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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B89V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245279**

2.STATE VENDOR OR MEDICAID NO.
(L2) **138218700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY**
(L4) **22 - 27TH AVENUE SOUTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55414**

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 **03/21/2012** (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 IMR	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 **165** (L18)

13.Total Certified Beds **165** (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	IMR
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date:
Patricia Kohls - HFE NEII
04/02/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/10/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 04/11/2012 CO.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/22/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5279

An extended survey was completed at Good Samaritan University Specialty Care on January 27, 2012. At the time of the survey, conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiency was found at a S/S level of F. As a result of the survey findings, the facility would be subject to the following:

- Loss of NATCEP effective January 27, 2012 due to an extended survey and SQC.

On March 21, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and determined that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to the standard survey, completed on January 27, 2012, effective March 21, 2012. Therefore, the remedies outlined in our letter dated April 2, 2012, will not be imposed. See attached CMS-2567B forms for the results of the March 21, 2012 revisit.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5279 April 10, 2012

Ms. Sharon St. Mary, Administrator
Good Samaritan Society - University Specialty Care
22 - 27th Avenue Southeast
Minneapolis, Minnesota 55414

Dear Ms. St. Mary:

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

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

Effective March 21, 2012 the above facility is certified for:

165 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 165 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

April 2, 2012

Ms. Sharon St. Mary, Administrator
Good Samaritan Society - University Specialty Care
22 - 27th Avenue Southeast
Minneapolis, Minnesota 55414

RE: Project Number S5279021

Dear Ms. St. Mary:

On February 17, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for an extended survey, completed on January 27, 2012. 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 March 21, 2012, the Minnesota Department of Health completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey, completed on January 27, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 21, 2012. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 27, 2012, effective March 21, 2012 and therefore remedies outlined in our letter to you dated February 17, 2012, will not be imposed.

However, as we notified you in our letter of February 17, 2012, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from January 27, 2012.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5279r112.rtf

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
245279	A. Building B. Wing	3/21/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

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 **F0157** Reg. # **483.10(b)(11)** LSC	Correction Completed **03/21/2012**	ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **03/21/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **03/21/2012**
ID Prefix **F0274** Reg. # **483.20(b)(2)(ii)** LSC	Correction Completed **03/21/2012**	ID Prefix **F0276** Reg. # **483.20(c)** LSC	Correction Completed **03/21/2012**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/21/2012**
ID Prefix **F0325** Reg. # **483.25(i)** LSC	Correction Completed **03/21/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **03/21/2012**	ID Prefix **F0463** Reg. # **483.70(f)** LSC	Correction Completed **03/21/2012**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/21/2012**	ID Prefix **F0496** Reg. # **483.75(e)(5)-(7)** LSC	Correction Completed **03/21/2012**	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	GL/sd	04/02/12	03023	03/21/12
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 1/27/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 26, 2012

Ms. Sharon St. Mary, Administrator
Good Samaritan Society - University Specialty Care
22 - 27th Avenue Southeast
Minneapolis, Minnesota 55414

Re: Enclosed Reinspection Results - Project Number S5279021

Dear Ms. St. Mary:

On March 21, 2012 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 27, 2012. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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

Please feel free to call me with any questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5279r112lic.rtf

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
00890	A. Building B. Wing	3/21/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

This report is completed by a State surveyor to show those deficiencies previously reported 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 State Survey Report (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 **20265** Reg. # **MN Rule 4658.0085** LSC	Correction Completed **03/21/2012**	ID Prefix **20545** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **03/21/2012**	ID Prefix **20550** Reg. # **MN Rule 4658.0400 Subp.** LSC	Correction Completed **03/21/2012**
ID Prefix **20910** Reg. # **MN Rule 4658.0525 Subp.** LSC	Correction Completed **03/21/2012**	ID Prefix **21685** Reg. # **MN Rule 4658.1415 Subp.** LSC	Correction Completed **03/21/2012**	ID Prefix **21990** Reg. # **MN St. Statute 626.557 Sul** LSC	Correction Completed **03/21/2012**
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	Date:	Signature of Surveyor:	Date:
	GL/sd	04/02/12	03023	03/21/12
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
1/27/2012				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: B89V

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245279**

2.STATE VENDOR OR MEDICAID NO.
(L2) **138218700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY**
(L4) **22 - 27TH AVENUE SOUTHEAST**
(L5) **MINNEAPOLIS, MN** (L6) **55414**

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 **01/27/2012** (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 IMR	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 **165** (L18)

13.Total Certified Beds **165** (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	IMR
	165			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 03/13/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/21/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

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

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
posted 3/22/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM

CCN #24-5279

An extended survey was completed at Good Samaritan University Specialty Care on January 27, 2012. At the time of the survey, conditions in the facility constituted Substandard Quality of Care (SQC) to resident health or safety. The most serious deficiency was found at a S/S level of F. As a result of the survey findings, the facility would be subject to the following:

- Loss of NATCEP effective January 27, 2012 due to an extended survey and SQC.

Post Certification Revisit to follow.

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8425

February 17, 2012

Ms. Sharon St. Mary, Administrator
Good Samaritan Society - University Specialty Care
22 - 27th Avenue Southeast
Minneapolis, Minnesota 55414

RE: Project Number S5279021

Dear Ms. St. Mary:

On January 27, 2012, an extended 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:

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

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

<u>Substandard Quality of Care</u> - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR §

483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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:

Gayle Lantto
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3794

Fax: (651) 201-3790

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 March 7, 2012, 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 March 7, 2012 the following remedy will be imposed:

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

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - University Specialty Care is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Program (NATCEP) or Competency Evaluation Programs for two years effective January 27, 2012. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR § 498.3(b)(13)(ii) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. The CMS Region V Office has authorized this Department to notify you of your appeal rights. If you disagree with the finding of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter.

Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,

- Include signature of provider and date.

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 April 27, 2012 (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 July 27, 2012 (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
Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Gayle Lantto

Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File 5279s12.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

(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 PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE 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	RECEIVED MAR 6 2012 COMPLIANCE MONITORING DIVISION LICENSE AND CERTIFICATION	
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative	F 157 POC accepted as Lanto 03/13/12	Resident #105s MD/NP was notified of resident's weight loss on 1/31/12 per telephone, and nutritional orders were changed. On 2/9/12 NP reviewed chart and spoke with team regarding resident's status. MD/NP have been working with team to address resident's nutritional needs and control of lower extremity edema which also contributed to weight increase/decrease since 12/9/11. Since weights did vary, units scale was in question of accuracy. Scale is now being serviced. All residents with unplanned weight loss will have notification of care provider, as per policy. All appropriate staff will be re-educated regarding the policy on physician notification of weight loss. The nurse manager, dietician and/or designee will monitor resident weights and will ensure that physicians are notified appropriately, as per policy. The QA/CQI committee will be responsible to audit for compliance. .	1/31/12 3/5/12 3/5/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: Executive Director (X6) DATE: 3-1-12

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

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F 157	Continued From page 1 or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident's physician when the resident experienced a significant weight loss for 1 of 5 residents (R105) who were at nutritional risk. Findings include: R105 experienced a 20.90% weight loss within a six month period and there was no indication the weight loss had been reported to the physician or nurse practitioner. R105's weights were recorded by several different nursing assistants as: 1/20/12 - 140 pounds; 12/23/11 - 159; 12/16/11 - 161.6; 12/2/11 - 177; 10/21/11 - 176; and 7/29/11 a weight of 177. The documented weights indicated there was a 20.90% weight loss between the 7/29/11 weight and 1/20/12 weight. At 7:38 a.m. on 1/25/12, the food service director (FSD) was interviewed regarding R105's weight loss. The FSD stated the facility registered	F 157		

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F 157	Continued From page 2 dietitians (RDs) reviews resident weights on a monthly basis, and nursing assistants (NAs) were to let the RDs know if there was a significant weight loss. When questioned at 10:10 a.m. on 1/25/12, RD-I stated all resident weights were reviewed at the end of every month. RD-I was unaware of R105's weight loss and said staff were to notify dietary when there was a five pound difference between recorded weights. RD-I stated R105 had been receiving fortified foods for some time, which included fortified Jell-O at meals. RD-I verified Glucose Control Boost was also being provided for the resident to add protein versus calories. After reviewing the recorded weights, RD-I verified R105 experienced a significant weight loss. At 10:55 a.m. on 1/15/12, NA-E stated she usually worked the evening shift and over the past 2-3 months and noticed a change in R105's eating ability and required assistance to eat more often. R105 ate culturally preferred food of flat bread and meat gravy provided at meal times, but nothing else. When asked if she had reported the decline, NA-E stated the evening nurse knew about it as the nurses were in the dining room at meal times. A trained medication aide-A (TMA-A) stated R105 "doesn't eat like he used to," but was unable to recall when the change was noted. TMA-A stated R105 preferred food from his native land. Nutritional assessments, completed by two different RDs on 9/19 and 12/9/11, revealed R105's weights for the each of those quarters	F 157		

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F 157	Continued From page 3 was reviewed. Each RD documented R105 weights as stable and within R105's usual body weight range of 177-180 pounds. The documentation also revealed R105 received a regular portion size, consistent carbohydrate, dysphasia (for swallowing disorder) diet, with two scoops of Bene Protein twice a day, for a low albumin (protein) level. On 12/22/11, the nurse practitioner discontinued the Bene Protein secondary to resident refusal and ordered one 8-ounce carton of Glucose Control Boost, twice a day to meet R105's protein requirements. The 9/11 RD note indicated that because of cultural needs, R105 received ground meat with gravy every day at lunch and required increased assistance from staff to be fed. There was no documentation indicating the nurse practitioner or physician was notified of R105's significant weight loss. A note by the physician on 12/27/11 only addressed a review of the 12/2/11 weight, despite additional recorded weights of 12/16 and 12/23/11, which indicated the significant weight loss.	F 157		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or	F 225	The facility reviewed the incidents and investigations for residents R169, R94, R142, R109, R158, R120, R63, R74 and R98 and R19. As per company policy, each incident not previously reported (R169, R94, R142 and R19) was reported online via the OHFC outline reporting system on 2/23/12. Investigations for incidents involving R160, R94, R142 and R19 were reviewed and where unclear, the documentation of the investigation was amended to provide clarity (cont.)	2/23/12

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F 225	Continued From page 4 other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to investigate and/or immediately report to the State agency (SA) including examples of 2 of 3 residents (R169 and R94) in the sample who had fractures of unknown origin; failed to provide evidence that all injuries of unknown origin were thoroughly investigated for 2 of 2 residents (R142, R19) who had bruises of unknown origin; and failed to immediately report	F 225	The facility has reviewed all incident reports beginning 1/1/12, in which the cause of the incident was labeled "unknown" to ensure thorough investigation and reporting, if necessary, and has reviewed incidents involving resident to resident altercations. Abuse and neglect prohibition policies and procedures were reviewed and all appropriate staff were re-educated on conducting investigations; and all mandatory reporters were re-educated regarding state and federal reporting requirements for injuries of unknown origin and resident to resident abuse. The Administrator, Director of Social Services and/or designee will be responsible to review all incidents daily to ensure compliance. The QA/CQI committee will be responsible to audit for compliance. .	1/1/12 3/5/12

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F 225	Continued From page 5 several cases of resident to resident altercations including 4 examples (109, R158, R120, R63, R74, R98) of 25 reports reviewed. Findings include: R169 was admitted to the facility on 9/15/11, with diagnoses including Huntington's Chorea with psychosis, and dementia. Documentation indicated R169 sustained a right humerus (arm) fracture, and was admitted to the hospital from 10/15 - 10/17/11 and the facility failed to thoroughly investigate and report the fracture of unknown origin to the SA. The admission minimum data set dated 9/21/11, indicated R169 was independent with bed mobility, transfers, walking, toileting, and personal hygiene. The incident report dated 10/13/11, indicated R169 had a fall on 10:45 a.m. The report stated that as R169 was walking down the hallway, staff observed a laceration on the back of the head measuring 3.6 centimeter (cm) by 0.3 cm. Documentation indicated an investigation of the incident revealed R169 had fallen in the bathroom. A body assessment was completed, and there were no other injuries recorded on the incident report. The interdisciplinary progress (IDP) notes dated 10/13/11 noted R169 was sent to the emergency room (ER), where the head laceration was closed and returned to the facility at 6:20 p.m. The hospital discharge note dated 10/13/11 indicated R169 "had Huntington's but very functional, cognitively intact, and walks on her own. Slipped	F 225		

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F 225	Continued From page 6 on some water in the bathroom and hit head on the toilet...Denies head, neck, back, chest, abd, (abdominal), or extremity pain." A review of IDP notes dated 10/13/11, 6:20 p.m. through 10/15/11, 10:00 p.m. indicated R169 denied pain/discomfort, ate and drank 100 percent of food and fluids. There was no indication anything was wrong with R169's right arm until a 10:00 p.m. note dated 10/15/11. This documentation indicated R169 was not moving right arm, was not dressing self, and the right arm dangled at her side. The documentation also revealed the antecubital (front part) area of the right arm was swollen; deltoid (muscle) was bruised and swollen. R169 was sent to the hospital for further evaluation. A nurses note dated 10/16/11, at 3:30 a.m. indicated R169 was admitted to the hospital with diagnoses of right humerus fracture and fever. The IDP note from 8:30 a.m. on 10/16/11, indicated there was possible cellulitis in the right arm, and R169 received intravenous antibiotics. R169 was readmitted to the facility on 10/17/11. The ER notes dated 10/13/11, the discharge notes dated 10/17/11, and the nurse practitioner's progress notes dated 10/18/11 were reviewed. There was no evidence in the medical record indicating the cause of the fracture. At 2:11 p.m. on 1/25/12, nurse manager-A (NM-A) stated there was no incident report completed on 10/15/11 when R169's fractured arm was discovered. There was no further information provided regarding investigation. At 10:30 a.m. on 1/26/12, the director of nursing	F 225		

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F 225	Continued From page 7 (DON) stated the nurse should have completed an incident report when the bruise was identified, and staff should have conducted an investigation and documented how the fracture had occurred. During interview with the administrator (ADM) at 10:40 a.m. on 1/26/12, the ADM stated staff were expected to document an incident report when injuries of unknown origin were identified, to investigate to determine what caused the injury, and also to report to the SA if needed. The ADM also stated he was not sure if R169 sustained the fracture during the fall on 10/13/11. The ADM further stated since there was no incident report with investigation in place for R169's fracture, it was only "speculation" that R169 did fracture her arm on 10/13/11, and no one could exactly say what happened between 10/13/11 and 10/15/11. R94 sustained a fracture to the base on the right thumb and a thorough investigation regarding this injury of unknown origin was not conducted, nor was the injury reported to the SA. An incident report dated 10/27/11, revealed R94 was being seen by occupational therapy (OT) to treat a splinted finger. However, the incident report was not clear as to why the finger was being treated by OT with a splint. Further record review revealed an X-ray of the right thumb was taken on 10/27/11. The report indicated there was a probable subacute fracture at the base of the thumb. Interview indicated and record review confirmed R94 had sustained a fractured finger. At 2:00 p.m. on 1/26/12, an interview with the	F 225		

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F 225	Continued From page 8 DON and unit manager was conducted. Both staff members indicated that R94 had a history of banging his hands on the table and this was a reasonable explanation as to how the fractured finger may have happened. However, the incident report dated 10/27/11 didn't come to that conclusion or summarize hand banging as a possible reason for the fracture. The DON stated the fractured finger was not reported to the SA because of the conclusion drawn on how the fracture may have happened. R142 alleged a staff person caused bruises to his right forearm and a thorough investigation to determine the cause was not completed, nor reported to the SA. An incident report dated 7/10/11, for R142, indicated, "Resident was noted to have bruises on his R (right) forearm. Police asked him how he got the bruise and resident point at staff nurse who was present. Writer was present too." The incident report also indicated staff were unable to assess R142 as the resident was being physically aggressive. Documentation revealed R142 was transported to a local hospital's crisis center via ambulance and police escort. During interview at 10:00 a.m. on 1/27/12, the DON verified there was no further investigation regarding R142's bruises or allegation that the bruises were caused by a staff member. The DON stated R142 was physically aggressive with staff on 7/5/11 and presented the incident report dated 7/5/11, which indicated R142 "was pushing+ hitting staff." At that time R142 had a lighter, would not give it to staff and threatened to burn down the staff and the building.	F 225		

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F 225	Continued From page 9 Even though R142 had sustained bruises the facility did not thoroughly investigate the cause, did not interview staff working and did not look at environmental factors to determine and document potential cause of of the bruises. The DON acknowledged at 9:25 a.m. on 1/27/12, that staff did not thoroughly investigate R142's bruises or allegation that staff caused the bruising. R19 sustained an injury of unknown origin to the labia which was not thoroughly investigated and reported to the SA. An incident report dated 6/25/11, indicated R19 was found to have "a bruise on resident R(right) labia region" measuring 3 cm by 1.5 cm. The potential cause of the bruise was not thoroughly investigated. The incident report indicated staff had documented the following: cause "unknown"; a bruise of "unknown" origin; and "since it's of unknown origin, could be urine burn or tight brief. Not to refuse change of brief when wet, wear brief loosely." The investigation section of the report dated 6/27/11, indicated R19 did not know how the bruise was caused, and denied that anyone had hurt her. During an interview at 10:10 a.m. on 1/27/12, the DON stated R19 denied being hurt by anyone and for that reason the facility excluded mistreatment and did not report this bruise to the SA. The DON also verified the investigation was not thorough, as the cause of the bruise was not identified. Even though R19 denied mistreatment the facility did not thoroughly investigate the cause, did not interview staff working and did not	F 225		

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F 225	Continued From page 10 look at environmental factors to determine a potential cause of the injury. R120 and R158 had an altercation that resulted in resident injury which was not immediately reported to the SA. A Vulnerable Adult Suspected Maltreatment (VASM) report dated 7/6/11, indicated there was an altercation between R158 and R120. The report noted, "The facility investigation was begun on 7/2/11 and continued over the next few days." The report revealed that on 7/2/11, R120 was sitting at the receptionist desk and witnessed R158 getting a cigarette from someone. R120 told the receptionist, "If no one else is going to stop her I am." The receptionist called a behavior call over the intercom. The receptionist saw R120 hit the cigarette out of R158's hand and then R158 ran behind the receptionist desk. The report continued that R120 was "hitting and pulling" on R158, and had her on the ground. R120 was very emotional, was not calming down, and was sent to crisis center. R120 incurred scratches on her right index finger, nose, neck, left hand and ear. R158 had a small abrasion on her left cheek. The incident report dated 7/2/11 at 7:00 p.m. indicated, "The other resident dislikes [R158], wants to see [R158] punished severely." An interview was conducted with the DON, ADM, 6th floor Program Manager, and Special Program Manager (SPM) at 2:35 p.m. on 1/26/12. SPM and DON verified the above information and indicated the incident was reported to the SA 4 days later. No further information was provided.	F 225		

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F 225	Continued From page 11 R63 allegedly sexually abused R74 which was not reported immediately to the SA. A VASM report dated 8/23/11 revealed that on 8/22/11, the unit nurse walked into the sixth floor dining room and witnessed R74 screaming. R63 had his mouth on R74's breast through her shirt. The floor nurse intervened, and no injuries were noted. Both residents were able to move around the unit independently and communicate verbally. The incident report dated 8/22/11 indicated the incident happened at 1:40 p.m., however the report to the SA was made the next day, on 8/23/11 (no time identified). During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that they had up to 24 hours to report an incident. R120 allegedly physically abused R98 which was not reported to the SA immediately. A VASM report dated 11/7/11, revealed an altercation between R120 and R98. The VASM report revealed, "The facility investigation begun on 11/5/11 and continued over the next few days." The investigation concluded that R120 and R98 were waiting in the dining room for supper when the unit nurse had heard R98 screaming. The nurse went to the dining room and found R120 standing very close to R98, who had a bloody nose. R120 reported to staff that R98 had been crying/screaming when R120 got frustrated and hit R98 with a closed fist. Even though the alleged abuse happened at 4:50 p.m. on 11/5/11, the report to the SA was not made	F 225		

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F 225	Continued From page 12 until 11/7/11 (no time identified). During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that the time frame for reporting incidents to the SA was up to 24 hours, and verified the above incident was reported to the SA 2 days later. R109 reported to staff on 11/26/11, that he was beaten and thrown into the car by his family. A report was made to the SA 48 hours later on 11/28/11. The VASM report submitted on 11/28/11 indicated, "His allegation was against his wife, ...while on leave of absence...The facility investigation began on 11/26/11 and continued over the next couple of days...The facility internal investigation was not able to substantiate (resident's name) allegations of being beaten and thrown into the car, and felt it most likely that the incident between (resident's name) and his family was handled appropriately when (resident's name) became angry about returning from LOA (leave of absence)." An interview was conducted with the DON, ADM, 6th floor Program Manager, and Special Program Manager (SPM) at 2:35 p.m. on 1/26/12. The SPM stated when the team reviews incident reports, the team discusses if the incident meets the criteria for reporting, and if the team feels the incident should be reported, a report is made to the SA no later than 24 hours after the team's knowledge of the incident. The LSW verified the above report was made 48 hours after the resident had made the allegation.	F 225		

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F 225	Continued From page 13 On 1/27/12, the licenses social worker (LSW) provided information indicating R109's incident occurred off premises, and was reported to the police. R109 was also seen at the hospital at the time of the incident. The LSW likely felt this met the reporting criteria to the SA, and that new information received upon a 11/28/11 interview prompted immediate online reporting to the State agency. The Abuse and Neglect policy/procedure, last revised 1/11, indicated: 1. "If a staff member receives an allegation of abuse, neglect, misappropriation of resident property or witness suspected abuse, neglect, or misappropriation of resident property, the staff member will immediately report this to a supervisor and complete Sections A through D of the 'Incident Details' on the Incident Report (GSS #401)." 2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation.... 4. When no determination of the cause of injury can be made OR when abuse or neglect is alleged or suspected, appropriate corrective action will be taken. 6. The investigation team (social worker, the administrator and the director of nursing services) will review all Incident Report (GSS#401) that involve residents including those that indicate al injury of unknown origin, abuse and neglect, misappropriation of resident property or involuntary seclusion no later than next working day following the incident. The investigation team will determine if further investigation is needed. The social worker or the designated person will notify the designated	F 225		

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F 225	Continued From page 14 agency(ies) in the state as soon as possible after reviewing the Incident Report (GSS#401) (i.e., if designated agency(ies) have not been notified, see 5b). The social worker or the designated person will also complete and submit any reports required by the designated agencies."	F 225		
F 226 SS=F	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and documentation review, the facility failed to ensure abuse prohibition policies and procedures included the immediate reporting of potential abuse, neglect and injuries of unknown origin to the designated State agency (SA) for 6 residents in reports reviewed from the previous nine months (R120, R158, R74, R63,R98 and R109). This had the potential to affect all residents in the facility. In addition, the facility failed to follow their own policies/procedures related the the investigation of allegations of abuse/neglect/ mistreatment and injuries of unknown origin for 4 of 5 (R169, R94, R142 and R19) allegations reviewed. Findings include: NOTIFICATION OF THE STATE AGENCY The Notification Procedure did not direct staff to immediately notify the designated SA of all	F 226	The facility disputes this deficiency and has filed a IIDR. The facility policies and procedures for the prohibition of abuse, neglect, maltreatment and misappropriation of property were reviewed and found to be fully compliant with State and Federal guidelines/mandates. Staff were re-educated regarding the investigating and reporting requirements for allegations of mistreatment and/or injuries of unknown origin. The incidents involving R169, R94, R142 and R19 were re-investigated, and as per company policy were reported to the State Agency on 2/23/12. The facility has reviewed all incident reports beginning 1/1/12 in which the cause of the incident was labeled "unknown" to ensure thorough investigation and reporting, if necessary, and has reviewed incidents involving resident to resident altercations. Abuse and neglect prohibition policies and procedures were reviewed and all appropriate staff were re-educated on conducting investigations; and all mandatory reporters were re-educated regarding state and federal reporting requirements for injuries of unknown origin and resident to resident abuse. (cont.)	2/23/12 1/1/12 3/5/12

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F 226	Continued From page 15 allegations of abuse/mistreatment and misappropriation of resident property. The facility staff stated an investigation would be conducted once an allegation or incident was reported to determine if the incident was reportable to the SA. The policy indicated: "6. The investigation team (social worker, the administrator and the director of nursing services) will review all Incident Reports (GSS#401) that involve residents including those that indicate all injury of unknown origin, abuse and neglect, misappropriation of resident property or involuntary seclusion no later than next working day following the incident. The investigation team will determine if further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the Incident Report (GSS#401)(i.e., if designated agency(ies) have not been notified, see 5b). The social worker or the designated person will also complete and submit any reports required by the designated agencies." Section 5b of the policy addressed crime reporting. R120 and R158 had an altercation that resulted in resident injury which was not reported to the SA until 4 days following the incident. A Vulnerable Adult Suspected Maltreatment (VASM) report dated 7/6/11, indicated there was an altercation between R158 and R120. The report noted, "The facility investigation was begun on 7/2/11 and continued over the next few days." The report revealed that on 7/2/11, R120 was sitting at the receptionist desk and witnessed R158 getting a cigarette from someone. R120	F 226	The Administrator, Director of Social Services and/or designee will be responsible to review all incidents daily to ensure compliance. The QA/CQI committee will be responsible to audit for compliance.	

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F 226	Continued From page 16 told the receptionist, "If no one else is going to stop her I am." The receptionist called a behavior call over the intercom. The receptionist saw R120 hit the cigarette out of R158's hand and then R158 ran behind the receptionist desk. The report continued that R120 was "hitting and pulling" on R158, and had her on the ground. R120 was very emotional, was not calming down, and was sent to crisis center. R120 incurred scratches on her right index finger, nose, neck, left hand and ear. R158 had a small abrasion on her left cheek. The incident report dated 7/2/11 at 7:00 p.m. indicated, "The other resident dislikes [R158], wants to see [R158] punished severely." An interview was conducted with the DON, ADM, 6th floor Program Manager, and Special Program Manager (SPM) at 2:35 p.m. on 1/26/12. SPM and DON verified the above information and indicated the incident was reported to the SA 4 days later. No further information was provided. R63 allegedly sexually abused R74 which was not reported immediately to the SA until the following day (time not able to be determined). A VASM report dated 8/23/11 revealed that on 8/22/11, the unit nurse walked into the sixth floor dining room and witnessed R74 screaming. R63 had his mouth on R74's breast through her shirt. The floor nurse intervened, and no injuries were noted. Both residents were able to move around the unit independently and communicate verbally. The incident report dated 8/22/11 indicated the incident happened at 1:40 p.m., however the report to the SA was made the next day, on 8/23/11 (no time identified).	F 226		

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F 226	Continued From page 17 During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that they had up to 24 hours to report an incident. R120 allegedly physically abused R98 which was not reported to the SA until 48 hours later. A VASM report dated 11/7/11, revealed an altercation between R120 and R98. The VASM report revealed, "The facility investigation begun on 11/5/11 and continued over the next few days." The investigation concluded that R120 and R98 were waiting in the dining room for supper when the unit nurse had heard R98 screaming. The nurse went to the dining room and found R120 standing very close to R98, who had a bloody nose. R120 reported to staff that R98 had been crying/screaming when R120 got frustrated and hit R98 with a closed fist. Even though the alleged abuse happened at 4:50 p.m. on 11/5/11, the report to the SA was not made until 11/7/11 (no time identified). During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that the time frame for reporting incidents to the SA was up to 24 hours, and verified the above incident was reported to the SA 2 days later. R109 reported to staff on 11/26/11, that he was beaten and thrown into the car by his family. A report was made to the SA 48 hours later on 11/28/11. The VASM report submitted on 11/28/11	F 226		

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F 226	Continued From page 18 indicated, "His allegation was against his wife, ...while on leave of absence .... The facility investigation began on 11/26/11 and continued over the next couple of days ...The facility internal investigation was not able to substantiate (resident's name) allegations of being beaten and thrown into the car, and felt it most likely that the incident between (resident's name) and his family was handled appropriately when (resident's name) became angry about returning from LOA (leave of absence)." An interview was conducted with the DON, ADM, 6th floor Program Manager, and Special Program Manager (SPM) at 2:35 p.m. on 1/26/12. The SPM stated when the team reviews incident reports, the team discusses if the incident meets the criteria for reporting, and if the team feels the incident should be reported, a report is made to the SA no later than 24 hours after the team's knowledge of the incident. The LSW verified the above report was made 48 hours after the resident had made the allegation. On 1/27/12, the licenses social worker (LSW) provided information indicating R109's incident occurred off premises, and was reported to the police. R109 was also seen at the hospital at the time of the incident. The LSW likely felt this met the reporting criteria to the SA, and that new information received upon a 11/28/11 interview prompted immediate online reporting to the State agency. An interview was conducted with the Director of Nursing (DON), Administrator (ADM), 6th floor Program Manager, and Special Program	F 226		

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F 226	Continued From page 19 Manager (SPM) at 2:35 p.m. on 1/26/12. The SPM stated when the team reviews incident reports, the team discusses if the incident meets the criteria for reporting. If the team thinks a report should be made to the SA, the report would be made to the SA no later than 24 hours (versus immediately) from the time of the occurrence. The DON and SPM verified that several of their reportable incidents over the past year were not reported immediately and/or had exceeded 24 hours post occurrence guideline. During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that they had up to 24 hours to report an incident to the SA. ALLEGATIONS LACKING INVESTIGATION AND/OR REPORTING TO THE SA. R169 was admitted to the facility on 9/15/11, with diagnoses including Huntington's Chorea with psychosis, and dementia. Documentation indicated R169 sustained a right humerus (arm) fracture, and was admitted to the hospital from 10/15 - 10/17/11 and the facility failed to thoroughly investigate and report the fracture of unknown origin to the SA. The admission minimum data set dated 9/21/11, indicated R169 was independent with bed mobility, transfers, walking, toileting, and personal hygiene. The incident report dated 10/13/11, indicated R169 had a fall on 10:45 a.m. The report stated that as R169 was walking down the hallway, staff	F 226		

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F 226	Continued From page 20 observed a laceration on the back of the head measuring 3.6 centimeter (cm) by 0.3 cm. Documentation indicated an investigation of the incident revealed R169 had fallen in the bathroom. A body assessment was completed, and there were no other injuries recorded on the incident report. The interdisciplinary progress (IDP) notes dated 10/13/11 noted R169 was sent to the emergency room (ER), where the head laceration was closed and returned to the facility at 6:20 p.m. The hospital discharge note dated 10/13/11 indicated R169 "had Huntington's but very functional, cognitively intact, and walks on her own. Slipped on some water in the bathroom and hit head on the toilet...Denies head, neck, back, chest, abd, (abdominal), or extremity pain." A review of IDP notes dated 10/13/11, 6:20 p.m. through 10/15/11, 10:00 p.m. indicated R169 denied pain/discomfort, ate and drank 100 percent of food and fluids. There was no indication anything was wrong with R169's right arm until a 10:00 p.m. note dated 10/15/11. This documentation indicated R169 was not moving right arm, was not dressing self, and the right arm dangled at her side. The documentation also revealed the antecubital (front part) area of the right arm was swollen; deltoid (muscle) was bruised and swollen. R169 was sent to the hospital for further evaluation. A nurses note dated 10/16/11, at 3:30 a.m. indicated R169 was admitted to the hospital with diagnoses of right humerus fracture and fever. The IDP note from 8:30 a.m. on 10/16/11, indicated there was possible cellulitis in the right	F 226		

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F 226	Continued From page 21 arm, and R169 received intravenous antibiotics. R169 was readmitted to the facility on 10/17/11. The ER notes dated 10/13/11, the discharge notes dated 10/17/11, and the nurse practitioner's progress notes dated 10/18/11 were reviewed. There was no evidence in the medical record indicating the cause of the fracture. At 2:11 p.m. on 1/25/12, nurse manager-A (NM-A) stated there was no incident report completed on 10/15/11 when R169's fractured arm was discovered. There was no further information provided regarding investigation. At 10:30 a.m. on 1/26/12, the director of nursing (DON) stated the nurse should have completed an incident report when the bruise was identified, and staff should have conducted an investigation and documented how the fracture had occurred. During interview with the administrator (ADM) at 10:40 a.m. on 1/26/12, the ADM stated staff were expected to document an incident report when injuries of unknown origin were identified, to investigate to determine what caused the injury, and also to report to the SA if needed. The ADM also stated he was not sure if R169 sustained the fracture during the fall on 10/13/11. The ADM further stated since there was no incident report with investigation in place for R169's fracture, it was only "speculation" that R169 did fracture her arm on 10/13/11, and no one could exactly say what happened between 10/13/11 and 10/15/11. R94 sustained a fracture to the base on the right thumb and a thorough investigation regarding this injury of unknown origin was not conducted, nor was the injury reported to the SA.	F 226		

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F 226	Continued From page 22 An incident report dated 10/27/11, revealed R94 was being seen by occupational therapy (OT) to treat a splinted finger. However, the incident report was not clear as to why the finger was being treated by OT with a splint. Further record review revealed an X-ray of the right thumb was taken on 10/27/11. The report indicated there was a probable subacute fracture at the base of the thumb. Interview indicated and record review confirmed R94 had sustained a fractured finger. At 2:00 p.m. on 1/26/12, an interview with the DON and unit manager was conducted. Both staff members indicated that R94 had a history of banging his hands on the table and this was a reasonable explanation as to how the fractured finger may have happened. However, the incident report dated 10/27/11 didn't come to that conclusion or summarize hand banging as a possible reason for the fracture. The DON stated the fractured finger was not reported to the SA because of the conclusion drawn on how the fracture may have happened. R142 alleged a staff person caused bruises to his right forearm and a thorough investigation to determine the cause was not completed, nor reported to the SA. An incident report dated 7/10/11, for R142, indicated, "Resident was noted to have bruises on his R (right) forearm. Police asked him how he got the bruise and resident point at staff nurse who was present. Writer was present too." The incident report also indicated staff were unable to	F 226		

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F 226	Continued From page 23 assess R142 as the resident was being physically aggressive. Documentation revealed R142 was transported to a local hospital's crisis center via ambulance and police escort. During interview at 10:00 a.m. on 1/27/12, the DON verified there was no further investigation regarding R142's bruises or allegation that the bruises were caused by a staff member. The DON stated R142 was physically aggressive with staff on 7/5/11 and presented the incident report dated 7/5/11, which indicated R142 "was pushing+ hitting staff." At that time R142 had a lighter, would not give it to staff and threatened to burn down the staff and the building. Even though R142 had sustained bruises the facility did not thoroughly investigate the cause, did not interview staff working and did not look at environmental factors to determine and document potential cause of of the bruises. The DON acknowledged at 9:25 a.m. on 1/27/12, that staff did not thoroughly investigate R142's bruises or allegation that staff caused the bruising. R19 sustained an injury of unknown origin to the labia which was not thoroughly investigated and reported to the SA. An incident report dated 6/25/11, indicated R19 was found to have "a bruise on resident R(right) labia region" measuring 3 cm by 1.5 cm. The potential cause of the bruise was not thoroughly investigated. The incident report indicated staff had documented the following: cause "unknown"; a bruise of "unknown" origin; and "since it's of unknown origin, could be urine burn or tight brief. Not to refuse change of brief when wet, wear brief	F 226		

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F 226	Continued From page 24 loosely." The investigation section of the report dated 6/27/11, indicated R19 did not know how the bruise was caused, and denied that anyone had hurt her. During an interview at 10:10 a.m. on 1/27/12, the DON stated R19 denied being hurt by anyone and for that reason the facility excluded mistreatment and did not report this bruise to the SA. The DON also verified the investigation was not thorough, as the cause of the bruise was not identified. Even though R19 denied mistreatment the facility did not thoroughly investigate the cause, did not interview staff working and did not look at environmental factors to determine a potential cause of the injury. The Abuse and Neglect policy/procedure, last revised 1/11, indicated: 1. "If a staff member receives an allegation of abuse, neglect, misappropriation of resident property or witness suspected abuse, neglect, or misappropriation of resident property, the staff member will immediately report this to a supervisor and complete Sections A through D of the 'Incident Details' on the Incident Report (GSS #401)." 2. The charge nurse or licensed nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation. ... 4. When no determination of the cause of injury can be made OR when abuse or neglect is alleged or suspected, appropriate corrective action will be taken. 6. The investigation team (social worker, the administrator and the director of nursing services) will review all Incident Report (GSS#401) that involve residents including those that indicate al injury of unknown origin, abuse	F 226		

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F 226	Continued From page 25 and neglect, misappropriation of resident property or involuntary seclusion no later than next working day following the incident. The investigation team will determine if further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the Incident Report (GSS#401)(i.e:, if designated agency(ies) have not been notified, see 5b). The social worker or the designated person will also complete and submit any reports required by the designated agencies."	F 226		
F 274 SS=D	483.20(b)(2)(ii) COMPREHENSIVE ASSESS AFTER SIGNIFICANT CHANGE A facility must conduct a comprehensive assessment of a resident within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a significant change means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess bladder function for 1 of 1 residents (R95) reviewed for a decrease in continence level at the time of a significant change in status assessment.	F 274	Resident #95 had a comprehensive bladder assessment done on 2/29/12 and the Care Plan was reviewed and updated as needed. All residents with a significant change in the previous quarter related to continence will be reviewed and a comprehensive assessment completed, if needed.. Appropriate staff were re-educated as needed. DON, Nurse Manager and/or designee will be responsible to ensure compliance. The QA/CQI committee will be responsible to audit for compliance.	2/29/12 3/5/12 3/5/12

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F 274	Continued From page 26 Findings include: R95 had an increase in incontinence and was not comprehensively reassessed to determine contributing factors related to incontinence. R95 was admitted to the facility on 9/29/11. The residents admission Minimum Data Set (MDS) assessment indicated the resident's primary diagnoses included history of stroke, dementia, aphasia (speech disorder), and depression. The MDS indicated the resident was occasionally incontinent of bladder and required extensive assistance from one person to use the toilet. A significant change MDS assessment was completed for R95 on 12/22/11. R95's toileting abilities decreased and the resident was then identified as "frequently incontinent" and needing two persons to physically assist with using the toilet. A bladder assessment was completed for R95 on 10/3/11. The assessment indicated R95 had "no problems" with toileting ability and was stable. Incontinence was not identified as a problem area. The assessment indicated R95 needed one person to physically assist with transfers and ambulation related to impaired balance and unsteady gait. The assessment was reviewed 12/20/11 and "no changes" were indicated on the bottom of the form. A nursing assistant (NA-A) was interviewed on 12/26/12 at 10:00 a.m. NA-A stated that R95 wore an adult brief at all times. NA-A explained that R95 independently voided at times, and also	F 274		

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F 274	Continued From page 27 required extensive assistance at times, depending on the resident's mood and behavior. R95 was described as frequently incontinent at night but is more continent during daytime hours. The MDS Coordinator (RN-MDS) was interviewed at 11:00 a.m. on 1/26/12. The RN-MDS reviewed R95's bladder assessment and indicated that it was not thorough enough to determine underlying factors and causes related to R95's incontinence. RN-MDS agreed that the assessment was not an accurate reflection of R95's current incontinence status. RN-MDS stated that the assessment and corresponding care plan would be updated to reflect the care and services provided for R95's incontinence. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff tto complete a bladder assessment after incontinence was identified or triggered on the MDS. The staff were to complete an accurate assessment of factors that predispodsed the resident to urinary incontinence and findings were to be documented on the Bladder Assessment form along with an individualized toileting plan.	F 274		
F 276 SS=D	483.20(c) QUARTERLY ASSESSMENT AT LEAST EVERY 3 MONTHS A facility must assess a resident using the quarterly review instrument specified by the State and approved by CMS not less frequently than once every 3 months. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 276	F169 had a comprehensive bladder assessment completed on 2/29/12 and the Care Plan was reviewed and updated as needed. All residents with decreased continence at their quarterly review will have a comprehensive assessment as indicated. The nurse manager and/or designee will be responsible to ensure that comprehensive assessments are completed according to policy and procedure. The QA/CQI committee is responsible to audit for compliance.	2/29/12 3/5/12

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F 276	Continued From page 28 review, the facility failed to comprehensively assess bladder function for 1 of 2 residents (R169) reviewed who experienced a decreased in continence at the time of a quarterly review. R169 had an increase in bladder incontinence and was not comprehensively assessed to determine cause and appropriate care and services to improve or maintain continence status. R169 was admitted to the facility with diagnoses including Huntington's chorea, anxiety, anemia, depressive disorder, and generalized pain. The admission minimum data set (MDS) dated 9/21/11, indicated R169 was always continent of bladder, and was independent with transfers, walking, personal hygiene, bed mobility and toilet use. However, a significant change MDS completed on 12/8/11 identified R169 as "frequently incontinent," and needing extensive assistance from one person for dressing, eating, and personal hygiene; as well as needing supervision for transfers, bed mobility and toilet use. A bladder assessment completed for R169 upon admission dated 9/19/11, indicated R169 had no problems with toileting abilities and incontinence was not identified as a problem area. The assessment also indicated R169 had an unsteady gait, but did not need assist with mobility. The assessment was reviewed on 12/4/11 and no changes were indicated on the bottom of the page. Another bladder assessment completed on	F 276		

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F 276	Continued From page 29 10/20/11, indicated R169 had occasional incontinence with no pattern. The assessment indicated R169 had impaired cognitive and physical ability to manage own hygiene and clothing. Per the assessment, R169 was seen by physical and occupational therapist due to a right upper arm fracture. Staff did not recommend a retraining/toileting program, but proposed assistance with hygiene and dressing as needed. This assessment was also reviewed on 12/4/11 and no changes were indicated on the bottom of the page. The Care Area Assessment (CAA) dated 12/15/11, indicated staff were to proceed to the care plan due to alteration in toileting and occasional urinary incontinence. Nursing Assistant (NA-D) was interviewed at 1:42 p.m. on 1/25/12, and stated that when R169 initially came to the facility she was continent of urine and was able to use the toilet independently. At the present time, R169 used incontinent products, was occasionally incontinent, and was at times able to manage her incontinence, and other times preferred to use incontinent products and have staff change the product. Registered nurse (RN-B) was interviewed at 1:50 p.m. on 1/25/12, and stated R169 was occasionally incontinent, was able to most of the time, use the toilet independently. At other times R169 exhibited the behavior of voiding in the incontinent product; and staff needed to assist R169 with changing the incontinent product. The MDS/Clinical Coordinator (MDS-CC) was	F 276		

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F 276	Continued From page 30 interviewed at 11:12 on 1/25/12. The MDS-CC reviewed R169's MDS from 9/21/11 and 12/8/11 and confirmed that R169 had a change in bladder continence status. The MDS-CC explained she used the data from the NA's documentation (Voided Record) which indicated during the 7 day observation period, R169 had 7 incontinence episodes. MDS-CC reviewed R169's bladder assessment and agreed that the assessments were not an accurate reflection of R169's current incontinence status. She further confirmed staff did not assess causative factors for incontinence and did not identify individualized toileting needs to attempt to restore/ maintain continence. MDS-CC also stated staff was supposed to complete a whole new comprehensive assessment on 12/4/11 instead of reviewing the previous ones, since there was a change in the resident's continence status. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff to complete a bladder assessment after bladder incontinence was identified or triggered on the MDS. Staff were to complete an accurate assessment of factors that predisposed the resident to urinary incontinence and findings were to be documented on the Bladder Assessment form, along with an individualized toileting plan. Although R169 had a change in her continence status, there was no indication a comprehensive reassessment had been completed for R169's individualized toileting needs.	F 276		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive	F 315		

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F 315	Continued From page 31 assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify potential care and services needed to improve or maintain bladder function for 2 of 3 residents (R95 and R169) reviewed after a decline in bladder continence status. Findings include: R95 had an increase in incontinence and was not comprehensively reassessed to determine appropriate care and services to maintain or improve continence status. R95 was admitted to the facility on 9/29/11. The residents admission Minimum Data Set (MDS) assessment indicated the resident's primary diagnoses included history of stroke, dementia, aphasia (speech disorder), and depression. The MDS indicated the resident was occasionally incontinent of bladder and required extensive assistance from one person to use the toilet. A significant change MDS assessment was completed for R95 on 12/22/11. R95's toileting	F 315	Residents #95 and #169 had their comprehensive bladder assessments done on 2/29/12 and Care Plans were revised as appropriate. System was reviewed and it was determined no changes were needed. The individuals involved were re-educated per policy and procedure. The Nurse Manager and/or designee will be responsible to ensure that comprehensive assessments are completed according to policy and procedure. The QA/CQI committee is responsible to audit for compliance. .	2/29/12

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F 315	Continued From page 32 abilities decreased and the resident was then identified as "frequently incontinent" and needing two persons to physically assist with using the toilet. A bladder assessment was completed for R95 on 10/3/11. The assessment indicated R95 had "no problems" with toileting ability and was stable. Incontinence was not identified as a problem area. The assessment indicated R95 needed one person to physically assist with transfers and ambulation related to impaired balance and unsteady gait. The assessment was reviewed 12/20/11 and "no changes" were indicated on the bottom of the form. R95's care plan dated 1/16/12 was reviewed. The care plan indicated the resident had an alteration in elimination related to history of stroke and dementia. The care plan instructed staff that R95 needed occasional assistance with toileting and adjusting clothing, and used the toilet to void. A nursing assistant (NA-A) was interviewed on 12/26/12 at 10:00 a.m. NA-A stated that R95 wore an adult brief at all times. NA-A explained that R95 independently voided at times, and also required extensive assistance at times, depending on the resident's mood and behavior. R95 was described as frequently incontinent at night but is more continent during daytime hours. The MDS Coordinator (RN-MDS) was interviewed at 11:00 a.m. on 1/26/12. The RN-MDS reviewed R95's bladder assessment and indicated that it was not thorough enough to determine underlying factors and causes related to R95's incontinence. RN-MDS agreed that the assessment was not an	F 315		

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F 315	Continued From page 33 accurate reflection of R95's current incontinence status. RN-MDS stated that the assessment and corresponding care plan would be updated to reflect the care and services provided for R95's incontinence. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff that a bladder assessment is to be completed after incontinence is identified or triggers on the MDS. The staff are to complete an accurate assessment of factors that predispose the resident to urinary incontinence and findings are to be documented on the Bladder Assessment form along with an individualized toileting plan. R169 had an increase in bladder incontinence and was not comprehensively assessed to determine cause and appropriate care and services to improve or maintain continence status. R169 was admitted to the facility with diagnoses including Huntington's chorea, anxiety, anemia, depressive disorder, and generalized pain. The admission Minimum Data Set (MDS) dated 9/21/11, indicated R169 was always continent of bladder, and was independent with transfers, walking, personal hygiene, bed mobility and toilet use. However, a significant change MDS completed on 12/8/11 identified R169 as "frequently incontinent," and needing extensive assistance from one person for dressing, eating, and personal hygiene; as well as needing supervision for transfers, bed mobility and toilet use.	F 315		

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F 315	Continued From page 34 R169 was observed laying in the bed at 8:10 and 8:45 a.m. on 1/25/12. R169 was wearing a pull-up (adult brief) that appeared to be dry. A bladder assessment completed for R169 upon admission dated 9/19/11, indicated R169 had no problems with toileting abilities and incontinence was not identified as a problem area. The assessment also indicated R169 had an unsteady gait, but did not need assist with mobility. The assessment was reviewed on 12/4/11 and no changes were indicated on the bottom of the page. Another bladder assessment completed on 10/20/11, indicated R169 had occasional incontinence with no pattern. The assessment indicated R169 had impaired cognitive and physical ability to manage own hygiene and clothing. Per the assessment, R169 was seen by physical and occupational therapist due to a right upper arm fracture. Staff did not recommend a retraining/toileting program, but proposed assistance with hygiene and dressing as needed. This assessment was also reviewed on 12/4/11 and no changes were indicated on the bottom of the page. The Care Area Assessment (CAA) dated 12/15/11, indicated staff were to proceed to the care plan due to alteration in toileting and occasional urinary incontinence. An nursing assistant (NA-D) was interviewed at 1:42 p.m. on 1/25/12 and stated that when R169 initially came to the facility she was continent of urine and was able to use the toilet independently. At the present time, R169 used	F 315		

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F 315	Continued From page 35 incontinent products, was occasionally incontinent, and was at times able to manage her incontinence and other times preferred to use incontinent products and have staff change the product. Registered nurse (RN-B) was interviewed at 1:50 p.m. on 1/25/12 and stated R169 was occasionally incontinent, was able to most of the time, use the toilet independently. At other times R169 exhibited the behavior of voiding in the incontinent product; and staff needed to assist R169 with changing the incontinent product. The MDS/Clinical Coordinator (MDS-CC) was interviewed at 11:12 on 1/25/12. The MDS-CC reviewed R169's MDS from 9/21/11 and 12/8/11 and confirmed that R169 had a change in bladder continence status. The MDS-CC explained she used the data from the NA's documentation (Voided Record) which indicated during the 7 day observation period R169 had 7 incontinence episodes. MDS-CC reviewed R169's bladder assessment and agreed that the assessments were not an accurate reflection of R169's current incontinence status. She further stated staff did not assess causative factors for incontinence and did not identify individualized toileting needs to attempt to restore/ maintain continence. MDS-CC also stated staff was supposed to complete a whole new comprehensive assessment on 12/4/11 instead of reviewing the previous ones, since there was a change in the resident's continence status. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff to complete a bladder assessment after	F 315		

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F 315	Continued From page 36 bladder incontinence was identified or triggered on the MDS. Staff were to complete an accurate assessment of factors that predisposed the resident to urinary incontinence and findings were to be documented on the Bladder Assessment form, along with an individualized toileting plan. Although R169 had a change in her continence status, there was no indication a comprehensive reassessment had been completed for R169's individualized toileting needs.	F 315		
F 325 SS=D	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate weight monitoring and follow up for 2 of 5 residents (R105 and R75) who were at nutritional risk. Findings include: Based on interview and document review, the	F 325	.Resident #75 was re-weighed and weight reported to MD on 12/28/11. Resident #105 was re-weighed and weight reported to MD on 1/31/12 per telephone, and nutritional orders were changed. On 2/9/12 NP reviewed chart and spoke with team regarding resident's status. MD/NP have been working with team to address resident's nutritional needs and control of lower extremity edema which also contributed to weight increase/decrease since 12/9/11. Since weights did vary, unit's scale was in question of accuracy. Scale is now being serviced. All residents who are nutritionally at risk will have their weights reviewed for proper notification of MD with weight change of 5 pounds in either direction, per policy. All appropriate staff will be re-educated on policy notification of weight changes. Nurse Manager and/or designee will conduct random audits on nutritionally at risk residents. QA/CQI will review all audits	12/28/11 1/31/12 3/5/12 3/5/12

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F 325	Continued From page 37 facility failed to notify the resident's physician when the resident experienced a significant weight loss for 1 of 5 residents (R105) who were at nutritional risk. Findings include: R105 experienced a 20.90% weight loss within a six month period and there was no indication the weight loss had been reported to the physician or nurse practitioner. R105's weights were recorded by several different nursing assistants as: 1/20/12 - 140 pounds; 12/23/11 - 159; 12/16/11 - 161.6; 12/2/11 - 177; 10/21/11 - 176; and 7/29/11 a weight of 177. The documented weights indicated there was a 20.90% weight loss between the 7/29/11 weight and 1/20/12 weight. At 7:38 a.m. on 1/25/12, the food service director (FSD) was interviewed regarding R105's weight loss. The FSD stated the facility registered dietitians (RDs) reviews resident weights on a monthly basis, and nursing assistants (NAs) were to let the RDs know if there was a significant weight loss. When questioned at 10:10 a.m. on 1/25/12, RD-I stated all resident weights were reviewed at the end of every month. RD-I was unaware of R105's weight loss and said staff were to notify dietary when there was a five pound difference between recorded weights. RD-I stated R105 had been receiving fortified foods for some time, which included fortified Jell-O at meals. RD-I verified Glucose Control Boost was also being provided for the resident to add protein versus calories.	F 325		

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F 325	Continued From page 38 After reviewing the recorded weights, RD-I verified R105 experienced a significant weight loss. At 10:55 a.m. on 1/15/12, NA-E stated she usually worked the evening shift and over the past 2-3 months and noticed a change in R105's eating ability and required assistance to eat more often. R105 ate culturally preferred food of flat bread and meat gravy provided at meal times, but nothing else. When asked if she had reported the decline, NA-E stated the evening nurse knew about it as the nurses were in the dining room at meal times. A trained medication aide-A (TMA-A) stated R105 "doesn't eat like he used to," but was unable to recall when the change was noted. TMA-A stated R105 preferred food from his native land. Nutritional assessments, completed by two different RDs on 9/19 and 12/9/11, revealed R105's weights for the each of those quarters was reviewed. Each RD documented R105 weights as stable and within R105's usual body weight range of 177-180 pounds. The documentation also revealed R105 received a regular portion size, consistent carbohydrate, dysphasia (for swallowing disorder) diet, with two scoops of Bene Protein twice a day, for a low albumin (protein) level. On 12/22/11, the nurse practitioner discontinued the Bene Protein secondary to resident refusal and ordered one 8-ounce carton of Glucose Control Boost, twice a day to meet R105's protein requirements. The 9/11 RD note indicated that because of cultural needs, R105 received ground meat with gravy every day at lunch and required increased	F 325		

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F 325	Continued From page 39 assistance from staff to be fed. There was no documentation indicating the nurse practitioner or physician was notified of R105's significant weight loss. A note by the physician on 12/27/11 only addressed a review of the 12/2/11 weight, despite additional recorded weights of 12/16 and 12/23/11, which indicated the significant weight loss. R75 was at risk of weight loss and did not receive consistent weekly weight measurement as recommended by the registered dietitian (RD). R75's quarterly Minimum Data Set (MDS) assessment dated 10/24/11, indicated R75's primary diagnoses included seizure disorder, traumatic brain injury, anxiety disorder and malnutrition. The assessment indicated R75 received 100 percent nutrition from enteral tube feeding. A document titled Initial Nutrition Data Collection dated 6/11/11 was reviewed. The assessment indicated R75 consumed nothing by mouth and was unable to verbalize food preferences. The assessment noted R75's height was 65 inches and weight was 129 pounds. The resident's goal weight was listed at 140 pounds, with the tube	F 325		

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F 325	Continued From page 40 feeding providing 30 to 35 calories per kilogram (kg). Dietary assessment notes for R75 were reviewed. A note on 10/31/11 indicated R75 had been on a planned weight loss program with a decreased amount of tube feeding. It was noted the resident had been gradually losing weight, but the most recent weight was much lower than usual (weight on 10/21/11 was 123 pounds). The dietitian requested a re-weigh of R75 to verify loss. No changes to the tube feeding were made at this time. An additional dietary note dated 11/8/11, indicated R75 was reweighed at 119 pounds. The RD indicated R75 was difficult to weigh due to frequent movements. The RD stated the resident did not appear to have lost a significant amount of weight and determined the current tube feeding was providing 35 calories per kilogram and 1.5 grams of protein per kg, which was noted as "should be sufficient" for the current weight. It was determined that an increase would be inappropriate and no changes were made. Weight monitoring logs from 11/11/11 to 1/12/12 for R75 were reviewed. During this time period there were three blank entries where R95 was to have been weighed and was not: 12/9/11, 12/30/11 and 1/6/12. R95's weight was logged only once in November (128 pounds) and once in December (115 pounds). On 12/27/11 a dietary note indicated R75 had exhibited weight loss for the past three months. At that time the tube feeding was increased by one can to provide 40 calories per kg and 1.7 grams protein per kg for a new goal weight of 130 pounds.	F 325		

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F 325	Continued From page 41 The RD was interviewed at 1:30 p.m. on 1/26/11. The RD indicated that R75 was considered at risk for nutritional compromise and directed weights be measured weekly to monitor for weight loss. The RD was unsure why weights were missed, but did mention that R75 was difficult to weigh related to frequent movements. The RD stated it was expected that nursing assistants weigh the resident weekly. If the resident's weight was three pounds above or below the last weight, or they are unable to weight the resident, they should alert the nursing staff, who would then alert the dietitian. The RD stated she had received no alerts regarding R75's weight in December and noted the weight loss when doing a monthly review at the end of December. The facility's Residents with Impaired Nutrition and Nutritional Risk policy last revised 3/09 was reviewed. The policy directed nursing staff to notify the dietary department within 24 hours if a resident had a significant weight change (including 3 pounds in 1 week).	F 325	Completion date can not be before survey exit date of completion	1/27/2012
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted	F 431	The facility audited all med rooms/med carts and removed all expired medications. All appropriate staff were re-educated on handling expired meds per policy and procedure. Nurse Managers and/or designee will audit med rooms and carts for undated or expired meds. QA/CQI will review all audits.	~~1/25/12~~

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F 431	Continued From page 42 professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to dispose of expired medications and to date medications when opened on 2 of 5 units (#3 and #6) where medication storage areas were reviewed. Findings include: Floor 3 had several expired medications and undated medications present in the medication carts. On 1/25/12 at 9 a.m. the medication storage cart	F 431		

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F 431	Continued From page 43 for Floor 3, even side, was examined. The cart contained 1 vial of Lantus Insulin 100 units/milliliter (u/ml) that expired 1/23/12 and 1 vial of Novolog Insulin 100 u/ml that expired 1/23/12; both were prescribed for R37. A vial of Novolog Insulin 100 u/ml prescribed for R65 was opened, but did not have a date label indicating when the vial was opened. The manufacturer's instructions indicated the medication should have been considered expired 28 days after opening the medication. A registered nurse (RN-C) stated that the expired medications should have been discarded on the expiration date. The undated vial would also be discarded. The odd side cart for Floor 3 was examined at 9:10 a.m. on 1/25/12. The cart contained 1 house stock bottle of Colace 200 milligram (mg) capsules that expired on 1/12, and a house stock bottle of Aspirin 325 mg tablets that expired on 1/12. A licensed practical nurse (LPN-B) stated she would have to check facility policy if the bottles were to be discarded at the beginning or end of the month of 1/12. The cart also contained a bottle of Nitrostat 0.4 mg prescribed for R59 with a broken seal that was undated when opened. LPN-C stated she would check the facility policy regarding disposal of the medication. The manufacturer's instructions indicated the medication should have been considered expires 12 months after opening. The facility's procedure for Acquisition, Receiving, Dispensing and Storage of Medications dated 1/12 was reviewed. The procedure directed staff to check expired medications in accordance with	F 431		

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F 431	Continued From page 44 state/pharmacy regulations and to label medications according to state pharmacy regulations. The policy included no direction as to whether the expiration date was effective at the beginning of the end of the month. The 6th floor odd side medication cart had 2 bottles of expired medication. The medication room and medication carts were inspected on the 6th floor at 8:06 a.m. on 1/26/12. There were 2 bottles of expired house stock aspirin. The 100 tablet (TB) adult low dose enteric coated aspirin 81 milligram (mg) bottle had manufacturer's expiration date of 11/11. The bottle was labeled with the date opened 12/11/11. The 36 tablet adult low dose enteric coated Aspirin 81 mg had expiration date 12/11 and was labeled with the date opened 12/15/11. The registered nurse (RN-B) verified the above, and stated there were two residents (R159 and R39) currently taking aspirin 81 mg.	F 431	F463 date of completion is 1/27/2012	
F 463 SS=D	483.70(f) RESIDENT CALL SYSTEM - ROOMS/TOILET/BATH The nurses' station must be equipped to receive resident calls through a communication system from resident rooms; and toilet and bathing facilities. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure call lights for 2 of 40 resident call lights that were checked (R128 and R66) were operational.	F 463	The Director of Facilities Management and/or designee will be responsible to monitor the operation of the facility call light system on an on going and scheduled basis. Random and scheduled call light system tests will be done by the Director of Facilities Management and/or designee to ensure the system is functional and in good repair. Scheduled reports will be submitted to the CQI committee for review and recommendations. Call light maintenance and preventive maintenance systems and procedures have been reviewed and revised as necessary. Tested and repaired all call lights.	1/27/2012 ~~1/23/12~~

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F 463	Continued From page 45 Finding include: At 4.39 p.m. on 1/23/12, R128's call light (room 605) was not functioning. The call light had a pneumatic bulb and when the bulb was pressed there was no sound at the nurses' station nor did the light above the door turn on. At this time the nurse manager (NM-B) stated R128 was alert and able to properly use the call light. NM-B confirmed the call light was not working. At 3:54 p.m. on 1/23/12, R66's call light (room 620) was checked and was not working. There was no sound at the nurses station or light above residents door. NM-B verified that and stated R66 would have bee unable to independently use the call light. The director of facility management (DFM) was interviewed at 11:40 a.m. on 1/26/12. The DFM explained the facility had a preventative maintenance program, which included monthly call light checks on every unit. The Monthly Floor Checklist dated 11/09, indicated "Check call lights on floor. Randomly select two rooms from each wing, also test shower rooms on both wings. Note location checked." The facility provided no documentation of completed checklists for confirmation that the floor audits were being completed.	F 463	Facility Maintenance did provide completed checklists for surveyor review. The monthly Floor Checklist dated 11/09 noted here is dated for the date the form was developed (November 2009). [redacted] date per admin. [redacted]. The 2 call lights identified on 1/23/12 as out of order were repaired immediately and on the day of the facility physical plant tour by surveyor, all call lights were still in working order.	~~1/23/12~~
F 465 SS=F	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for	F 465	The Director of Facilities Management and/or designee will be responsible to monitor the overall condition of the physical plant on an ongoing basis. (cont.)	

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F 465	Continued From page 46 residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to maintain cleanable surfaces on resident dresser drawers, floors, walls and ceilings in common areas. This had the potential to affect all the resident living in the facility. Findings include: The facility environmental tour was conducted on 1/26/12 from 9:55 a.m. through 11:52 a.m. with the director of facility management (DFM). During the tour, the DFM stated there was one maintenance staff assigned to two floors, whose job it was to check for items needing repair or maintenance, including cosmetic maintenance of such items as walls, ceilings, and resident room items. The DFM stated there was no preventative maintenance program for cosmetic areas that needed maintenance. During the tour the following environmental concerns were noted: The facility had two elevators in use which transported residents and staff from the 1st to the 7th floors. The doors and walls in the elevator had numerous scraped, scratched and marred areas. 7th floor - In the dining room, the radiator cover was disconnected from the frame and the corner of the cover was resting on the floor. Room 723 had a gouge out of the drywall. The hallway	F 465	Random and scheduled physical plant audits will be done by the Director of Facilities Management and/or designee to ensure the facility is safe, functional, clean and comfortable. Scheduled reports will be submitted to the CQI committee for review and recommendations. Maintenance, preventive maintenance and housekeeping schedules, systems and procedures have been reviewed and revised as necessary. Recovered walls with IPC. Reattached and mechanically secured cover. Patched and painted walls.	3/5/12 3/5/12 1/27/12 3/5/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

(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 465	Continued From page 47 ceiling by room 715/713 had three yellow spots. At 10:05 a.m. the DFM was asked what caused the spots and the DFM stated it was from water condensation in the summer. Room 722 and 727 bathroom call light cords were a dark brown color. At 10:15 a.m. the DFM confirmed the call cords should be checked and replaced when dirty or soiled. 6th floor - The east wing had a cloth-like wallpaper. Approximately 26 inches from the floor and the entire length of the hallway, the wallpaper was soiled or stained with medium to dark brown stains. The bedroom kick plate in room 613 was marred and scratched. The dining room area had loose base boards. The door between the two dining room areas was gouged and scraped. At 10:30 a.m. the DFM stated it was part of the facility maintenance program to refinish the doors. 5th floor - Room 520A had a privacy curtain torn at the hook; room 512 had loose base boards and one of the resident dressers top was worn down to the wood. The dining room had built up dirt and debris under the radiators and around the edges of the room and counters. The 5 east wing hallway drywall was scraped and scratched. The 5 east lounge area walls were discolored, scraped and gouged. The area by the elevator had two corner plates that had a piece of base board missing. 4th floor - Room 413B had a deep gouge out of the floor linoleum. In room 416B the drywall was scraped and marred. 3rd floor - Room 314A had peeling wall paint.	F 465	Replaced stained tiles. Replaced all floor call cords with washable cords. Primed and painted all areas below hand rails on 6th Floor corridors. Repainted door. Repaired cove base. Painted door. Replaced curtain. Replace cove base, restain residents personal dresser. Stripped excess wax from corners and cleaned floors. Patched and painted walls. Cleaned and painted walls. Caulked gap at base of corner guard. Patched damaged floor. Repainted room. Repainted room.	3/5/12 2/5/12 2/5/12 2/25/12 2/25/12 2/1/12 1/26/12 3/5/12 3/5/12 2/28/12 3/5/12 2/27/12 1/16/12 2/27/12 2/28/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	01/27/2012

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GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

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F 465	Continued From page 48 At 11:10 a.m. the DFM stated they planned to relocate to a new building toward the end of the year, but confirmed that cosmetic areas of the building should still have been maintained until the move took place.	F 465		
F 496 SS=E	483.75(e)(5)-(7) NURSE AIDE REGISTRY VERIFICATION, RETRAINING Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless the individual is a full-time employee in a training and competency evaluation program approved by the State; or the individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the State and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered. Before allowing an individual to serve as a nurse aide, a facility must seek information from every State registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act the facility believes will include information on the individual. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.	F 496	On January 31, 2012 NA-F's employment was terminated. On February 2, 2012 re-training was provided to the staff person responsible for verifying NA registry. On January 31, 2012 we checked registration of all NARs. All were found to be active and current on Minnesota registry. Systemic changes were implemented on February 2, 2012 to ensure this deficiency does not reoccur. Human Resources (HR) will be responsible to verify active and current status on the NA registry for active NA/R employees annually. Prior to hire, HR staff will verify registry status and will ensure new hires will be registered on their first day of employment with no pending termination of active status prior to the next annual registry update. If notification is received from the registry that an NA/R has been dropped from the registry, they will be terminated from employment immediately. The Administrator, and/or designee, will be responsible to ensure compliance through periodic audits.	01/31/12 02/02/12 02/02/12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

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F 496	Continued From page 49	F 496		

This REQUIREMENT is not met as evidenced by:
Based on a review of documentation, the facility failed to ensure 1 of 88 nursing assistants (NA-F) employed by the facility was listed on the State's nursing assistant registry as required. This had the potential to affect residents residing on the units where the NA was assigned work.

Findings include:

A review of nursing assistant registration with the State Agency indicated NA-F, hired on 5/9/11, was not listed on the registry. Verbal information received from the State Agency on 1/31/12 indicated the facility was provided two rejection notices for NA-F, informing the facility the NA was not listed on the registry.

The administrator communicated via email on 2/2/11 that NA-F was given a conditional job offer and at the time of the offer, was listed on the registry. The SA registry staff, however, sent email information on 2/3/11 indicating the facility was notified that NA-F was due to be removed from the registry listing on 5/7/11, and therefore should not have been hired by the facility on 5/9/11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/25/2012**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - UNIVERSITY SPECIALTY CARE	**22 - 27TH AVENUE SOUTHEAST** **MINNEAPOLIS, MN 55414**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society University was found 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. This 8-story building was built at two different times.The original 8-story building was built in 1971 and determined to be Type II (222). An 8-story addition was added to the southside in 1980 and was determined to be Type I (332). Because the orginal building was built to a lesser construction type allowed the facility was surveyed as one building Type II (222). It has no basement and is fully fire sprinklered throughout. The facility 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 165 beds and had a census of 1152 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

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

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 4939 8425

February 17, 2012

Ms. Sharon St. Mary, Administrator
Good Samaritan Society - University Specialty Care
22 - 27th Avenue Southeast
Minneapolis, Minnesota 55414

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5279021

Dear Ms. St. Mary:

The above facility was surveyed on January 23, 2012 through January 27, 2012 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.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). 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.

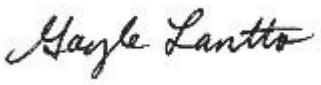
When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, P.O. Box 64900, St. Paul, Minnesota 55164-0900. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

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

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

Please feel free to call me with any questions.

Sincerely,



Gayle Lantto, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3794 Fax: (651) 201-3790

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

5279s12lic.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00890	A. BUILDING _____ B. WING _____	01/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - UNIVERSITY SI	22 - 27TH AVENUE SOUTHEAST MINNEAPOLIS, MN 55414

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 23-27, 2012 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	Minnesota Department of Health is documenting the State Licensing Correction Orders using the 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	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 3-1-12

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 000	Continued From page 1 Certification Programs; 85 East Seventh Place, Suite 220; P.O. Box 64900, St. Paul, Minnesota 55164-0900.	2 000	entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 265	MN Rule 4658.0085 Notification of Chg in Resident Health Status A nursing home must develop and implement policies to guide staff decisions to consult physicians, physician assistants, and nurse practitioners, and if known, notify the resident's legal representative or an interested family member of a resident's acute illness, serious accident, or death. At a minimum, the director of nursing services, and the medical director or an attending physician must be involved in the development of these policies. The policies must have criteria which address at least the	2 265		

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2 265	Continued From page 2 appropriate notification times for: A. an accident involving the resident which results in injury and has the potential for requiring physician intervention; B. a significant change in the resident's physical, mental, or psychosocial status, for example, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications; C. a need to alter treatment significantly, for example, a need to discontinue an existing form of treatment due to adverse consequences, or to begin a new form of treatment; D. a decision to transfer or discharge the resident from the nursing home; or E. expected and unexpected resident deaths. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to notify the resident's physician when the resident experienced a significant weight loss for 1 of 5 residents (R105) who were at nutritional risk. Findings include: R105 experienced a 20.90% weight loss within a six month period and there was no indication the weight loss had been reported to the physician or nurse practitioner. R105's weights were recorded by several different nursing assistants as: 1/20/12 - 140	2 265		

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2 265	Continued From page 3 pounds; 12/23/11 - 159; 12/16/11 - 161.6; 12/2/11 - 177; 10/21/11 - 176; and 7/29/11 a weight of 177. The documented weights indicated there was a 20.90% weight loss between the 7/29/11 weight and 1/20/12 weight. At 7:38 a.m. on 1/25/12, the food service director (FSD) was interviewed regarding R105's weight loss. The FSD stated the facility registered dietitians (RDs) reviews resident weights on a monthly basis, and nursing assistants (NAs) were to let the RDs know if there was a significant weight loss. When questioned at 10:10 a.m. on 1/25/12, RD-I stated all resident weights were reviewed at the end of every month. RD-I was unaware of R105's weight loss and said staff were to notify dietary when there was a five pound difference between recorded weights. RD-I stated R105 had been receiving fortified foods for some time, which included fortified Jell-O at meals. RD-I verified Glucose Control Boost was also being provided for the resident to add protein versus calories. After reviewing the recorded weights, RD-I verified R105 experienced a significant weight loss. At 10:55 a.m. on 1/15/12, NA-E stated she usually worked the evening shift and over the past 2-3 months and noticed a change in R105's eating ability and required assistance to eat more often. R105 ate culturally preferred food of flat bread and meat gravy provided at meal times, but nothing else. When asked if she had reported the decline, NA-E stated the evening nurse knew about it as the nurses were in the dining room at meal times. A trained medication aide-A (TMA-A) stated R105	2 265		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 265	Continued From page 4 "doesn't eat like he used to," but was unable to recall when the change was noted. TMA-A stated R105 preferred food from his native land. Nutritional assessments, completed by two different RDs on 9/19 and 12/9/11, revealed R105's weights for the each of those quarters was reviewed. Each RD documented R105 weights as stable and within R105's usual body weight range of 177-180 pounds. The documentation also revealed R105 received a regular portion size, consistent carbohydrate, dysphasia (for swallowing disorder) diet, with two scoops of Bene Protein twice a day, for a low albumin (protein) level. On 12/22/11, the nurse practitioner discontinued the Bene Protein secondary to resident refusal and ordered one 8-ounce carton of Glucose Control Boost, twice a day to meet R105's protein requirements. The 9/11 RD note indicated that because of cultural needs, R105 received ground meat with gravy every day at lunch and required increased assistance from staff to be fed. There was no documentation indicating the nurse practitioner or physician was notified of R105's significant weight loss. A note by the physician on 12/27/11 only addressed a review of the 12/2/11 weight, despite additional recorded weights of 12/16 and 12/23/11, which indicated the significant weight loss. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review and revise the policies and procedures regarding notification of the physician and family members. All staff involved with notifying the physician of resident changes could be educated regarding the procedure. The quality assurance committee	2 265		

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2 265	Continued From page 5 could randomly audit records to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30) days.	2 265		
2 545	MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency Subp. 3. Frequency. Comprehensive resident assessments must be conducted: A. within 14 days after the date of admission; B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess bladder function for 1 of 1 residents (R95) reviewed for a decrease in continence level at the time of a significant change in status assessment. Findings include: R95 had an increase in incontinence and was not comprehensively reassessed to determine contributing factors related to incontinence. R95 was admitted to the facility on 9/29/11. The residents admission Minimum Data Set (MDS) assessment indicated the resident's primary diagnoses included history of stroke, dementia, aphasia (speech disorder), and depression. The MDS indicated the resident was occasionally incontinent of bladder and required extensive assistance from one person to use the toilet.	2 545		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 545	Continued From page 6 A significant change MDS assessment was completed for R95 on 12/22/11. R95's toileting abilities decreased and the resident was then identified as "frequently incontinent" and needing two persons to physically assist with using the toilet. A bladder assessment was completed for R95 on 10/3/11. The assessment indicated R95 had "no problems" with toileting ability and was stable. Incontinence was not identified as a problem area. The assessment indicated R95 needed one person to physically assist with transfers and ambulation related to impaired balance and unsteady gait. The assessment was reviewed 12/20/11 and "no changes" were indicated on the bottom of the form. A nursing assistant (NA-A) was interviewed on 12/26/12 at 10:00 a.m. NA-A stated that R95 wore an adult brief at all times. NA-A explained that R95 independently voided at times, and also required extensive assistance at times, depending on the resident's mood and behavior. R95 was described as frequently incontinent at night but is more continent during daytime hours. The MDS Coordinator (RN-MDS) was interviewed at 11:00 a.m. on 1/26/12. The RN-MDS reviewed R95's bladder assessment and indicated that it was not thorough enough to determine underlying factors and causes related to R95's incontinence. RN-MDS agreed that the assessment was not an accurate reflection of R95's current incontinence status. RN-MDS stated that the assessment and corresponding care plan would be updated to reflect the care and services provided for R95's incontinence. The facility's Bladder Assessment policy last	2 545		

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2 545	Continued From page 7 revised 9/10 was reviewed. The policy directed staff tto complete a bladder assessment after incontinence was identified or triggered on the MDS. The staff were to complete an accurate assessment of factors that predispodsed the resident to urinary incontinence and findings were to be documented on the Bladder Assessment form along with an individualized toileting plan. SUGGESTED METHOD OF CORRECTION: The DON or designee could review and revise the policies and procedures for doing a comprehensive assessment after a significant change for a resident has occurred. Policies and procedures could then be reviewed by all staff and audits could be performed to assure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 545		
2 550	MN Rule 4658.0400 Subp. 4 Comprehensive Resident Assessment; Review Subp. 4. Review of assessments. A nursing home must examine each resident at least quarterly and must revise the resident's comprehensive assessment to ensure the continued accuracy of the assessment. This MN Requirement is not met as evidenced by: R169 had an increase in bladder incontinence and was not comprehensively assessed to determine cause and appropriate care and services to improve or maintain continence status. R169 was admitted to the facility with diagnoses	2 550		

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2 550	Continued From page 8 including Huntington's chorea, anxiety, anemia, depressive disorder, and generalized pain. The admission minimum data set (MDS) dated 9/21/11, indicated R169 was always continent of bladder, and was independent with transfers, walking, personal hygiene, bed mobility and toilet use. However, a significant change MDS completed on 12/8/11 identified R169 as "frequently incontinent," and needing extensive assistance from one person for dressing, eating, and personal hygiene; as well as needing supervision for transfers, bed mobility and toilet use. R169 was observed laying in the bed at 8:10 and 8:45 a.m. on 1/25/12. R169 was wearing a pull-up (adult brief) that appeared to be dry. A bladder assessment completed for R169 upon admission dated 9/19/11, indicated R169 had no problems with toileting abilities and incontinence was not identified as a problem area. The assessment also indicated R169 had an unsteady gait, but did not need assist with mobility. The assessment was reviewed on 12/4/11 and no changes were indicated on the bottom of the page. Another bladder assessment completed on 10/20/11, indicated R169 had occasional incontinence with no pattern. The assessment indicated R169 had impaired cognitive and physical ability to manage own hygiene and clothing. Per the assessment, R169 was seen by physical and occupational therapist due to a right upper arm fracture. Staff did not recommend a retraining/toileting program, but proposed assistance with hygiene and dressing as needed. This assessment was also reviewed on 12/4/11	2 550		

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2 550	Continued From page 9 and no changes were indicated on the bottom of the page. The Care Area Assessment (CAA) dated 12/15/11, indicated staff were to proceed to the care plan due to alteration in toileting and occasional urinary incontinence. An nursing assistant (NA-D) was interviewed at 1:42 p.m. on 1/25/12 and stated that when R169 initially came to the facility she was continent of urine and was able to use the toilet independently. At the present time, R169 used incontinent products, was occasionally incontinent, and was at times able to manage her incontinence and other times preferred to use incontinent products and have staff change the product. Registered nurse (RN-B) was interviewed at 1:50 p.m. on 1/25/12 and stated R169 was occasionally incontinent, was able to most of the time, use the toilet independently. At other times R169 exhibited the behavior of voiding in the incontinent product; and staff needed to assist R169 with changing the incontinent product. The MDS/Clinical Coordinator (MDS-CC) was interviewed at 11:12 on 1/25/12. The MDS-CC reviewed R169's MDS from 9/21/11 and 12/8/11 and confirmed that R169 had a change in bladder continence status. The MDS-CC explained she used the data from the NA's documentation (Voided Record) which indicated during the 7 day observation period R169 had 7 incontinence episodes. MDS-CC reviewed R169's bladder assessment and agreed that the assessments were not an accurate reflection of R169's current incontinence status. She further stated staff did not assess causative factors for incontinence and	2 550		

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2 550	Continued From page 10 did not identify individualized toileting needs to attempt to restore/ maintain continence. MDS-CC also stated staff was supposed to complete a whole new comprehensive assessment on 12/4/11 instead of reviewing the previous ones, since there was a change in the resident's continence status. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff to complete a bladder assessment after bladder incontinence was identified or triggered on the MDS. Staff were to complete an accurate assessment of factors that predisposed the resident to urinary incontinence and findings were to be documented on the Bladder Assessment form, along with an individualized toileting plan. Although R169 had a change in her continence status, there was no indication a comprehensive reassessment had been completed for R169's individualized toileting needs. SUGGESTED METHOD OF CORRECTION: The administrator and the director of nursing (DON) or her designee could develop policies and procedures to ensure comprehensive assessments are completed at the time of the quarterly MDS. The DON or her designee could educate all appropriate staff on these policies and procedures. The DON or her designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (14) days.	2 550		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence	2 910		

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2 910	Continued From page 11 Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to identify potential care and services needed to improve or maintain bladder function for 2 of 3 residents (R95 and R169) reviewed after a decline in bladder continence status. Findings include: R95 had an increase in incontinence and was not comprehensively reassessed to determine appropriate care and services to maintain or improve continence status. R95 was admitted to the facility on 9/29/11. The residents admission Minimum Data Set (MDS) assessment indicated the resident's primary diagnoses included history of stroke, dementia, aphasia (speech disorder), and depression. The MDS indicated the resident was occasionally	2 910		

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2 910	Continued From page 12 incontinent of bladder and required extensive assistance from one person to use the toilet. A significant change MDS assessment was completed for R95 on 12/22/11. R95's toileting abilities decreased and the resident was then identified as "frequently incontinent" and needing two persons to physically assist with using the toilet. A bladder assessment was completed for R95 on 10/3/11. The assessment indicated R95 had "no problems" with toileting ability and was stable. Incontinence was not identified as a problem area. The assessment indicated R95 needed one person to physically assist with transfers and ambulation related to impaired balance and unsteady gait. The assessment was reviewed 12/20/11 and "no changes" were indicated on the bottom of the form. R95's care plan dated 1/16/12 was reviewed. The care plan indicated the resident had an alteration in elimination related to history of stroke and dementia. The care plan instructed staff that R95 needed occasional assistance with toileting and adjusting clothing, and used the toilet to void. A nursing assistant (NA-A) was interviewed on 12/26/12 at 10:00 a.m. NA-A stated that R95 wore an adult brief at all times. NA-A explained that R95 independently voided at times, and also required extensive assistance at times, depending on the resident's mood and behavior. R95 was described as frequently incontinent at night but is more continent during daytime hours. The MDS Coordinator (RN-MDS) was interviewed at 11:00 a.m. on 1/26/12. The RN-MDS reviewed R95's bladder assessment and indicated that it	2 910		

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2 910	Continued From page 13 was not thorough enough to determine underlying factors and causes related to R95's incontinence. RN-MDS agreed that the assessment was not an accurate reflection of R95's current incontinence status. RN-MDS stated that the assessment and corresponding care plan would be updated to reflect the care and services provided for R95's incontinence. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff that a bladder assessment is to be completed after incontinence is identified or triggers on the MDS. The staff are to complete an accurate assessment of factors that predispose the resident to urinary incontinence and findings are to be documented on the Bladder Assessment form along with an individualized toileting plan. R169 had an increase in bladder incontinence and was not comprehensively assessed to determine cause and appropriate care and services to improve or maintain continence status. R169 was admitted to the facility with diagnoses including Huntington's chorea, anxiety, anemia, depressive disorder, and generalized pain. The admission Minimum Data Set (MDS) dated 9/21/11, indicated R169 was always continent of bladder, and was independent with transfers, walking, personal hygiene, bed mobility and toilet use. However, a significant change MDS completed on 12/8/11 identified R169 as "frequently incontinent," and needing extensive assistance from one person for dressing, eating, and personal hygiene; as well as needing supervision for transfers, bed mobility and toilet	2 910		

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2 910	Continued From page 14 use. R169 was observed laying in the bed at 8:10 and 8:45 a.m. on 1/25/12. R169 was wearing a pull-up (adult brief) that appeared to be dry. A bladder assessment completed for R169 upon admission dated 9/19/11, indicated R169 had no problems with toileting abilities and incontinence was not identified as a problem area. The assessment also indicated R169 had an unsteady gait, but did not need assist with mobility. The assessment was reviewed on 12/4/11 and no changes were indicated on the bottom of the page. Another bladder assessment completed on 10/20/11, indicated R169 had occasional incontinence with no pattern. The assessment indicated R169 had impaired cognitive and physical ability to manage own hygiene and clothing. Per the assessment, R169 was seen by physical and occupational therapist due to a right upper arm fracture. Staff did not recommend a retraining/toileting program, but proposed assistance with hygiene and dressing as needed. This assessment was also reviewed on 12/4/11 and no changes were indicated on the bottom of the page. The Care Area Assessment (CAA) dated 12/15/11, indicated staff were to proceed to the care plan due to alteration in toileting and occasional urinary incontinence. An nursing assistant (NA-D) was interviewed at 1:42 p.m. on 1/25/12 and stated that when R169 initially came to the facility she was continent of urine and was able to use the toilet independently. At the present time, R169 used	2 910		

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2 910	Continued From page 15 incontinent products, was occasionally incontinent, and was at times able to manage her incontinence and other times preferred to use incontinent products and have staff change the product. Registered nurse (RN-B) was interviewed at 1:50 p.m. on 1/25/12 and stated R169 was occasionally incontinent, was able to most of the time, use the toilet independently. At other times R169 exhibited the behavior of voiding in the incontinent product; and staff needed to assist R169 with changing the incontinent product. The MDS/Clinical Coordinator (MDS-CC) was interviewed at 11:12 on 1/25/12. The MDS-CC reviewed R169's MDS from 9/21/11 and 12/8/11 and confirmed that R169 had a change in bladder continence status. The MDS-CC explained she used the data from the NA's documentation (Voided Record) which indicated during the 7 day observation period R169 had 7 incontinence episodes. MDS-CC reviewed R169's bladder assessment and agreed that the assessments were not an accurate reflection of R169's current incontinence status. She further stated staff did not assess causative factors for incontinence and did not identify individualized toileting needs to attempt to restore/ maintain continence. MDS-CC also stated staff was supposed to complete a whole new comprehensive assessment on 12/4/11 instead of reviewing the previous ones, since there was a change in the resident's continence status. The facility's Bladder Assessment policy last revised 9/10 was reviewed. The policy directed staff to complete a bladder assessment after bladder incontinence was identified or triggered on the MDS. Staff were to complete an accurate	2 910		

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2 910	Continued From page 16 assessment of factors that predisposed the resident to urinary incontinence and findings were to be documented on the Bladder Assessment form, along with an individualized toileting plan. Although R169 had a change in her continence status, there was no indication a comprehensive reassessment had been completed for R169's individualized toileting needs. SUGGESTED METHOD OF CORRECTION: The director of nurses (DON) or designee could develop policies and procedures to ensure residents identified with urinary incontinence receive the appropriate treatment and services, which is based on a comprehensive assessment. The director of nursing or designee could educate all appropriate staff members on the processes. The director of nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days	2 910		
21685	MN Rule 4658.1415 Subp. 2 Plant Housekeeping, Operation, & Maintenance Subp. 2. Physical plant. The physical plant, including walls, floors, ceilings, all furnishings, systems, and equipment must be kept in a continuous state of good repair and operation with regard to the health, comfort, safety, and well-being of the residents according to a written routine maintenance and repair program. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21685		

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21685	Continued From page 17 review, the facility failed to ensure call lights for 2 of 40 resident's (R128 and R66) were in good working order, and to maintain cleanable surfaces on resident dresser drawers, floors, walls and ceilings in common areas. This had the potential to affect all the resident living in the facility. Finding include: At 4.39 p.m. on 1/23/12, R128's call light (room 605) was not functioning. The call light had a pneumatic bulb and when the bulb was pressed there was no sound at the nurses' station nor did the light above the door turn on. At this time the nurse manager (NM-B) stated R128 was alert and able to properly use the call light. NM-B confirmed the call light was not working. At 3:54 p.m. on 1/23/12, R66's call light (room 620) was checked and was not working. There was no sound at the nurses station or light above residents door. NM-B verified that and stated R66 would have bee unable to independently use the call light. The director of facility management (DFM) was interviewed at 11:40 a.m. on 1/26/12. The DFM explained the facility had a preventative maintenance program, which included monthly call light checks on every unit. The Monthly Floor Checklist dated 11/09, indicated "Check call lights on floor. Randomly select two rooms from each wing, also test shower rooms on both wings. Note location checked." The facility provided no documentation of completed checklists for confirmation that the floor audits were being completed.	21685		

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21685	Continued From page 18 The facility environmental tour was conducted on 1/26/12 from 9:55 a.m. through 11:52 a.m. with the director of facility management (DFM). During the tour, the DFM stated there was one maintenance staff assigned to two floors, whose job it was to check for items needing repair or maintenance, including cosmetic maintenance of such items as walls, ceilings, and resident room items. The DFM stated there was no preventative maintenance program for cosmetic areas that needed maintenance. During the tour the following environmental concerns were noted: The facility had two elevators in use which transported residents and staff from the 1st to the 7th floors. The doors and walls in the elevator had numerous scraped, scratched and marred areas. 7th floor - In the dining room, the radiator cover was disconnected from the frame and the corner of the cover was resting on the floor. Room 723 had a gouge out of the drywall. The hallway ceiling by room 715/713 had three yellow spots. At 10:05 a.m. the DFM was asked what caused the spots and the DFM stated it was from water condensation in the summer. Room 722 and 727 bathroom call light cords were a dark brown color. At 10:15 a.m. the DFM confirmed the call cords should be checked and replaced when dirty or soiled. 6th floor - The east wing had a cloth-like wallpaper. Approximately 26 inches from the floor and the entire length of the hallway, the wallpaper was soiled or stained with medium to dark brown stains. The bedroom kick plate in room 613 was marred and scratched. The dining room area had	21685		

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21685	Continued From page 19 loose base boards. The door between the two dining room areas was gouged and scraped. At 10:30 a.m. the DFM stated it was part of the facility maintenance program to refinish the doors. 5th floor - Room 520A had a privacy curtain torn at the hook; room 512 had loose base boards and one of the resident dressers top was worn down to the wood. The dining room had built up dirt and debris under the radiators and around the edges of the room and counters. The 5 east wing hallway drywall was scraped and scratched. The 5 east lounge area walls were discolored, scraped and gouged. The area by the elevator had two corner plates that had a piece of base board missing. 4th floor - Room 413B had a deep gouge out of the floor linoleum. In room 416B the drywall was scraped and marred. 3rd floor - Room 314A had peeling wall paint. At 11:10 a.m. the DFM stated they planned to relocate to a new building toward the end of the year, but confirmed that cosmetic areas of the building should still have been maintained until the move took place. SUGGESTED METHOD OF CORRECTION: The director of maintenance or his designee could develop and implement policies and procedures to ensure that the nursing home was maintained in a safe, clean, functional, comfortable and homelike manner and permitted residents to use personal belongings to the extent possible. The director of maintenance or his designees could then monitor staff for adherence to these policies.	21685		

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	00890	A. BUILDING _____ B. WING _____	01/27/2012

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21685	Continued From page 20 TIME PERIOD FOR CORRECTION: Twenty-one (21) days	21685		
21990	MN St. Statute 626.557 Subd. 4 Reporting - Maltreatment of Vulnerable Adults Subd. 4. Reporting. A mandated reporter shall immediately make an oral report to the common entry point. Use of a telecommunications device for the deaf or other similar device shall be considered an oral report. The common entry point may not require written reports. To the extent possible, the report must be of sufficient content to identify the vulnerable adult, the caregiver, the nature and extent of the suspected maltreatment, any evidence of previous maltreatment, the name and address of the reporter, the time, date, and location of the incident, and any other information that the reporter believes might be helpful in investigating the suspected maltreatment. A mandated reporter may disclose not public data, as defined in section 13.02, and medical records under section 144.335, to the extent necessary to comply with this subdivision. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to investigate and/or immediately report to the State agency (SA) including examples of 2 of 3 residents (R169 and R94) in the sample who had fractures of unknown origin; failed to provide evidence that all injuries of unknown origin were thoroughly investigated for 2 of 2 residents (R142, R19) who had bruises of unknown origin; and failed to immediately report several cases of resident to resident altercations including 4 examples (109, R158, R120, R63,	21990		

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21990	Continued From page 21 R74, R98) of 25 reports reviewed. R169 was admitted to the facility on 9/15/11, with diagnoses including Huntington's Chorea with psychosis, and dementia. Documentation indicated R169 sustained a right humerus (arm) fracture, and was admitted to the hospital from 10/15 - 10/17/11 and the facility failed to thoroughly investigate and report the fracture of unknown origin to the SA. The admission minimum data set dated 9/21/11, indicated R169 was independent with bed mobility, transfers, walking, toileting, and personal hygiene. The incident report dated 10/13/11, indicated R169 had a fall on 10:45 a.m. The report stated that as R169 was walking down the hallway, staff observed a laceration on the back of the head measuring 3.6 centimeter (cm) by 0.3 cm. Documentation indicated an investigation of the incident revealed R169 had fallen in the bathroom. A body assessment was completed, and there were no other injuries recorded on the incident report. The interdisciplinary progress (IDP) notes dated 10/13/11 noted R169 was sent to the emergency room (ER), where the head laceration was closed and returned to the facility at 6:20 p.m. The hospital discharge note dated 10/13/11 indicated R169 "had Huntington's but very functional, cognitively intact, and walks on her own. Slipped on some water in the bathroom and hit head on the toilet...Denies head, neck, back, chest, abd, (abdominal), or extremity pain." A review of IDP notes dated 10/13/11, 6:20 p.m. through 10/15/11, 10:00 p.m. indicated R169	21990		

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21990	Continued From page 22 denied pain/discomfort, ate and drank 100 percent of food and fluids. There was no indication anything was wrong with R169's right arm until a 10:00 p.m. note dated 10/15/11. This documentation indicated R169 was not moving right arm, was not dressing self, and the right arm dangled at her side. The documentation also revealed the antecubital (front part) area of the right arm was swollen; deltoid (muscle) was bruised and swollen. R169 was sent to the hospital for further evaluation. A nurses note dated 10/16/11, at 3:30 a.m. indicated R169 was admitted to the hospital with diagnoses of right humerus fracture and fever. The IDP note from 8:30 a.m. on 10/16/11, indicated there was possible cellulitis in the right arm, and R169 received intravenous antibiotics. R169 was readmitted to the facility on 10/17/11. The ER notes dated 10/13/11, the discharge notes dated 10/17/11, and the nurse practitioner's progress notes dated 10/18/11 were reviewed. There was no evidence in the medical record indicating the cause of the fracture. At 2:11 p.m. on 1/25/12, nurse manager-A (NM-A) stated there was no incident report completed on 10/15/11 when R169's fractured arm was discovered. There was no further information provided regarding investigation. At 10:30 a.m. on 1/26/12, the director of nursing (DON) stated the nurse should have completed an incident report when the bruise was identified, and staff should have conducted an investigation and documented how the fracture had occurred. During interview with the administrator (ADM) at 10:40 a.m. on 1/26/12, the ADM stated staff were expected to document an incident report when	21990		

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21990	Continued From page 23 injuries of unknown origin were identified, to investigate to determine what caused the injury, and also to report to the SA if needed. The ADM also stated he was not sure if R169 sustained the fracture during the fall on 10/13/11. The ADM further stated since there was no incident report with investigation in place for R169's fracture, it was only "speculation" that R169 did fracture her arm on 10/13/11, and no one could exactly say what happened between 10/13/11 and 10/15/11. R94 sustained a fracture to the base on the right thumb and a thorough investigation regarding this injury of unknown origin was not conducted, nor was the injury reported to the SA. An incident report dated 10/27/11, revealed R94 was being seen by occupational therapy (OT) to treat a splinted finger. However, the incident report was not clear as to why the finger was being treated by OT with a splint. Further record review revealed an X-ray of the right thumb was taken on 10/27/11. The report indicated there was a probable subacute fracture at the base of the thumb. Interview indicated and record review confirmed R94 had sustained a fractured finger. At 2:00 p.m. on 1/26/12, an interview with the DON and unit manager was conducted. Both staff members indicated that R94 had a history of banging his hands on the table and this was a reasonable explanation as to how the fractured finger may have happened. However, the incident report dated 10/27/11 didn't come to that conclusion or summarize hand banging as a possible reason for the fracture. The DON stated the fractured finger was not reported to the SA because of the conclusion drawn on how the	21990		

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21990	Continued From page 24 fracture may have happened. R142 alleged a staff person caused bruises to his right forearm and a thorough investigation to determine the cause was not completed, nor reported to the SA. An incident report dated 7/10/11, for R142, indicated, "Resident was noted to have bruises on his R (right) forearm. Police asked him how he got the bruise and resident point at staff nurse who was present. Writer was present too." The incident report also indicated staff were unable to assess R142 as the resident was being physically aggressive. Documentation revealed R142 was transported to a local hospital's crisis center via ambulance and police escort. During interview at 10:00 a.m. on 1/27/12, the DON verified there was no further investigation regarding R142's bruises or allegation that the bruises were caused by a staff member. The DON stated R142 was physically aggressive with staff on 7/5/11 and presented the incident report dated 7/5/11, which indicated R142 "was pushing+ hitting staff." At that time R142 had a lighter, would not give it to staff and threatened to burn down the staff and the building. Even though R142 had sustained bruises the facility did not thoroughly investigate the cause, did not interview staff working and did not look at environmental factors to determine and document potential cause of of the bruises. The DON acknowledged at 9:25 a.m. on 1/27/12, that staff did not thoroughly investigate R142's bruises or allegation that staff caused the bruising. R19 sustained an injury of unknown origin to the	21990		

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21990	Continued From page 25 labia which was not thoroughly investigated and reported to the SA. An incident report dated 6/25/11, indicated R19 was found to have "a bruise on resident R(right) labia region" measuring 3 cm by 1.5 cm. The potential cause of the bruise was not thoroughly investigated. The incident report indicated staff had documented the following: cause "unknown"; a bruise of "unknown" origin; and "since it's of unknown origin, could be urine burn or tight brief. Not to refuse change of brief when wet, wear brief loosely." The investigation section of the report dated 6/27/11, indicated R19 did not know how the bruise was caused, and denied that anyone had hurt her. During an interview at 10:10 a.m. on 1/27/12, the DON stated R19 denied being hurt by anyone and for that reason the facility excluded mistreatment and did not report this bruise to the SA. The DON also verified the investigation was not thorough, as the cause of the bruise was not identified. Even though R19 denied mistreatment the facility did not thoroughly investigate the cause, did not interview staff working and did not look at environmental factors to determine a potential cause of the injury. R120 and R158 had an altercation that resulted in resident injury which was not immediately reported to the SA. A Vulnerable Adult Suspected Maltreatment (VASM) report dated 7/6/11, indicated there was an altercation between R158 and R120. The report noted, "The facility investigation was begun on 7/2/11 and continued over the next few days." The report revealed that on 7/2/11, R120 was	21990		

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21990	Continued From page 26 sitting at the receptionist desk and witnessed R158 getting a cigarette from someone. R120 told the receptionist, "If no one else is going to stop her I am." The receptionist called a behavior call over the intercom. The receptionist saw R120 hit the cigarette out of R158's hand and then R158 ran behind the receptionist desk. The report continued that R120 was "hitting and pulling" on R158, and had her on the ground. R120 was very emotional, was not calming down, and was sent to crisis center. R120 incurred scratches on her right index finger, nose, neck, left hand and ear. R158 had a small abrasion on her left cheek. The incident report dated 7/2/11 at 7:00 p.m. indicated, "The other resident dislikes [R158], wants to see [R158] punished severely." An interview was conducted with the DON, ADM, 6th floor Program Manager, and Special Program Manager (SPM) at 2:35 p.m. on 1/26/12. SPM and DON verified the above information and indicated the incident was reported to the SA 4 days later. No further information was provided. R63 allegedly sexually abused R74 which was not reported immediately to the SA. A VASM report dated 8/23/11 revealed that on 8/22/11, the unit nurse walked into the sixth floor dining room and witnessed R74 screaming. R63 had his mouth on R74's breast through her shirt. The floor nurse intervened, and no injuries were noted. Both residents were able to move around the unit independently and communicate verbally. The incident report dated 8/22/11 indicated the incident happened at 1:40 p.m., however the report to the SA was made the next day, on 8/23/11 (no time identified).	21990		

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21990	Continued From page 27 During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that they had up to 24 hours to report an incident. R120 allegedly physically abused R98 which was not reported to the SA immediately. A VASM report dated 11/7/11, revealed an altercation between R120 and R98. The VASM report revealed, "The facility investigation begun on 11/5/11 and continued over the next few days." The investigation concluded that R120 and R98 were waiting in the dining room for supper when the unit nurse had heard R98 screaming. The nurse went to the dining room and found R120 standing very close to R98, who had a bloody nose. R120 reported to staff that R98 had been crying/screaming when R120 got frustrated and hit R98 with a closed fist. Even though the alleged abuse happened at 4:50 p.m. on 11/5/11, the report to the SA was not made until 11/7/11 (no time identified). During interview with the DON at 10:05 a.m. on 1/27/12, the DON stated staff were under the impression that the time frame for reporting incidents to the SA was up to 24 hours, and verified the above incident was reported to the SA 2 days later. R109 reported to staff on 11/26/11, that he was beaten and thrown into the car by his family. A report was made to the SA 48 hours later on 11/28/11. The VASM report submitted on 11/28/11 indicated, "His allegation was against his wife, ...while on leave of absence...The facility investigation began on 11/26/11 and continued	21990		

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21990	Continued From page 28 over the next couple of days...The facility internal investigation was not able to substantiate (resident's name) allegations of being beaten and thrown into the car, and felt it most likely that the incident between (resident's name) and his family was handled appropriately when (resident's name) became angry about returning from LOA (leave of absence)." An interview was conducted with the DON, ADM, 6th floor Program Manager, and Special Program Manager (SPM) at 2:35 p.m. on 1/26/12. The SPM stated when the team reviews incident reports, the team discusses if the incident meets the criteria for reporting, and if the team feels the incident should be reported, a report is made to the SA no later than 24 hours after the team's knowledge of the incident. The LSW verified the above report was made 48 hours after the resident had made the allegation. On 1/27/12, the licenses social worker (LSW) provided information indicating R109's incident occurred off premises, and was reported to the police. R109 was also seen at the hospital at the time of the incident. The LSW likely felt this met the reporting criteria to the SA, and that new information received upon a 11/28/11 interview prompted immediate online reporting to the State agency. The Abuse and Neglect policy/procedure, last revised 1/11, indicated: 1. "If a staff member receives an allegation of abuse, neglect, misappropriation of resident property or witness suspected abuse, neglect, or misappropriation of resident property, the staff member will immediately report this to a supervisor and complete Sections A through D of the 'Incident Details' on the Incident Report (GSS #401)." 2.	21990		

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21990	Continued From page 29 The charge nurse or licensed nurse will be notified immediately, assess the situation to determine if any emergency treatment or action is required, and complete an initial investigation.... 4. When no determination of the cause of injury can be made OR when abuse or neglect is alleged or suspected, appropriate corrective action will be taken. 6. The investigation team (social worker, the administrator and the director of nursing services) will review all Incident Report (GSS#401) that involve residents including those that indicate al injury of unknown origin, abuse and neglect, misappropriation of resident property or involuntary seclusion no later than next working day following the incident. The investigation team will determine if further investigation is needed. The social worker or the designated person will notify the designated agency(ies) in the state as soon as possible after reviewing the Incident Report (GSS#401) (i.e., if designated agency(ies) have not been notified, see 5b). The social worker or the designated person will also complete and submit any reports required by the designated agencies." SUGGESTED METHOD FOR CORRECTION: The administrator, director of nurses (DON), social services or designee(s) could review and revise, as necessary, the policies and procedures regarding the process of reporting/investigating suspected abuse or maltreatment of a resident. The administrator, DON, social services or designee (s) should provide training for all appropriate staff on these policies and procedures. The administrator, DON, social services or designee (s) could monitor accidents/incidents of unknown origin to assure all reports of suspected abuse or maltreatment are being reported and investigated in a timely manner.	21990		

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21990	Continued From page 30 TIME PERIOD FOR CORRECTION: Fourteen (14) days.	21990		