms exhibited during the night but had not identified what the behaviors were or how frequently they had occurred and the boxes that identified non-pharmacological interventions and pharmacological interventions were left blank. Further documentation identified R48 appeared to rest comfortably through the night. No further behavior documentation noted. -Review of the monthly nursing documentation dated as completed on 1/24/15, revealed R48 had no behavioral or mood symptoms. The documentation identified R48 got very anxious and paced up and down the hallways, unable to redirect most of the time. New medications included Seroquel started on 12/18/14. Night shift monthly nursing documentation completed 1/18/15, identified R48 had mood and behavior symptoms exhibited during the night but had not identified what the behaviors were or how frequently they had occurred and the boxes that identified non-pharmacological interventions and pharmacological interventions were left blank. Further documentation identified R48 appeared to rest comfortably through the night. The monthly pharmacist drug regimen review reports were reviewed from 9/1/14-2/1/15, and the following was identified: -On 11/17/14, the pharmacist recommendations included: "Please update care plan to reflect non	21535		

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21535	Continued From page 52 pharm interventions to try, consider discontinuing the Seroquel after the non- pharm interventions in place. If medication is needed, consider trazodone 12.5 mg BID instead of Seroquel. Please document non pharm interventions which failed and perform qualitative and quantitative analysis at least quarterly of this information to determine triggers of the behaviors and re-assess/update care plan as needed." There was no indication that this pharmacy recommendation had been acted on in its entirety. The Seroquel had been discontinued on 11/17/14, however trazodone had not been started in it's place, and qualitative and quantitative analysis of R48's behavior had not been completed. -On 12/15/14, the pharmacist made the following recommendations for all facility residents': "Discussed need to care plan non pharm interventions and target behaviors for psychotropics with DON and staff. They are aware. Utilize antipsychotic when all other reasons for behaviors are ruled out. Be sure documenting interventions failed and perform analysis of behaviors at least quarterly for patterns, # of times, other pertinent information around the behaviors. Update care plan as needed.- continues from Nov." On 2/18/2015 11:20 a.m. R48 was observed seated in the common lounge area nicely dressed holding her purse. R48 told the surveyor that she was getting ready to go home and that her house was a few blocks away from here and that she was just working here filling in. R48 stated she still had a car in the garage at home and was planning on taking it for a drive into the country	21535		

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21535	Continued From page 53 later today. R48 stated she was working here in the nursing home now only part time as she was retired. R48 stated that she was a licensed practical nurse (LPN) and liked visiting with the residents and helping them as much as she could. On 2/19/2015, at 1:20 p.m. the pharmacist stated she had verbally expressed her concerns with starting antipsychotic medication for R48 without first doing a complete assessment of the behavior then identifying and exhausting all non-pharmacological interventions. The pharmacist stated that the indications for using the antipsychotic medication for R48 included elopement attempts and attempting to care for other residents in the facility (the pharmacist also stated that R48 had been a former employee of the facility working as a licensed practical nurse for over 40 years). The pharmacist confirmed R48 did not have an adequate indication for the use of the antipsychotic medication Seroquel and stated she had also explained this to the director of nursing (DON). The pharmacist revealed she had explained to the facility staff that using antipsychotic medication without an adequate indication for its use could be a chemical restraint and the facility would need to assess R48's behavior and develop non-pharmacological interventions and determine that all of them had failed including the use of more appropriate pharmacological medications before using antipsychotic medication for R48 and stated that she had included the aforementioned information in her monthly drug regimen review for R48. On 2/19/15, at 2:30 p.m. nursing assistant (NA)-F stated R48's behavior was not a huge problem	21535		

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21535	Continued From page 54 and R48 was easily redirected if she started helping residents too much. NA-F stated it was hard for R48 to remember that she was not working here in the nursing home anymore. NA-F stated R48 was usually redirected easily by giving her a cup of coffee or setting her out in the common lounge area where other residents hang out so that she could converse with them. On 2/20/15 at 9:33 a.m. the DON stated R48 had been an employee of the nursing home for over 40 years. The DON stated R48 was receiving Seroquel for indications which included elopement from the facility and attempting to assist other residents. The DON stated she could not provide a comprehensive assessment of R48's behaviors and provide all non-pharmacological interventions attempted and those that had failed to deter R48's behavior. The DON confirmed R48 had never successfully eloped from the facility and using antipsychotic medication to deter elopement and assisting other residents was not an adequate indication for the use of antipsychotic medication including Seroquel. On 2/20/2015, at 10:17 a.m. licensed practical nurse (LPN)-C stated R48 had behaviors in the evening that included trying to help other residents. LPN-C stated R48 would never harm anyone, and didn't really think of R48's actions as a behavior...and R48 would never hurt anyone. LPN-C also stated R48 liked to be around other people and there were no residents in danger as a result of R48 trying to be helpful. LPN-C stated R48 was easy to redirect by asking her to have a cup of coffee or getting her involved in reading to	21535		

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21535	Continued From page 55 other residents. An antipsychotic use policy was requested and not provided. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and provide staff education related to the use of antipsychotic meedication. The administrator or designee could develop an auditing system in order to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-One (21) days.	21535		