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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BZJW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMU**
(L4) **3815 WEST BROADWAY**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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 **03/31/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Wong, HFE NE II 04/04/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/04/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **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

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

CMS Certification Number (CCN): 245279

April 4, 2016

Ms. Nicole Mattson, Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Dear Ms. Mattson:

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 23, 2016 the above facility is certified for:

96 Skilled Nursing Facility/Nursing Facility Beds

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

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

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

Minnesota Department of Health

Protecting, Maintaining and Improving the Health of all Minnesotans

May 4, 2016

Ms. Nicole Mattson, , Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Dear Ms. Mattson:

On April 4, 2016 we sent out an all corrected letter along with the 2567b's for your facility. The 2567b's were send out with an incorrect date for the correction of the state orders and federal deficiences. We have revised the documents. Please review and save a copy for your records.

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
April 4, 2016

Ms. Nicole Mattson, Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

RE: Project Number S5279026

Dear Ms. Mattson:

On March 3, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 12, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections were required.

On March 31, 2016, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 29, 2016 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 12, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 23, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 12, 2016, effective March 31, 2016 and therefore remedies outlined in our letter to you dated March 3, 2016, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION		DATE OF REVISIT
245279 Y1	A. Building B. Wing	****Please note this form has been revised to reflect a change in the Correction Completed Date.** Y2	3/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0221	Correction	ID Prefix F0246	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.13(a)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix F0253	Correction	ID Prefix F0278	Correction	ID Prefix F0279	Correction
Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix F0314	Correction	ID Prefix F0318	Correction	ID Prefix F0322	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(g)(2)	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix F0323	Correction	ID Prefix F0431	Correction	ID Prefix	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. #	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	05/02/2016	30951	03/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON 2/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245279	A. Building 02 - MAIN BLDG B. Wing	3/29/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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

ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)	ITEM (Y4)	DATE (Y5)
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 03/23/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 03/23/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) TL/kfd	DATE 4/4/2016	SIGNATURE OF SURVEYOR 37009	DATE 03/29/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
2/11/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
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Department
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Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

April 4, 2016

Ms. Nicole Mattson, Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Re: Reinspection Results - Project Number S5279026

Dear Ms. Mattson:

On March 31, 2016 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 February 12, 2016. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION		DATE OF REVISIT
00890 Y1	A. Building B. Wing	****Please note this form has been revised to reflect a change in the Correction Completed Date.** Y2	3/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20510	Correction	ID Prefix 20560	Correction	ID Prefix 20565	Correction
Reg. # MN Rule 4658.0300 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix 20830	Correction	ID Prefix 20890	Correction	ID Prefix 20900	Correction
Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 2 A	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix 20920	Correction	ID Prefix 20930	Correction	ID Prefix 21565	Correction
Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0525 Subp. 7 B.	Completed	Reg. # MN Rule 4658.1325 Subp. 4	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix 21630	Correction	ID Prefix 21685	Correction	ID Prefix 21810	Correction
Reg. # MN Rule 4658.1350 Subp. 2 A.B.	Completed	Reg. # MN Rule 4658.1415 Subp. 2	Completed	Reg. # MN St. Statute 144.651 Subd. 6	Completed
LSC	03/23/2016	LSC	03/23/2016	LSC	03/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	05/02/2016	30951	03/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?
2/12/2016	☐ YES ☐ NO

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00890 Y1	A. Building B. Wing Y2	3/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20510	Correction	ID Prefix 20560	Correction	ID Prefix 20565	Correction
Reg. # MN Rule 4658.0300 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 2	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix 20830	Correction	ID Prefix 20890	Correction	ID Prefix 20900	Correction
Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0525 Subp. 2 A	Completed	Reg. # MN Rule 4658.0525 Subp. 3	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix 20920	Correction	ID Prefix 20930	Correction	ID Prefix 21565	Correction
Reg. # MN Rule 4658.0525 Subp. 6 B	Completed	Reg. # MN Rule 4658.0525 Subp. 7 B.	Completed	Reg. # MN Rule 4658.1325 Subp. 4	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix 21630	Correction	ID Prefix 21685	Correction	ID Prefix 21810	Correction
Reg. # MN Rule 4658.1350 Subp. 2 A.B.	Completed	Reg. # MN Rule 4658.1415 Subp. 2	Completed	Reg. # MN St. Statute 144.651 Subd. 6	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	4/4/2016	30951	03/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ **YES** ☐ **NO**

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245279 Y1	A. Building B. Wing Y2	3/31/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0176	Correction	ID Prefix F0221	Correction	ID Prefix F0246	Correction
Reg. # 483.10(n)	Completed	Reg. # 483.13(a)	Completed	Reg. # 483.15(e)(1)	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix F0253	Correction	ID Prefix F0278	Correction	ID Prefix F0279	Correction
Reg. # 483.15(h)(2)	Completed	Reg. # 483.20(g) - (j)	Completed	Reg. # 483.20(d), 483.20(k)(1)	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix F0282	Correction	ID Prefix F0309	Correction	ID Prefix F0312	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25	Completed	Reg. # 483.25(a)(3)	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix F0314	Correction	ID Prefix F0318	Correction	ID Prefix F0322	Correction
Reg. # 483.25(c)	Completed	Reg. # 483.25(e)(2)	Completed	Reg. # 483.25(g)(2)	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	03/31/2016
ID Prefix F0323	Correction	ID Prefix F0431	Correction	ID Prefix	Correction
Reg. # 483.25(h)	Completed	Reg. # 483.60(b), (d), (e)	Completed	Reg. #	Completed
LSC	03/31/2016	LSC	03/31/2016	LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	GD/kfd	4/4/2016	30951	03/31/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/12/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: BZJW

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00890

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

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

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMU**
(L4) **3815 WEST BROADWAY**
(L5) **ROBBINSDALE, MN** (L6) **55422**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **02/12/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

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

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

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

17. SURVEYOR SIGNATURE Date :
Magdalene Jares, HFE NE II 03/15/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/25/2016 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically delivered

Ms. Nicole Mattson, Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

RE: Project Number S5279026

Dear Ms.. Mattson:

On February 12, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute actual harm that is not immediate jeopardy (Level G), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 23, 2016 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 23, 2016 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility 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 ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 12, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 12, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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:

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245279	A. BUILDING _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete self-administration of medication assessments and ensure safe administration of nebulizer and inhalers medications for 2 of 2 residents (R122, R74) who self-administered medication. Findings include: R122's medication administration was observed on 2/11/16, at 8:44 a.m. registered nurse (RN)-A entered R122's room, assessed R122's lung sounds and heart rate. RN-A emptied the	F 176	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. For the purposes of any allegation that the center is not insubstantial compliance with federal requirements of participation, this response and plan of correction	3/23/16

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

Electronically Signed | 03/11/2016

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F 176	Continued From page 1 Duo-neb vial into nebulizer (a medication delivery system that administers medication in a mist that is inhaled into the lungs) cup. RN-A attached the nebulizer cup to face mask and RN-A applied the nebulizer mask to R122 and left room. At 8:51 a.m. RN-A returned and look into R122's room. The nebulizer was still running. R122 was lying in bed with the head of the bed elevated and mask on face. Nebulizer was still running. At 8:59 a.m. RN-A entered room removed face mask and turned off the nebulizer. There was no medication left in the cup. After washing the nebulizer cup, RN-A checked R122 lung sounds and heart rate. The Cognitive Care Area Assessment (CAA) dated 9/15/15, was triggered information on the 9/3/15, annual Minimum Data Set (MDS) indicated R122 had severely impaired cognition, verbal and physical behaviors, rejection of cares and wandered one to three times during the assessment reference period. The CAA also indicated resident had Parkinson's and dementia with the overall objective of addressing cognition on the care plan to minimize risks to R122. R122 quarterly MDS dated 11/26/15, indicated R122 was severely cognitively impaired, requires assistance with all ADLs including eating. R122's diagnoses on quarterly MDS included dementia, Parkinson's, depression, and respiratory failure. R122's care plan printed 2/12/16, did not address self-administration of any medications. R122's Medication Review Report dated 2/12/16, included DuoNeb solution 0.5 to 2.5 (3) milligrams/3 milliliters (a medication that improves breathing), one vial inhale orally three times a day for shortness of breath. The staff were to	F 176	constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. Resident R122□s incident occurred because staff did not follow policy. RN-A was re-educated on 2/16/2016 to follow policy regarding nebulizer treatments for residents with cognitive impairments, which states that staff are to stay with resident during treatment. Resident R74 care plan was reviewed. TMA-B was re-educated on 3/8/2016 to follow policy regarding inhalant medication treatments for residents that do not have an order for self-administration. Care plans for all residents with orders for nebulizer and inhaler treatments were reviewed to ensure self-administration assessments, if appropriate, were completed and addressed on current care plan, if appropriate. All appropriate staff were reeducated on nebulizer, inhaler and self-administration procedures. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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F 176	Continued From page 2	F 176		

document the pulse and lung sounds pre- and post-administration and record the total time nursing spent with resident. There was no order for self-administration of medications was on the medication review report. Review of the medical record did not include evidence of an assessment related to R122's ability to self-administer medications.

During interview on 2/12/16, at 9:12 a.m. RN-J stated, "No, they [the nurses] should be staying in there with him because he could pull it [the mask] off. That is what our procedure is. Nobody gives their own medications up here." RN-J verified R122 did not have a self-administration of medication assessment, care plan or order.

During interview on 2/12/16, at 10:52 a.m. pharmacist said, "If the resident does not have an order for self-administration of nebs [neb treatments] the staff should administer the neb medication or get an order for self-administration. Before getting the order they do need to do an assessment to make sure it is safe for them [the resident] to self-administer the neb."

Procedure Nebulizer revised 9/15, instructed staff: "If resident is cognitively impaired, stay with the resident during the treatment."

R74's medication administration was observed on 2/12/16, at 7:32 a.m. The trained medication aide (TMA)-B gave R74 a Proair 90 mcg (microgram) inhaler without shaking the inhaler. TMA-B did not give any instructions to R74 and turned back toward Electronic Medication Administration Record. R74 inhaled one puff and gave inhaler back to TMA. R122 did not breathe out deeply before taking a puff from the inhaler or hold

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F 176	Continued From page 3 breath for 10 seconds after taking a puff. R74's care plan revised 10/8/13, indicated "The resident has impaired cognitive function/ dementia or impaired thought processes R/T [related to] Huntington's Disease E/B [evidence by] needs assistance with decision making. Wife assists with all decision making. Res. [resident] does not self-administer medications." R74's quarterly MDS dated 11/5/15, indicated R74 was cognitively intact, able to understand others, requires supervision with eating, dressing and hygiene. R74's diagnoses on quarterly MDS included dementia, Huntington's, depression, and asthma. R74's Medication Review Report dated 2/12/16, included the Albuterol Sulfate inhaler and staff was to adminsiter one dose orally in the morning for shortness of breath/wheeze. There was no order for self-administration of medications was on the medication review report. The review of the medical record did not include evidence of an assessment related to R74's ability to self-administer medications. During interview on 2/12/16, at 9:19 a.m. RN-I said we would assess if it is appropriate for a resident to self-administer their own medications including inhalers. "Up here it would be a real stretch, [R74] is here because of his lack of medication set up. I would expect that the inhaler would be handed to a resident. If I know the resident I do not necessarily repeat the instructions." RN-I verified R74 did not have a self-administration of medication assessment, order or care plan.	F 176		

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F 176	Continued From page 4 During interview on 2/12/16, at 9:25 a.m. TMA-B said, "Yes for the inhaler [R74] does have a self-administration order. If they [residents] do not have an order I would tell the resident what to do, open mouth, use one puff or two puffs." TMA-B verified turning back to the medication drawer before resident used the inhaler. During interview on 2/12/16, at 10:52 a.m. pharmacist said, "They (the nurse) should be shaking inhalers before administering the inhaler. If a resident does not have an order for self-administration of inhalers staff should administer the inhaler. They need to hold the inhaler. Before getting the order the facility staff do need to do an assessment to make sure it is safe for the resident to self-administer the inhaler." Procedure Inhalant Medication Metered Dose Inhalers revised 9/15, instructed staff: "3. Have resident sit up if condition permits or elevate head of bed 30 to 45 degrees. 4. Listen to breath sounds and observe respiratory pattern. 5. Shake the container well. 6. Remove the mouthpiece cover and position canister upright (nozzle down). 7. Spacers are often used in the elderly when there is Trouble coordinating the actuation of the canister with inhalation; ass the spacer if indicated. 8. Instruct resident to take a deep breath and the exhale completely. Have him or her place the mouthpiece in his or her mouth and close his or her lips around the mouthpiece. 9. As you firmly push the device ask the resident to inhale slowly and to continue inhaling until his or her lungs feel full.	F 176		

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F 176	Continued From page 5 10. Ask the resident to try to hold breath for several seconds to help medications reach deep into lungs. Ask resident to exhale out as slowly as possible through pursed lips." Procedure Resident Self-Administration of Medication Revised 7/14, instructed staff: "1. Complete the Resident Self-Administration of Medications UDA (user defined assessment) to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process.... 6. The interdisciplinary team's determination that the resident can safely self-administer medications must be documented in the medical record... 7. A physician's order must be obtained prior to the resident self-administering medications. The order must be specific to the medications being self-administered... 8. The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of the administration, if applicable..."	F 176		
F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the use of a bilateral (bilat) thigh positioning device as a	F 221	Resident R97 had a restraint assessment completed on 3/11/2014 and again on 3/9/2016 and care plan was amended.	3/23/16

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F 221	Continued From page 6 potential restraint for 1 of 3 residents (R97) reviewed for restraints, and who was capable of standing up from her wheel chair. Findings include: R97's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated she was severely cognitively impaired and required extensive assist of two staff for transfers. The MDS further noted R97 did not use restraints. R97's care plan dated 12/3/15, indicated risk for falls related to gait/balance problems, impulsivity and poor decision making. The care plan directed staff to apply a "bilateral thigh positioning device" while up in chair and directed staff to check the device every 30 minutes and reposition every two hours. Care planned behaviors included resistance to cares, ambulating in the hall disrobed and striking out at staff. An Occupation Therapy Progress Note dated 3/17/14, indicated R97 was assessed for wheel chair management. The progress note indicated R97 was able to sit in high back chair with back latching positioning device for four hours. There was no evidence R97 had been re-assessed since 2014. A Good Samaritan Society Specialty Care Community Progress Note dated 1/11/16, indicated R97 needed assist with mobility, assist with transfers, and "will walk short distances." The progress note further indicated R97 was using a Broda (a wheel chair that reclines) with bilateral thigh pads due to "frequent standing and fall risk, not considered a restraint due to unable to transfer safely indep [independently]."	F 221	Resident R97 was picked up on OT case load on 3/10/16. All residents with bilateral thigh straps were reviewed and reassessed. The policy & procedure for Physical Restraints was reviewed with the appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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F 221	Continued From page 7	F 221		

During an observation on 2/9/16, at 4:28 p.m. R97 was seated in a high backed padded wheel chair. Across each of her upper thighs was a strap that extended from under her legs and attached behind and out of reach of resident.

During an interview on 2/11/16, at 12:24 p.m., nursing assistant (NA)-D stated R97 had "positioning straps." NA-D stated R97 was a fall risk and the straps helped maintain position in her wheel chair. He further stated she was not able to release the device on her own. He stated if she opens it "she could fall."
- At 12:39 p.m. licensed practical nurse (LPN)-B stated he thought they did an assessment prior to using the positioning device. LPN-B further stated the positioning device was used for safety due to constant falling. He stated the straps are released to reposition R97.
- At 1:32 p.m. registered nurse (RN)-I stated "without those straps, [R97] would probably be on the floor." She further stated, "We are not trying to restrain her." RN-I stated an assessment was initiated on 3/11/14, but was not required because the facility did not consider the positioning device to be a restraint. Even though the device restricted R97's mobility and prevented her from rising from her chair on her own. She stated there was no ongoing assessment to determine if the device continued to be appropriate.

A policy titled Good Samaritan Society Restraints: Physical, dated 8/2014 indicated "residents will be free from physical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. The facilities procedure titled Physical Restraints, dated 10/13, identified a physical

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F 221	Continued From page 8 restraint as, "any manual method or physical or mechanical device, material or equipment attached or adjacent to the resident's body that the individual cannot remove." The procedure for physical restraints directed staff to complete documentation of response to previous interventions attempted and continually monitor and evaluate the use of the restraint and pursue the least restrictive device. The procedure further directed staff to complete a physical device and restraint review quarterly. While the facility policy indicated the use of bilateral thigh restraints as a physical restraint, there was no evidence R97 was properly assessed for use of a physical restraint, nor was there evidence a less restrictive device was attempted since March 2014.	F 221		
F 246 SS=D	483.15(e)(1) REASONABLE ACCOMMODATION OF NEEDS/PREFERENCES A resident has the right to reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure 1 of 3 resident's (R252) call light was in reach for a resident who was at risk for falls. Findings include: On 2/10/16, at 10:41 a.m. during interview R252	F 246	Call light for resident R252 was placed within reach on 2/10/16. Staff on Prairie unit, including LPN-A, were reeducated to follow policy regarding call light placement for all residents that are capable of using call lights on 2/10/2016 and 2/11/2016.	3/23/16

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F 246	Continued From page 9 asked surveyor for help locating the call light. At 10:42 a.m. the licensed practical nurse (LPN)-A entered R252's room, located the call light and handed the call light to R252. The call light was observed on the night stand that was located behind R252 and not within reach. On 2/10/16, at 10:43 a.m. LPN-A verified R252 was able to use call light and call light was not within reach. LPN-A stated all call lights should be within reach for residents who were capable of using call lights. On 2/10/16, at 10:44 a.m. nursing assistant (NA)-A stated R252 was capable of using call light. R252's fall care plan dated 2/9/16, indicated R252 was at risk for falls related to partial amputation of right foot due to osteomyelitis as evidenced by deconditioning and gait/balance problems. The goal was noted to be "Resident will be free of falls through the review date." The care plan directed staff to remind resident not to bend over to pick up dropped items. Encourage to use grabber or to ask for assistance. The care plan did not address call light accessibility even though it directed staff to encourage to ask for assistance. On 2/11/16, at 2:00 p.m. registered nurse (RN)-D, the Prairie unit nurse manager, stated the expectation was call lights should be within reach of residents capable of using them. - At 1:11 p.m. during the environmental tour the administrator stated, "Yes" when asked if the call light was supposed to be in reach for residents who was capable of using a call light. The facility's call light policy dated 9/12, directed	F 246	All staff were reeducated on call light procedure. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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F 246	Continued From page 10 staff to ensure that a resident has a method of calling for assistance and further directed staff to place call light with reach of a resident.	F 246		
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 2 residents (R37) wheelchair was maintained in good repair reviewed for environmental concerns. Findings include: On 2/9/16, at 4:13 p.m. during resident room observation, the Broda wheelchair (specialized wheelchair) handles were observed wrapped with peeling black electrical tape around the gray porous foam type of material. In addition, the pink vinyl covering on the wheelchair frame to the left back was observed ripped exposing the mesh cloth underneath not making it a cleanable surface. When asked about the porous foam and electrical tape that was peeling exposing the adhesive part, trained medication aide (TMA)-A stated it was wrapped to protect the environment, such as the walls to prevent gouges. TMA-A verified the concerns and stated tore up pink vinyl was due to being hit on the edges of the door jam. On 2/11/16, at 1:20 p.m. the environmental tour	F 253	Resident R37□s wheelchair was repaired on 3/1/2016. All wheelchairs and Broda chairs utilized by our residents were inspected on 3/9/2016. All identified repairs were made. All staff were reeducated on their responsibility for reporting equipment, furniture, or any unsafe condition (including resident wheelchairs, Broda chairs, etc) on the units or in resident rooms that are in need of repair by completing a work order. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	3/23/16

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F 253	Continued From page 11 was conducted with the director of facilities (DOF), administrator and intern. DOF brought the wheelchair out of the room both him and the administration verified the tape was peeling and was exposing the foam underneath making it not a cleanable surface. In addition, both verified the tore up vinyl on the side. When asked who checked the W/C's to make sure they were in good repair, the administrator stated staff was supposed to put a work order and the chairs were looked at by therapy. R37's quarterly Minimum Data Set (MDS) dated 1/14/16, indicated R37 had severely impaired cognition, required extensive physical assistance of one staff with transfers from bed to wheelchair, un-steady and used a wheelchair for mobility. R37's care plan dated 10/6/14, indicated resident had limited physical mobility related to cerebrovascular accident (CVA) with hemiplegia, supranucular palsy as manifested by altered standing and sitting balance and gait disturbance. Care plan indicated resident used a Broda chair with front side and rear tip bars bilateral thigh positioning device. Wheel Chair and Walker Cleaning Procedure revised 3/2013, directed staff, "All chairs and walkers requiring repair will be identified and work orders will be filled out and distributed for repair."	F 253		
F 278 SS=D	483.20(g) - (j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED The assessment must accurately reflect the resident's status. A registered nurse must conduct or coordinate	F 278		3/23/16

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F 278	Continued From page 12 each assessment with the appropriate participation of health professionals. A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than $5,000 for each assessment. Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the oral dental status was accurately coded on annual Minimum Data Set (MDS) for 1 of 2 residents (R73) reviewed for dental status. Findings include: During morning cares observation on 2/11/16, at 7:09 a.m. R73 was observed with missing and chipped teeth on his upper jaw.	F 278	This coding error occurred due to an individual employee not following proper procedure. Employee was reeducated on 2/12/16. An oral assessment of Resident R73 was done on 7/8/2015 but was not accurately reflected on the last annual MDS. Resident R73 last annual MDS was corrected via a "significant correction to last comprehensive assessment" MDS with an ARD date of 3/10/16. Resident	

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F 278	Continued From page 13 Review of R73's medical record revealed the Apple Tree Dental MDS 3.0 Oral/Dental Assessment Form dated 6/12/15, indicated R73 had obvious or likely cavity or broken natural teeth, had root tips, missing teeth, inflamed or bleeding gums or loose natural teeth and required direct staff assistance with oral cares. No oral assessment was found in the record for completion of annual MDS on 7/8/15. R73's annual MDS dated 7/8/15, indicated R73 did not have any dental concerns which included but not limited to broken or loosely fitting full or partial denture, no natural teeth or tooth fragments, abnormal mouth tissue, obvious cavity or loose natural teeth, inflamed or bleeding gums, mouth or facial pain, discomfort or difficulty with chewing, unable to examine with "None of the above" option had been checked. In addition, the dental section Care Area Assessment (CAA) did not trigger for completion on 7/8/15. On 2/11/15, at 2:55 p.m. registered nurse (RN)-D the unit manager who also completed the R73's annual MDS verified that no annual oral assessment was completed for the annual MDS on 7/8/15 and stated that oral assessment was optional. RN-D reviewed Aplle Tree Dental MDS 3.0 Oral/Dental Assessment Form dated 6/12/15 and statd that she should have coded obvious or likely cavity or broken natural teeth, had root tips, missing teeth, inflamed or bleeding gums or loose natural teeth on the annual MDS. RN-D acknowledged if the information would have been entered in the annual MDS the dental CAA would have triggered for completion on 7/8/15, and stated further that there should be an oral care plan to address R73's dental issues.	F 278	R73□s care plan was updated on 2/11/16. MDS'□s for all residents will be reviewed for oral dental status and modified as needed. All appropriate staff were re-educated on the proper MDS coding procedure. The Director of Nursing Services will be responsible to ensure compliance through random monthly audits. QAPI will monitor audits monthly.	

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F 278	Continued From page 14 According to the Long Term Care Facility Resident Assessment Instrument User's Manual version 3.0 last revised on October 2015, dental status must be coded on the MDS when all of the following criteria are met: -"Check L0200 A, broken or loosely fitting full or partial denture: if the denture or partial is chipped cracked, uncleanable, or loose. A denture is coded as loose if the resident complains that it is loose, the denture visibly moves when the resident opens his or her mouth, or the denture moves when the resident tries to talk." - "Check L0200 B, no natural teeth or tooth fragment(s) (edentulous): if the resident is edentulous or lacks all natural teeth or parts of teeth. " -"Check L0200 C, abnormal mouth tissue (ulcers, masses, oral lesions): Select if any ulcer, mass, or oral lesion is noted on any oral surface." -"Check L0200 D, obvious or likely cavity or broken natural teeth: if any cavity or broken tooth is seen." - "Check L0200 E, inflamed or bleeding gums or loose natural teeth: if gums appear irritated, red, swollen, or bleeding. Teeth are coded as loose if they readily move when light pressure is applied with a fingertip." - "Check L0200F, mouth or facial pain or discomfort with chewing: if the resident reports any pain in the mouth or face, or discomfort with chewing." - "Check L0200G, unable to examine: if the resident ' s mouth cannot be examined." - "Check L0200Z, none of the above: if none of conditions A through F is present"	F 278		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS	F 279		3/23/16

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F 279	Continued From page 15 A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care planned interventions to prevent pressure ulcers for 1 of 2 residents (R97) reviewed for pressure ulcers. Findings include: During an observation on 2/11/16, at 8:22 a.m., R97's morning cares were observed. R97 was lying in bed on her right side. R97's incontinent brief was saturated with urine and soiled with bowel. Following incontinent cares, R97 was noted to have a reddened coccyx area with a 1/2 inch long fissure that appeared to be open.	F 279	Resident R97□s care plan was reviewed on 2/12/2016 and skin integrity focus, goal and corresponding interventions were added. Resident R97 was picked up on OT caseload on 3/10/2016. Care plans for all residents with potential for skin integrity issues were reviewed and modified as needed on 3/9/2016. Policy for Care Plans and Procedures for Skin Assessments, Pressure Ulcer Prevention and Documentation Requirements and Weekly Skin Checks	

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F 279	Continued From page 16 During a subsequent observation of cares on 2/12/16, at 8:02 a.m. registered nurse (RN)-B assessed R97's skin. RN-B stated R97 had a stage one pressure ulcer (a non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) on her coccyx. She described the pressure ulcer as "a little bit open." A review of Good Samaritan Society Specialty Care Community Medication Review Report indicated, on 3/24/15, an order was received to "monitor buttocks for worsening of maceration/skin breakdown." A Review on Good Samaritan Society Special Care Community Progress Notes dated 8/2/15 through 2/12/16, indicated R97 had a history of refusing repositioning at least daily. A Pressure Ulcer Care Area Assessment (CAA) dated 8/20/15, identified R97 was at risk for impaired skin integrity related to a need for assistance for mobility, and refused to lie down. The CAA indicated R97 had "no pressure areas but has been getting excoriated from incont [incontinence], refusals to lay down, chorea [an abnormal involuntary movement disorder] pelvic thrusts." R97's care plan dated 9/4/15, indicated R97 had a self-care deficit, required assistance for all activities of daily living, and was incontinent of bowel and bladder. The care plan directed staff to provide incontinent cares every two hours and as needed. The care plan did not address R97's risk	F 279	were reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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for skin impairment or identify interventions to prevent skin breakdown. A care plan addressing skin was initiated after the surveyor identified the pressure ulcer on 2/12/16.

A Progress Note dated 12/6/15, indicated R97's skin check indicated "skin is still reddened by sacral area, but this is not new." A noted dated 12/20/15, indicated "sacral area slightly pink." A Progress Note dated 12/26/15, indicated "the skin on res [resident] buttocks looks good, maceration is healing." A quarterly Nursing Note dated 1/11/16, indicated "red rash intermittent on buttocks...creams applied...encourage to reposition but often refuses." A Progress Note dated 1/16/16, indicated "skin breakdown on buttocks healing." A Progress Note dated 2/10/16, indicated R97 had some reddened areas at the right side of the gluteal fold indicating some "pressure points." While the facility assessments and progress notes indicated R97 had ongoing skin issues dating back several months and continual refusals of attempts to reposition, there were no further care planned interventions implemented to reduce the risk for skin breakdown.

During an interview on 2/11/16, at 8:26 a.m. nursing assistant (NA)-D stated he did not know when R97 was last toileted or repositioned. He stated it was last done on the night shift but did not know what time. NA- D further stated he was unaware of any skin concerns regarding R97.

During an interview on 2/11/16, at 8:41 a.m. NA-E stated staff had a hard time getting R97 to lay down. NA-E stated R97 had redness to her coccyx on and off and it was "very ongoing." She stated staff use cream on R97's bottom and

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check on her every two hours. NA-E further stated when R97 sits in her chair, "all her pressure goes on her coccyx."

During an interview on 2/11/16, at 12:43 a.m. licensed practical nurse (LPN)-B stated R97 had an ongoing treatment for her reddened coccyx that staff was applying cream to it. He further stated, "All the time the pressure is there."

During an interview on 2/12/16, at 7:38 a.m. RN-B stated, R97 did not have any skin concerns that she was aware of. RN-B further explained even though R97's treatment record directed staff to "monitor buttocks for worsening of maceration/skin breakdown" each shift, the nurse did not look at R97's bottom daily. She stated, "The trained medication aides (TMAs) look at it and report concerns to the nurse."

During an interview on 2/12/16, at 8:58 a.m. RN-I stated R97 has had some "excoriation going on." She further stated R97's skin should be addressed in the care plan, but had not been. RN-I stated R97 refused offloading, but staff continue to try.

During an interview on 2/12/16, at 11:18 a.m. the director of nursing (DON) stated her expectation was R97's skin would have been monitored on a routine basis and with cares. She stated other interventions should have been initiated for R97 such as therapy and/or specialized mattress.

A facility policy labeled Care plan, dated February 2002 indicated, residents will receive and be provided necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.

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F 279	Continued From page 19 The policy indicated "each resident will have an individualized comprehensive care plan that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing.....needs. The resident assessment instrument and review of the physician ' s orders, any problems, needs, and concerns identified will be addressed. This plan of care will be modified to reflect the care currently required/provided for the resident."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff reported pain with cares for 1 of 2 residents (R73) who experienced unnecessary pain during cares. In addition, the facility staff failed to provide nail care, rolled wash cloth and range of motion (ROM) for 1 of 2 residents (R73) who required staff assistance with activities of daily living (ADLs) who were reviewed for ADLs and ROM. Findings include: Pain: R73 was admitted to the facility on 5/13/10, had a cerebral vascular accident (stroke) affecting the left side in October, 2010. The facility failed to re-assess R73 for pain related to contractures of	F 282	Resident R73□s pain was reassessed on 2/12/2016 and care plan modified as appropriate. NA-B and TMA-F were reeducated on 2/11/2016, NA-C was reeducated on 2/12/2016, NA-D was reeducated on 3/10/2016 about stopping cares and reporting to the nurse if they observe any signs and symptoms of verbal or non-verbal pain. Range of motion was discussed with the nurse practitioner and ROM order was clarified on 3/1/2016. Physical therapy completed a range of motion assessment with resident R73 on 2/12/2016. Range of motion tasks were added to R73□s	3/23/16

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F 282	Continued From page 20 the left hand, wrist, elbow and shoulder and the facility staff did not stop providing ADLs cares when R73 experienced pain, report to the nurse, reassess and provide necessary treatment to minimize the pain experienced during morning cares. On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room, R73's left arm rested firmly against his body with the left hand rested on his chest, wrist bent at about a 90 degrees angle at the forearm and three fingers on the left hand in a closed fist position. R73 was not able to open his clenched left hand when asked to do so. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. nursing assistant (NA)-B washed R73's face with a wash cloth and tried to pull R73's left arm away from his body to wash armpit. NA-B attempted unsuccessfully to put two different shirts on R73 before stopping cares to go get help. NA-B and NA-D unsuccessfully attempted to put on a shirt while R73 was in bed. R73 fidgeted, grimaced, moaned and yelled "ouch" approximately six to eight times during cares especially when staff held and pulled on R73's left arm. NA-B and NA-C did not stop providing morning cares when R73 fidgeted, grimaced, moaned and yelled "ouch" multiple times. R73 was observed during morning cares on 2/12/16, at 8:12 a.m. NA-C was providing care to R73 under close supervision of registered nurse (RN)-D who was there to assess R73's pain during morning cares. NA-C attempted to wash R73's face with a wash cloth, R73 immediately turned his head away from NA-C, fidgeted and	F 282	Kardex assignment sheet and point of care (POC) documentation schedule on 2/15/2016. Resident R73□s rolled wash cloth nursing order dated 12/30/2015 for purposes of contracture management and skin integrity was not followed as directed. Individual employees who were found not to be following this order were reeducated on 2/12/2016. Resident R73□s nails were trimmed on 2/11/2016. Care plans for all residents with contractures were reviewed and modified as needed on 3/10/2016. Policies for Care Plans, Pain Management-Resident Assistance, Non-Pharmacological Pain Interventions and Range of Motion and Procedures for Pain Data Collection, Nail Care and Range of Motion and Guidelines for Range of Motion Exercises were reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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F 282	Continued From page 21 moaned. RN-D, who was present in the room asked NA-C to stop morning cares. RN-D stated R73's facial expressions indicated R73 was in discomfort and will need to medicate R73 with pain medication and re-attempt morning cares later. On 2/12/16, at 9:05 a.m. RN-D and NA-C returned to R73's room to complete morning cares. R73 did not seem to be any discomfort during cares but grimaced and moaned only when staff attempted to open R73's fingers on left hand. Review R73's electronic medication administration record (EMAR) for, December 2015, January and February 2016, revealed that R73 received as needed (PRN) pain medications two times on 1/2/16, which was documented as being ineffective and on 1/11/16, which was documented as being effective on the EMAR. The medical record lacked evidence that R73's pain was assessed prior to administration of PRN pain medication and/or during cares. R73's care plan dated 1/5/16, indicated the resident had potential for pain/discomfort related to a cerebral vascular accident, hemiplegia (paralysis on one side of the body) and end stage disease processes as evidenced by grinding teeth and restlessness. The goal for R73, decrease in behaviors of inadequate pain control restlessness, grimacing and grinding teeth. The facility staff were to report to nurse any signs or symptoms of non-verbal pain, changes in breathing, vocalizations, mood and behavior changes, and nursing staff to administer analgesia as per orders. Both NAs did not stop cares and report R73's pain to the nurse on 2/11/16, as the care plan directed.	F 282		

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During interview on 2/11/16, at 7:12 a.m. NA-B stated she heard R73 moaning and yelling "ouch" during morning cares, and continued to state whenever she assisted with R73's cares, R73 always moaned and groaned during cares and she believed R73 was "in pain" when working on his left upper extremity.

On 2/11/16, at 9:40 a.m. licensed practical nurse (LPN)-C verified R73 had a diagnosis of chronic pain for which he received pain medications. Further stated nurses administered Roxanol (a narcotic pain medication) to R73 sometimes when he was in bed or when already up in a wheelchair. LPN-C stated she would expect nursing assistants to report any pain or discomfort with residents to the nurse. LPN-C denied anyone reporting any pain or discomfort with R73 during morning cares on 2/11/16.

On 2/11/16, at 12:49 p.m. trained medication aide (TMA)-F stated R73 always groaned and clenched his teeth "like he is in pain." TMA-F further stated she administered pain medication to R73 except Roxanol that was administered by the nurse, half the time when R73 in bed and when already up in a wheelchair. TMA-F denied anyone reporting any pain or discomfort with R73 during morning cares on 2/11/16.

On 2/12/16, at 9:27 a.m. NA-C stated that she usually works with R73 and always moaned/ groaned sometimes yelled "ouch" when attempting to left R73's left upper extremity to wash or get R73 dressed. NA-C further stated she believed R73 was "probably in pain." NA-C stated did not report her observations to the nurse stating "it is like that every day thing with him." NA-C stated after R73 got pain medications

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F 282	Continued From page 23 on 2/12/16, prior to morning cares "it went better for him today" as she smiled and seemed happy. During a joint interview on 2/11/16, at 2:35 p.m. the nurse manager of the unit RN-D and the unit's MDS coordinator RN-F were informed of surveyor observations and staff reports of pain during morning cares with R73. RN-D and RN-F both stated they were not aware of any pain issues during morning cares with R73. RN-D continued to state she expected nursing assistants to report voiced or observed pain to the nurse. RN-F verified he assessed R73's pain and R73 was assessed as to have no pain. RN-F further stated R73 was to continue with current pain regimen but he could not recall the circumstances of R73's pain assessments. RN-F acknowledged he was not aware that R73 was in pain during cares and could not recall if he ever assessed R73's pain during cares. During interview on 2/12/16, at 8:30 a.m. after RN-D completed pain assessment on R73, she noted R73 fidgeted and moved face away when NA-C attempted to wash R73's face, indicating that R73 was in some discomfort and opted to stop morning cares. RN-D stated requested nurse to administer pain medications to R73 prior to completion of morning cares from here on. On 2/12/16, at 9:38 a.m. RN-D further stated after R73 received pain medications, R73 was more relaxed during morning cares. RN-D stated she expected nursing assistants to stop cares, report voiced or observed pain to the nurse and the nurse was expected to complete a pain assessment. During interview on 2/12/16, at 12:40 p.m. the facility's director of nursing (DON) stated the	F 282		

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facility staff were expected to watch for nonverbal cues of pain for residents who cannot talk, if any signs or symptoms of pain are observed the facility staff are to stop cares and report to the nurse. The nurses are expected to assess resident for pain, medicate with pain medication as appropriate, review care plan and update physician for adjustment of pain medication. DON further stated that R73 might have experienced unnecessary pain on 2/11/16, during morning cares that could have been avoided.

The facility's policy titled "PAIN DATA COLLECTION AND ASSESSMENT" revised 9/15, directed staff to continually monitor and evaluate the pain management plan for residents with pain. The policy directed the nursing assistants to make a resident who is in pain comfortable and verbally communicate with the nurse on duty observed or reported pain. The policy further directed the RN to document effectiveness of the pain management plan weekly if high risk for pain and at least monthly if pain plan is effective and resident is stable.

ROM/rolled washcloth and nail care:
R73 was admitted to the facility on 5/13/10, had a cerebral vascular accident (stroke) affecting the left side in October, 2010. The facility failed to specialized treatments for contractures to R73 to maintain functional ROM and prevent a decline in ROM. As a result R73 developed left upper extremity contractures (including shoulder, elbow, wrist and three fingers).

On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room, R73's finger nails on both hands were observed to be long and untrimmed

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(approximately quarter [1/4] inch in length). There was no splint or rolled wash cloth placed in R73's left hand.

During interview on 2/9/16, at 7:25 p.m. RN-F stated R73 had a contracture on left hand, left side hemiparesis (weakness of the entire left or right side of the body) due to a previous stroke, resident did not use any splints or received any restorative ROM.

On 2/10/16, at 3:08 p.m. R73 was observed in bed awake, R73's left arm rested against his chest, finger nails on both hands were observed to be long and untrimmed. There was no rolled wash cloth placed in R73's left hand.

R73 was observed during morning cares on 2/11/16, at 7:03 a.m. provided by nursing assistant (NA)-B. NA-B did not provide any ROM services to R73 during morning cares. R73's finger nails on both hands were observed to be long and untrimmed. There was no rolled wash cloth placed in R73's left hand. At 10:23 a.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room. LPN-C verified R73's nails were long and dirty underneath. There was no rolled wash cloth placed in R73's left hand.

R73 was observed during morning cares on 2/12/16, at 9:05 a.m. provided by NA-C. NA-C did not provide any ROM services to R73 during morning cares. There was rolled wash cloth placed in R73's left hand.

R73's care plan dated 1/5/16, indicated R73 was dependent on staff for all ADLs. The care plan directed staff to assist R73 with all of his personal

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hygiene care needs and to provide gentle range of motion as tolerated to left upper and lower extremities with morning and bedtime cares.

Review of R73's Physician Orders dated 2/12/16, revealed a nursing order for rolled wash cloth in left hand.

During interview on 2/11/16, at 12:05 p.m., NA-B stated R73 did not receive any ROM services because ROM was not indicated in the Kardex (NA assignment sheet) for NAs to complete.

On 2/11/16, at 9:40 a.m. the LPN-C stated R73 had a ROM program and the care plan directed staff to provide gentle ROM to upper and lower extremities as tolerated with morning and bedtime cares. LPN-C explained that nursing assistants were responsible for the completion of ROM and nurses were responsible for ensuring completion of all cares. At 10:23 a.m. LPN-C reviewed R73's medical record and did not find any documentation of refusals of nail care by R73. LPN-C reviewed R73's medical record and verified R73 was scheduled for a bath on 1/31, 2/3, 2/7 and 2/10/16.

On 2/12/16, at 8:47 a.m. LPN-C verified R73 did not have a rolled wash cloth on 2/10/16 and 2/11/16. At 11:00 a.m. the physical therapist (PT) stated she just completed a ROM assessment on R73 upper left extremity. PT stated R73 had contractures on the left upper extremity affecting the joints in the shoulder, elbow, wrist, hand and fingers. PT further stated provision of ROM services, splint devices and rolled wash cloth in palm usually helped prevent further decline in contractures. At 11:14 a.m. NA-C stated R73 did not receive any specialized treatments for

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F 282	Continued From page 27 contractures, tried finding Kardex and stated the Kardex did not direct the facility staff to do ROM services for R73. At 11:43 a.m. RN-D verified the ROM program was not included in R73's Kardex as one of the cares for nursing assistants to provide therefore R73 had not been receiving ROM. RN-D stated she expected staff to follow resident's care plan. During interview on 2/12/16, at 12:06 p.m. the facility's DON stated she staff were expected to follow resident's care plan and the nurse managers to make sure that all cares were included in the Kardex. R73 did not receive the care and services as directed per the plan of care. The facility's policy titled NAIL CARE revised 11/13, directed staff to keep resident's nails clean and trimmed to promote well-being. The facility's policy titled ACTIVITIES OF DAILY LIVING revised 6/14, directed staff to assist residents who are unable to carry out activities of daily living and ensure that they receive necessary services to maintain good personal hygiene.	F 282		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.	F 309		3/23/16

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F 309	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess, and provide pain management for 1 of 3 residents (R73) residents reviewed for activities of daily living (ADLs) and range of motion (ROM). Findings include: R73 was admitted to the facility on 5/13/10, and experienced a cerebral vascular accident (stroke) affecting the left side in October 2010, per the Admission Record. The facility failed to re-assess R73 for pain related to contractures of the left hand, wrist, elbow and shoulder, Consequently the facility had not modified interventions to ensure comfort and pain relief prior to providing ADL cares. On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room. R73's left arm was observed to rest firmly against his body with the left hand against his chest, wrist bent at approximately a 90 degree angle at the forearm, and three fingers on the left hand held firmly in a closed fist position. When requested at that time, R73 was unable to open his clenched left hand. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. Nursing assistant (NA)-B was observed to attempt to pull R73's left arm away from his body enough so as to wash the resident's armpit. In addition, NA-B attempted unsuccessfully to put two different shirts on R73 before stopping cares to go get help. At approximately 7:15 a.m., NA-B and NA-D	F 309	Resident R73□s pain was reassessed on 2/12/2016 and care plan modified as appropriate. NA-B and TMA-F were reeducated on 2/11/2016, NA-C was reeducated on 2/12/2016, NA-D was reeducated on 3/10/2016 about stopping cares and reporting to the nurse if they observe any signs and symptoms of verbal or non-verbal pain. Care plans for all residents were reviewed for pain management and modified as needed. Policies for Care Plans, Pain Management-Resident Assistance, Non-Pharmacological Pain Interventions and Range of Motion and Procedures for Pain Data Collection, and Range of Motion and Guidelines for Range of Motion Exercises were reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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unsuccessfully attempted to put a shirt on R73 while he remained in bed. R73 fidgeted, grimaced, moaned and yelled "ouch" approximately six to eight times during cares especially when staff attempted to manipulate or move R73's left arm. NA-B and NA-D did not stop providing R73's care even when R73 fidgeted, grimaced, moaned and yelled "ouch" multiple times.

At 10:23 a.m. on 2/11/16, R73 was observed sitting in a wheelchair in the common area at a table across from his room. The fingernails on R73's right hand were observed to be quite long. A licensed practical nurse (LPN)-C unsuccessfully attempted to extend the fingers on R73's left hand to check the nail length and the condition of R73's palm. R73 moaned and yelled "ouch" when LPN-C attempted to extend his fingers. LPN-C verified R73 appeared to be in discomfort during this assessment.

On 2/12/16, at 8:12 a.m. registered nurse (RN)-D stated R73's facial expressions may indicate discomfort, a need to medicate with pain medication, and the need to re-attempt care later.

The annual Minimum Data Set (MDS) dated 7/8/15, and quarterly MDS dated 9/23/15 & 12/17/15, indicated R73 demonstrated no signs of pain such as non-verbal sounds (moaning, or groaning), facial expression (grimaces, clenched teeth or jaw), protective body movements or posture (bracing, guarding, clutching or holding a body part during movement). As a result, the Care Area Assessment (CAA) for the 7/8/15 annual MDS did not trigger a need for assessment related to pain.

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F 309	Continued From page 30 R73's quarterly Pain Data collection dated 12/17/15, indicated that the resident had advanced dementia, was rarely/never understood, and a PAINAD (tool used to evaluate effectiveness of pain regimen for dementia residents) dated 4/5/15, 7/5/15, 9/23/15, and 12/17/15, indicated the resident's breathing was normal, no negative vocalizations, and that the resident was smiling or had inexpressive facial expression with relaxed body language. In addition, a review of the record revealed the following documentation about pain: 4/8/15- notes indicated R73 was not at high risk for pain, current medication regimen was working, and that staff should continue to follow the current plan of care for pain. 7/5/15- notes indicated R73 was not at high risk for pain, current medication regimen was working, and that staff should continue to follow the current plan of care for pain. The medical record lacked evidence as to whether staff providing direct care for R73 had been interviewed about the resident's level of pain during care, and/or whether pain assessments were completed during provision of care to ensure R73 maintained his highest functional level and comfort. Review R73's electronic medication administration record (EMAR) for December 2015 and January and February 2016, revealed R73 received as needed (PRN) pain medications twice on 1/2/16. Documentation for 1/2/16 indicated the PRN pain medication use was ineffective. On 1/11/16, documentation indicated the use of PRN medication was effective. The medical record lacked any evidence that R73's pain was assessed prior to administration of PRN pain medication.	F 309		

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R73's care plan dated 1/5/16, indicated the resident had potential for pain/discomfort related to a cerebral vascular accident, hemiplegia (paralysis on one side of the body) and end stage disease processes, as evidenced by grinding teeth and restlessness. The goal was for R73 to have a decrease in behaviors indicating inadequate pain control including: restlessness, grimacing and grinding teeth. Interventions indicated staff were to report to the nurse any signs or symptoms of non-verbal pain, changes in breathing, vocalizations, mood or behavior changes, and that nursing staff were supposed to administer pain medications as ordered.

R73's Physician Order Summary Report dated 2/12/16, revealed diagnoses including: cerebral vascular accident (stroke), hemiparesis (weakness of the entire left or right side of the body) and pain. Although current physician orders revealed R73 utilized the following medications for pain control: Roxanol 2.5 milligrams (mg) two times daily; Tylenol Extra Strength (ES) 1000 mg three times a day; Roxanol 10 mg every two hours as needed (PRN) for moderate to severe pain; and Roxanol 5 mg PRN for mild pain, facility staff had not identified specific criteria for when to administer (ie., before or after care), in order to assure the client received the most effective pain control.

During interview on 2/11/16, at 7:12 a.m. NA-B stated R73 was very stiff and it was difficult to lift his left arm to wash his armpits and to get him dressed. NA-B stated she heard R73 moaning and yelling "ouch" during morning care, and stated whenever she assisted with R73's care he moaned and groaned. NA-B said she believed

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R73 was "in pain" when they worked with his left upper extremity.

On 2/11/16, at 9:40 a.m. licensed practical nurse (LPN)-C verified R73 had a diagnosis of chronic pain for which he received pain medications. LPN-C stated the nurses administered the Roxanol (a narcotic pain medication) to R73 sometimes while he was still in bed, and sometimes when he was already up in his wheelchair. LPN-C stated the NAs should be reporting any pain or discomfort expressed by residents to the nurse. When asked whether staff had reported R73's discomfort during care that morning, LPN-C said no.

During interview on 2/11/16, at 12:39 p.m. NA-D stated she usually worked on the evening shift and was regularly assigned to take care of R73. NA-D stated R73 always moans/groans whenever staff move his left arm, and stated she believed R73 was in pain when he moaned/groaned. When asked whether she'd ever reported the pain to the nurse, NA-D said she had. However, a review of the resident's Progress Notes from 4/28/15 through 2/11/16, failed to indicate this had occurred.

On 2/11/16, at 12:49 p.m. trained medication aide (TMA)-F stated R73 always groans and clenches his teeth "like he is in pain." TMA-F further stated she administered pain medication to R73, except the Roxanol which was administered by the nurse. TMA-F confirmed half the time R73 gets the medication while he's still in bed and the other half of the time when he's already up in his wheelchair.

During a joint interview on 2/11/16, at 2:35 p.m.

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the nurse manager of the unit, RN-D. and the unit's MDS coordinator RN-F, were informed of surveyor observations and staff reports of pain experienced by R73 during morning cares. RN-D and RN-F both stated they were unaware of any pain issues during morning cares with R73. RN-D stated she expected the nursing assistants to report voiced or observed pain to the nurse. RN-F verified he'd previously assessed R73's pain, when R73 had no pain. RN-F further stated R73 was to continue with the current pain regimen but he could not recall the circumstances of the pain assessments such as whether or not the resident had been assessed while receiving care.

During interview on 2/12/16, at 8:30 a.m. RN-D said she'd completed a pain assessment on R73 during his morning care. She verified R73 fidgeted and moved his face away even when NA-C attempted to wash R73's face, indicating R73 was in some discomfort. RN-D stated she had requested the nurse administer pain medications to R73 prior to completion of morning cares from now on. On 2/12/16, at 9:38 a.m. RN-D stated that after R73 had received the pain medication, he appeared more relaxed during his morning cares. RN-D stated she expected the nursing assistants to stop cares, report voiced or observed pain to the nurse, and for the nurse to conduct an assessment of the resident's pain.

On 2/12/16, at 9:27 a.m. NA-C stated she regularly works with R73 and that he always moans and groans, and sometimes yells "ouch" when staff attempt to move his left upper extremity to wash him or get him dressed. NA-C stated she believed R73 was "probably in pain" and stated she didn't always report her

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observations to the nurse. NA-C stated, "it's like an every day thing with him." NA-C also said after R73 had received his medications that morning, prior to morning cares, "it went better for him" as he smiled and seemed happy.

During interview on 2/12/16, at 12:40 p.m. the facility's director of nursing (DON) stated the staff were expected to watch for nonverbal cues of pain for residents who cannot talk, to observe whether any signs or symptoms of pain are present, and for staff to stop care if the resident is in pain and report to the nurse. The DON also said the nurses are expected to assess residents for pain, medicate with pain medication as appropriate, review resident care plans for appropriateness, and update their physicians for any required adjustments of pain medication. The DON further stated R73 may have experienced unnecessary pain on 2/11/16, during his morning cares that could have been avoided.

An effort was made to call R73's primary physician on 2/16/16, at 3:00 p.m. Although a message was left for the physician, no return call was received.

The facility's policy titled "PAIN DATA COLLECTION AND ASSESSMENT" revised 9/15, directed staff to continually monitor and evaluate the pain management plan for residents with pain. The policy directed nursing assistants to make a resident who is in pain comfortable, and to verbally communicate with the nurse on duty regarding any observed or reported pain. The policy further directed the RN to document effectiveness of the pain management plan weekly if high risk for pain and at least monthly regarding whether the pain plan is effective and

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F 309	Continued From page 35 the resident is stable.	F 309		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident received grooming assistance for nail care for 1 of 4 residents (R73) reviewed for activities of daily living (ADLs). Findings include: R73's nails were observed long and soiled on 2/9/16, at 4:48 p.m. and during subsequent days of the survey, 2/10/16 and 2/11/16. On 2/9/16, at 4:48 p.m. R73's finger nails on both hands were observed to be long and untrimmed (approximately quarter [1/4] inch in length). On 2/10/16, at 3:08 p.m. R73 was observed in bed awake, R73's left arm rested against his chest, finger nails on both hands were observed to be long and untrimmed. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. finger nails on both hands were observed to be long and untrimmed. On 2/11/16, at 10:23 a.m., R73 was observed sitting	F 312	Resident R73□s nails were trimmed on 2/11/2016. Fingernails of all residents were reviewed for appropriate length. Procedure for Nail Care was reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	3/23/16

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in a wheelchair in the common area at a table across from his room. Licensed practical nurse (LPN)-C verified R73's nails were long and dirty underneath.

R73's quarterly Minimum Data Set dated 12/17/15, identified R73 required total physical assist of one staff with dressing and personal hygiene needs. The CAA for Cognitive Loss/Dementia dated 7/14/15, identified R73 with confusion, forgetfulness and inability to make decisions related to end stage dementia.

The care plan dated 1/5/16, identified R73 needs assistance with ADL's due to dementia and cerebral vascular accident. Goal "will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene..." R73's Kardex (the facility nursing assistant assignment sheet) directed R73 required total assistance with personal hygiene cares.

R73's Physician Order Summary Report dated 2/12/16, revealed diagnoses included cerebral vascular accident (stroke), hemiparesis (weakness of the entire left or right side of the body) and dementia.

On 2/11/16, at 12:49 p.m. the trained medication aide (TMA)-F stated R73's nails were approximately quarter (1/4) inch in length.

On 2/11/16, at 10:23 a.m. LPN-C stated NAs were responsible for nail care weekly on bath days and nurses are responsible to ensure it was completed. LPN-C further stated nursing assistant are to report to the nurse any time a resident refuses nail care and nurses document

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F 312	Continued From page 37 in the resident's record the refusals. LPN-C reviewed R73's medical record and did not find any documentation of refusals of nail care by R73. LPN-C reviewed R73's medical record and verified R73 was scheduled for a bath on 1/31, 2/3, 2/7 and 2/10/16. On 2/11/16, at 2:00 p.m. the unit's nurse manager, registered nurse (RN)-D stated she expected staff to have resident's nail care done once a week with shower/bath and if not able to be completed, the nursing assistant was expected to let the nurse know. RN-D further stated she expected nurses to document on resident's medical record whenever nail care was not completed. The facility's policy titled NAIL CARE revised 11/13, directed staff to keep resident's nails clean and trimmed to promote well-being.. The facility's policy titled ACTIVITIES OF DAILY LIVING revised 6/14, directed staff to assist residents who are unable to carry out activities of daily living and ensure that they receive necessary services to maintain good personal hygiene.	F 312		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		3/23/16

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F 314	Continued From page 38 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent the development of pressure ulcers for 1 of 2 residents (R97) reviewed for pressure ulcers. Findings include: During an observation on 2/11/16, at 8:22 a.m. R97's morning cares were observed. R97 was lying in bed on her right side. R97's incontinent brief was saturated with urine and soiled with bowel. Following incontinent cares, R97 was noted to have a reddened coccyx area with a 1/2 inch long fissure that appeared to be open. During a subsequent observation of cares on 2/12/16, at 8:02 a.m. registered nurse (RN)-B assessed R97's skin. RN-B stated R97 had a stage one pressure ulcer (a non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) on her coccyx. She described the pressure ulcer as "a little bit open." A review of Good Samaritan Society Specialty Care Community Medication Review Report indicated, on 3/24/15, an order was received to "monitor buttocks for worsening of maceration/skin breakdown." A Review on Good Samaritan Society Special	F 314	Resident R97□s care plan was reviewed on 2/12/2016 and skin integrity focus, goal and corresponding interventions were added. Resident R97 was picked up on OT caseload on 3/10/2016. Care plans for all residents with potential for skin integrity issues were reviewed and modified as needed on 3/9/2016. Policy for Care Plans and Procedures for Skin Assessments, Pressure Ulcer Prevention and Documentation Requirements and Weekly Skin Checks were reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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Care Community Progress Notes dated 8/2/15 through 2/12/16, indicated R97 had a history of refusing repositioning at least daily.

A Pressure Ulcer Care Area Assessment (CAA) dated 8/20/15, identified R97 was at risk for impaired skin integrity related to a need for assistance for mobility, and refused to lie down. The CAA indicated R97 had "no pressure areas but has been getting excoriated from incont [incontinence], refusals to lay down, chorea [an abnormal involuntary movement disorder] pelvic thrusts." Although the CAA indicated R97 was non-compliant with refusals to lie down, it did not include any alternate interventions to direct staff on how to relieve pressure if R97 refused to lie down.

R97's care plan dated 9/4/15, indicated R97 had a self-care deficit, required assistance for all activities of daily living, and was incontinent of bowel and bladder. The care plan directed staff to provide incontinent cares every two hours and as needed. The care plan did not address R97's risk for skin impairment or identify interventions to prevent skin breakdown. A care plan addressing skin was initiated after the surveyor identified the pressure ulcer on 2/12/16.

R97's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated she was severely cognitively impaired and required extensive assistance of two staff for bed mobility, transfers, dressing and toileting.

A Progress Note dated 12/6/15, indicated R97's skin check indicated "skin is still reddened by sacral area, but this is not new." A noted dated 12/20/15, indicated "sacral area slightly pink." A

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Progress Note dated 12/26/15, indicated "the skin on res [resident] buttocks looks good, maceration is healing." A quarterly Nursing Note dated 1/11/16, indicated "red rash intermittent on buttocks...creams applied...encourage to reposition but often refuses." A Progress Note dated 1/16/16, indicated "skin breakdown on buttocks healing." A Progress Note dated 2/10/16, indicated R97 had some reddened areas at the right side of the gluteal fold indicating some "pressure points." While the facility assessments and progress notes indicated R97 had ongoing skin issues dating back several months and continual refusals of attempts to reposition, there were no further care planned interventions implemented to reduce the risk for skin breakdown.

During an interview on 2/11/16, at 8:26 a.m. nursing assistant (NA)-D stated he did not know when R97 was last toileted or repositioned. He stated it was last done on the night shift but did not know what time. NA-D further stated he was unaware of any skin concerns regarding R97.

During an interview on 2/11/16, at 8:41 a.m. NA-E stated staff had a hard time getting R97 to lay down. NA-E stated R97 had redness to her coccyx on and off and it was "very ongoing." She stated staff use cream on R97's bottom and check on her every two hours. NA-E further stated when R97 sits in her chair, "all her pressure goes on her coccyx." NA-E stated she reported R97's open area to the nurse that day.

During an interview on 2/11/16, at 12:43 a.m. licensed practical nurse (LPN)-B stated R97 had an ongoing treatment for her reddened coccyx that staff was applying cream to it. He further

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stated, "All the time the pressure is there." He stated R97 had a small area that was being monitored and "now it is better."

During an interview on 2/12/16, at 7:38 a.m. RN-B stated, R97 did not have any skin concerns that she was aware of. RN-B further explained even though R97's treatment record directed staff to "monitor buttocks for worsening of maceration/skin breakdown" each shift, the nurse did not look at R97's bottom daily. She stated, "The trained medication aides (TMAs) look at it and report concerns to the nurse."

During an interview on 2/12/16, at 8:58 a.m. RN-I stated R97 has had some "excoriation going on." She further stated R97's skin should be addressed in the care plan, but had not been. RN-I stated R97 refuses offloading, but staff continue to try. She also stated R97 had a pressure redistribution mattress in her wheel chair and on her bed but stated a specialized mattress and cushion had not been tried. RN-I stated R97 was toileted and repositioned every two hours at night but she did not know what times. She stated nurses should be doing a skin check at least weekly and documenting in a progress note, however, the medical record lacked evidence of weekly skin checks were completed for R97.

During an interview on 2/12/16, at 11:18 a.m. the director of nursing (DON) stated her expectation was R97's skin would have been monitored on a routine basis and with cares. She stated other interventions should have been initiated for R97 such as therapy and/or specialized mattress.

A facility policy labeled Care plan, dated February

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F 314	Continued From page 42 2002 indicated, residents will receive and be provided necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The policy indicated "each resident will have an individualized comprehensive care plan that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing.....needs. The resident assessment instrument and review of the physician's orders, any problems, needs, and concerns identified will be addressed. This plan of care will be modified to reflect the care currently required/provided for the resident." A facility policy titled Good Samaritan Society: Pressure Ulcers, dated September 2012, was reviewed. The policy indicated its purpose was to provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary. The policy indicated residents would receive appropriate assessments and services to promote and maintain skin integrity.	F 314		

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GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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F 314	Continued From page 43	F 314		
F 318 SS=G	. 483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services including assessment and range of motion (ROM) for 1 of 3 residents (R73) reviewed for activities of daily living (ADLs) and contractures. As a result of these failures, R73 experienced atual harm, a decline in ROM of the left upper extremity, Findings include: R73 was admitted to the facility on 5/13/10, and experienced a cerebral vascular accident (stroke)	F 318	Resident R73□s pain was reassessed on 2/12/2016 and care plan modified as appropriate. NA-B and TMA-F were reeducated on 2/11/2016, NA-C was reeducated on 2/12/2016, NA-D was reeducated on 3/10/2016 regarding stopping cares and reporting to the nurse if they observe any signs and symptoms of verbal or non-verbal pain. Range of motion was discussed with the	3/23/16

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F 318	Continued From page 44 affecting the left side in October 2010, per the Admission Record. The facility failed to conduct assessment and provide ROM services to R73 to maintain functional ROM and prevent a decline in ROM. As a result R73 developed left upper extremity contractures (including shoulder, elbow, wrist and fingers). During interview on 2/9/16, at 7:25 p.m. registered nurse (RN)-F stated R73 had a contracture to his left hand, left side hemiparesis (weakness of the entire left or right side of the body) due to a previous stroke, and that the resident did not use any splints or receive any restorative ROM. On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room. R73's left arm was observed to rest firmly against his body with the left hand against his chest, wrist bent at approximately a 90 degree angle at the forearm, and three fingers on the left hand held firmly in a closed fist position. When requested at that time, R73 was unable to open his clenched left hand. There was no splint or rolled wash cloth in place in R73's left hand. On 2/10/16, at 3:08 p.m. R73 was observed to be in bed. R73's left arm rested against his chest with the elbow bent at an angle, and three fingers on the left hand were tightly clenched into a closed fist. There was no splint or rolled wash cloth in place in the R73's left hand. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. Nursing assistant (NA)-B was observed to attempt to pull R73's left arm away from his body enough so as to wash the	F 318	nurse practitioner and ROM order was clarified on 3/1/2016. Physical therapy completed a range of motion assessment with resident R73 on 2/12/2016. Range of motion tasks were added to R73□s Kardex assignment sheet and point of care (POC) documentation schedule on 2/15/2016. Resident R73□s rolled wash cloth nursing order dated 12/30/2015 for purposes of contracture management and skin integrity was not followed as directed. Individual employees who were found not to be following this order were reeducated on 2/12/2016. Resident R73□s nails were trimmed on 2/11/2016. Care plans for all residents with contractures were reviewed and modified as needed on 3/10/2016. Policies for Care Plans, Pain Management-Resident Assistance, Non-Pharmacological Pain Interventions and Range of Motion and Procedures for Pain Data Collection, and Range of Motion and Guidelines for Range of Motion Exercises were reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance	

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resident's armpit. In addition, NA-B attempted unsuccessfully to put two different shirts on R73 before stopping cares to go get help. At approximately 7:15 a.m., NA-B and NA-D unsuccessfully attempted to put a shirt on R73 while he remained in bed. R73 fidgeted, grimaced, moaned and yelled "ouch" approximately six to eight times during cares especially when staff attempted to manipulate or move R73's left arm. Neither NA-B or NA-D attempted to provide any ROM services to R73 during morning cares.

During interview on 2/11/16, at 7:12 a.m. NA-B confirmed R73 was very stiff and it was difficult to lift his left arm to wash his armpits, and to get him dressed. NA-B stated whenever she assisted with R73's cares, R73 always moaned and groaned during cares.

On 2/11/16, at 9:40 a.m. LPN-C stated R73 had a ROM program, and the care plan directed staff to provide gentle ROM to upper and lower extremities as tolerated with morning and bedtime cares. LPN-C further explained the NAs were responsible for the completion of ROM, and the nurses were responsible to ensuring overall completion of all cares. LPN-C acknowledged she did not know how long R73's contractures had been present.

At 10:23 a.m. on 2/11/16, R73 was observed sitting in a wheelchair in the common area at a table across from his room. A licensed practical nurse (LPN)-C unsuccessfully attempted to extend the fingers on R73's left hand to check the nail length and the condition of R73's palm. R73 moaned and yelled "ouch" when LPN-C attempted to extend his fingers. There was no

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splint or rolled wash cloth in place in the R73's left hand.

During additional interview with NA-B on 2/11/16 at 12:05 p.m., NA-B stated R73 did not receive any ROM services because ROM was not indicated in the Kardex/NA assignment sheet as an intervention.

During interview on 2/12/16, at 8:47 a.m. LPN-C stated the nurses were responsible for ensuring R73 had a rolled wash cloth placed in the palm of his left hand. LPN-C verified R73 had not had a wash cloth placed in the palm of his hand on 2/10/16 or 2/11/16. However when R73's treatment administration record (TAR) was reviewed at that time, it indicated LPN-C had documented the rolled wash cloth to the palm of R73's hand had been in place. LPN-C stated she had no explanation for the discrepancy.

R73 was observed to receive assistance with morning cares from NA-C on 2/12/16, at 9:05 a.m. R73 fidgeted and moaned whenever NA-C manipulated R73's left upper extremity to wash him, or to get him dressed. NA-C did not provide any ROM services to R73 during morning cares.

During interview on 2/12/16, at 11:00 a.m. the physical therapist (PT) stated she had just completed a ROM assessment for R73's upper left extremity. The PT confirmed R73 had contractures to the left upper extremity affecting the joints in the shoulder, elbow, wrist, hand and fingers. The PT further stated provision of ROM services, use of splint devices and/or use of a rolled wash cloth to the palm, would usually helped prevent further decline in contractures.

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During interview on 2/12/16, at 11:14 a.m. NA-C stated she had worked with R73 regularly for years. NA-C said R73 was very contracted on the left arm which made cares and dressing difficult, and stated R73 did not receive any special treatment for the contractures. At that time, NA-C reviewed the Kardex/NA assignment sheet. NA-C verified the Kardex did not direct staff to provide ROM services for R73. NA-C further stated she had never provided ROM services for R73.

An interdisciplinary progress note dated 11/10/11, identified the first documentation related to R73's contracture. The note indicated R73 had weakness to his left hand which looked contracted, and that hospice had been notified and would bring in a splint for R73 to use.

A significant change Minimum Data Set (MDS) assessment dated 1/18/11, indicated R73 had been discharged from hospice on 12/2/10, and was totally dependent on staff for personal hygiene, toileting, bathing, needed extensive assist with bed mobility, transfers and eating. The assessment further noted R73 utilized a splint to his left wrist because it was weaker secondary to his stroke. The record lacked evidence of any assessment related to the noted contracture on the left hand and wrist.

R73's care plan dated 1/5/16, indicated the resident had limited physical mobility related to a stroke with hemiplegia (paralysis of one side of the body). The goal indicated R73 was to remain free of complications related to immobility, including contractures. Care plan interventions indicated nursing staff were to "Provide gentle range of motion as tolerated to (L) [left] upper and

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F 318	Continued From page 48 lower extremities with a.m, (morning) and hs (bedtime) cares." R73's annual and quarterly MDSs from 10/20/10 to 10/18/12, indicated R73 had no functional limitation in ROM. However subsequent annual and quarterly MDSs, from 10/18/12 to 12/17/15, inconsistently identified R73 either had functional limitation in ROM on one side, or had no functional limitation in ROM. The annual MDS dated 7/8/15, and quarterly MDSs from 9/23/15 and 12/17/15, identified R73 had diagnoses including hemiparesis related to the stroke affecting the left side. Each of these MDSs indicated R73 was totally dependent on two staff with transfers and bed mobility, and had an impairment in ROM to one side, on the upper and lower extremity. The Care Area Assessments (CAA) for the annual MDS related to impaired ROM did not trigger for completion. A medical progress note dated 2/9/16, titled Communication/Visit with Physician, indicated a discussion had occurred with the nurse practitioner regarding a decline to a contracture on R73's left arm which had gotten slightly worse, and identified a goal to ensure comfort for R73. However, review of prior progress notes, including Geriatric Services of Minnesota Progress Notes (the progress notes from R73's primary physician and nurse practitioner), dated 6/16/15, 8/10/15, 8/11/15, 8/12/15, 10/11/15 and 2/9/15 failed to identify any medical assessment or discussion about R73's contractures. On 2/12/16, at 11:43 a.m. during a joint interview with RN-D and RN-F, they verified R73 had been admitted to the facility in May 2010 and had experienced a stroke in October 2010. They	F 318		

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stated R73 had developed the contractures after the stroke. Neither RN-D or RN-F were able to state when the staff had first identified R73's contractures. RN-D reviewed the Kardex and verified the ROM program had not been included as care the NAs were to provide. RN-D acknowledged that was likely why R73 had not been receiving any ROM. RN-D reviewed R73's care plan and stated ROM services for R73 had first been identified on the care plan on 10/30/12, but that a "K" had not been checked next to the care intervention, therefore the ROM services had not transfered to the Kardex/NA assignment sheet as an intervention for the NAs to complete. RN-D and RN-F further explained they completed functional ROM assessments at the time of quarterly and annual MDSs. They said they were then responsible to update the care plan and ensure the interventions were included on the Kardex. However, both acknowledged they had not verified whether the ROM services for R73 had been included in the Kardex for NAs to complete. RN-D acknowledged R73's decline in functional ROM had occurred while he'd resided in the facility.

During interview on 2/12/16, at 12:06 p.m. the facility's director of nursing (DON) stated staff were expected to follow each resident's care plan and the nurse managers were to make sure that all appropriate cares were included on the Kardex/NA assignment sheets. The DON also stated the facility should do everything possible to prevent further decline for any resident who has contractures. The DON was unable to state when the facility staff had first identified R73's contractures. The DON acknowledged R73's decline in functional ROM could have been related to lack of assessments and failure to

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F 318	Continued From page 50 provide care such as rolled wash cloth and ROM services. An effort was made to call R73's primary physician on 2/16/16, at 3:00 p.m. Although a message was left for the physician, no return call was received. Assessments completed since R73's contractures and were first identified by the facility staff were requested but none were provided. The facility's RANGE OF MOTION Policy dated 9/12, indicated that based on the resident's comprehensive assessment, "the facility will ensure that a resident entering the facility without a limited range of motion will not experience reduction of motion unless resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. In addition, the facility will ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion."	F 318		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or	F 322		3/23/16

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F 322	Continued From page 51 gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed for check placement of the gastrostomy tube (G-tube) prior to administration of medication for 2 of 4 residents (R77, R2). Findings Include R77's quarterly Minimum Data Set (MDS) dated 12/23/15, identified R77's cognition was assessed by staff and his memory was ok. MDS further identified R77 was totally dependent on staff for all activities of daily living (ADLs), required a feeding tube and had diagnoses of multiple sclerosis (MS), aphasia, anxiety and depression. R77's Care Area Assessment (CAA) dated 4/21/15, identified R77 received tube feedings related to stroke and poor oral intake, and precautions were taken to prevent aspiration. R77's care plan printed 2/11/16, identified R77 had end-stage MS and history of stroke. The care plan further identified R77 required a tube feeding to meet nutrition and hydration needs and R77	F 322	Incidents occurred due to two staff not properly following procedure. RN-A and LPN-D were reeducated to the proper procedure on 2/16/2016 and 2/11/2016 respectively. The Medication Administration via Tube Procedure was reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance.	

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had no desire to eat or drink anything by mouth. R77 was to be free of side effects or complications related to tube feeding.

The Medication Review Report dated 2/11/16, staff was to change the G-tube as needed if plugged or leaking and that all oral medications were to be administered by g-tube.

On 2/11/16, at 7:29 a.m. registered nurse (RN-A) was observed crushing R77's individual medications R77's and emptied each crushed medication into its own 30 milliliter (ml) medication cup. RN-A proceeded to fill each medication cup to the top with water and stirred each medication with a separate plastic white spoon. RN-A then removed the cap from R77's gastric tube, inserted syringe into the tube and poured the fist medication in water into the syringe without first checking placement. RN-A added 30 ml water to the syringe after each medication and provided a total of 460 ml's of water plus a protein supplement during the course of the medication administration. At the time of the observation, RN-A stated she thought tube placement was to be checked weekly, but was not sure. She stated she was not sure when R77's tube placement had been checked, but stated she felt placement was checked in a sense several times a day because if it was not placed right, it would not work. RN-A stated she does not necessarily check tube placement every time before she administers medications, and did not instill air into the tube to confirm placement. She stated she usually checks to see if it was working by adding a little bit of water to the syringe and if it drains she felt it was working.

On 2/11/16, at 12:59 p.m. during follow-up

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interview RN-A stated the tube placement checking process is when you instill air and use a stethoscope to listen for gurgling to confirm placement. She stated she thought the night nurse who started R77's g-tube feeding should check the placement. She stated it was possible she was told at one point to check the tube placement before administering medications, but could not remember. She confirmed she did not check the placement of R77's tube today before medication administration.

On 2/11/16, at 1:08 p.m. unit manager (UM)-A stated she expected the nurses to check tube placement first, and every time before they put anything in the tube. She stated she she would expect the nurses to blow air into tube and use a stethoscope to make sure the tube was where it should be and aspirate stomach contents, assess the contents and put back in. UM-A stated adding water and watching to see if it drains was not acceptable for checking tube placement.

R2's diagnoses listed on the February 2015, Physician Orders included persistent vegetative state, neuromuscular dysfunction, tracheostomy, gastro esophageal reflux disease and convulsions.

R2's care plan printed 2/12/16, identified R2 was in persistent vegetative state and unable to tolerate oral intake safely. The care plan further identified R2 required a tube feeding to meet nutrition and hydration needs. R2 was able to tolerate tube feeding and water flushes.

During medication administration observation and enteral feeding via R2's G-tube on 2/9/16, from 6:49 p.m. until 7:02 p.m. licensed practical nurse

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F 322	Continued From page 54 (LPN)-D was observed to flush the G-tube with 10 cubic centimeters (cc) of water without first checking placement. LPN-D then continued to administer medications via gravity through a syringe. After administering medications LPN-D flushed the G-tube with 100 cc of water and connected R2's Jevity 1.2 (a calorically dense nutritional formula for tube feeding) and turned on the tube feeding machine infused at 85 mls/hour. On 2/9/16, at 7:02 p.m. LPN-D acknowledged that he did not check the G-tube placement. LPN-G verified G-tube placement should have been checked before giving the medication and connecting the tube feeding for infusion. LPN-D stated the facility's policy required checking placement whenever giving meds and checking residuals prior to administration of G-tube feeding. Medication Administration Via Tube procedure dated 11/2013, identified the facility would administer medications through a gastric tube in a safe and appropriate manner. The policy instructed staff to: "3. Check tube placement and patency a. Observe for change in external length of the tube by determining whether the mark placed at the tubes exit site has moved. b. Remove cap from feeding tube and inject 5 -10 ml of air through the tube to clear the tube. Aspirate gastric contents to be sure the tube is in the stomach. c. Check the pH of the gastric contents and refer to pH strip for exact values."	F 322		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES	F 323		3/23/16

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F 323	Continued From page 55 The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure bed grab bars were safely secured to the bed frame to minimize the risk of injury for 1 of 4 residents (R38) reviewed for accidents. Findings include: On 2/9/16, at 3:46 p.m. when asked if resident had side rails (includes half or quarter rails) used for R38, RN-D stated resident had two grab bars for mobility. On 2/9/16, at 4:45 p.m. during room observation bed was observed with two grab bars. R38 was lying on her back in bed. The right grab bar close to the door was observed very loose and could be moved one to two inches back and forth. In addition, the bolt portion of the grab bar was loose and moved around when the grab bar was touched. On 2/10/15, at 10:00 a.m. the right grab bar remained loose. When asked if she used the grab bar resident stated she did use it to turn side to side. On 2/11/16, at 12:42 p.m. when asked if resident	F 323	The right pivoting assist bar on resident R38□s bed was tightened on 2/11/2016. Resident R38 discharged on 2/26/2016. All pivoting assist grab bars attached to resident beds were inspected on 3/1/2016. Procedures for reporting equipment issues and completion of work orders were reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance	

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	245279	A. BUILDING _____ B. WING _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 56 used the grab bar for turning side to side when in bed during cares, nursing assistant (NA)-A stated "Yes." Surveyor and NA-A went to room and verified the grab bar was very loose. When asked if she had assisted resident during morning cares to get ready, NA-A stated therapy had assisted R38. When asked how maintenance was notified of any concerns, NA-A brought surveyor to the nursing station and showed surveyor a maintenance slip then indicated was going to fill one out. -At 12:51 p.m. registered nurse (RN)-B stated resident used the grab bars to turn side to side during cares or when using a bedpan. When asked if she expected staff to report any concerns with the grab bar being loose, RN-B stated, "as a matter of fact I believe [RN-C] had filled a maintenance slip for the grab bar last week." On 2/11/16, at 1:03 p.m. occupational therapist (OT) stated she had assisted resident that day with morning cares. OT indicated resident was independent with activities of daily living and did get herself dressed as she was learning to do it supine when getting on pants using a Reacher. -When asked if resident used the grab bars, OT stated resident used them when rolling side to side and OT stated she but had not noticed if the right grab bar was loose. -When asked how staff reported concerns such as loose grab bar, OT stated would fill a maintenance slip and left it at the reception desk to be picked up. -When asked if she had assisted resident on 2/10/16, OT indicated she did however had not noticed the grab bar as she worked with resident from the left side by the window. OT further she was chatting at the same time writing notes and	F 323		

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F 323	Continued From page 57	F 323		

resident never said anything regarding the grab bar.
-When asked if she would expect nursing staff to have reported the issue, OT stated "I would imagine but I think she is up during day" thought the question was hard to answer. As OT was talking to surveyor, PT joined on the conversation and stated she too had worked with her but had not noticed the loose grab bar because she also was working from the left side, as this was resident preferred side.

On 2/11/16, at 1:12 p.m. the environmental tour was conducted with the director of facilities (DOF), administrator and Intern. DOF verified the grab bar was loose. DOF stated would expect staff to put in a work order. Surveyor requested DOF to check for a slip regarding the grab bar filled by RN-C.

On 2/12/16, at approximately 10:50 a.m. the administrator stated DOF had checked and there was no slip filled for the grab bar last week.

On 2/12/16, at 11:14 a.m. when asked if she expected the staff to report, any concerns with resident care equipment such as grab bars; the director of nursing (DON) stated staff was supposed to report it to maintenance immediately. When asked if the care plan was supposed to identify the grab bars for mobility, DON stated if a resident used them to be independent, she would have expected care plan to mention the grab bars.

R38's diagnoses included encounter for orthopedic aftercare following surgical amputation, unspecified systolic (congestive) heart failure and acquired absence of right leg

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F 323	Continued From page 58 above knee obtained from electronic medication record dated February 2016. R38's care plan dated 1/12/16, indicated resident was at risk for falls related to right leg above knee amputation and deconditioning as evidenced by balance instability. Care plan directed staff educate/instruct resident and family on safe use of assistive devices(s), remind resident not to bend over to pick up dropped items and encourage to use a grabber or to ask for assistance. The care plan did not address/identify R38 used grab bars for bed mobility.	F 323		
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 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.	F 431		3/23/16

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F 431	Continued From page 59 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, facility failed to ensure expired medications were properly disposed off for 3 of 6 units. In addition, the facility failed to ensure 1 of 6 medication refrigerators was kept clean and sanitary. Findings include: Bluff Country medication room: During observation of the Bluff Country medication room on 2/11/2016, at 9:40 a.m. an open multi dose vial of influenza (flu) vaccine was located in the medication refrigerator. The vial was dated as having been opened 10/7/15, the licensed practical nurse (LPN)-C stated multi dose flu vaccine vials are good for 30 days once opened. LPN-C verified date vial was opened on 10/7/15, and that it was greater than 30 days. In addition the top shelve of the refrigerator was noted with pinkish-whitish stains. LPN-C verified that the refrigerator was not kept clean and sanitary. LPN-C further stated the nurses on night shift were supposed to be cleaning the	F 431	All expired medication/vaccines on were disposed of on 2/12/2016. The refrigerator on Bluff was cleaned on 2/12/2016. All medication rooms were inspected for expired medications and refrigerators checked for cleanliness on 2/12/2016. Nurse Manager for 3rd floor unit gave list of vaccination dates to surveyor on 2/12/2016. Procedures for Disposition of Medication and Vaccine Handling Storage Parameters will be reviewed with all appropriate staff. The Director of Nursing Services and/or designee will be responsible to ensure compliance through random monthly audits. The QAPI committee will monitor audits for ongoing compliance	

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F 431	Continued From page 60	F 431		

refrigerator and freezer once a week.

During interview on 2/12/16, at 11:55 a.m. the unit's nurse manager, registered nurse (RN)-D stated she expected medications to be properly disposed off when expired and the refrigerator to be kept clean and sanitary.
Boundary Waters medication room on the third floor:
During observation of the Boundary Waters medication room on 2/12/16, at 6:56 a.m. an open bottle of milk of magnesia (MOM-a medication for constipation) was noted to have expired on 10/15.

RN-E verified the MOM had expired in October of 2015. RN-E was unable to say who had received the MOM but that it most likely had been used after it had expired.

Arrowhead medication room on the third floor:
During observation of the Arrowhead medication room on 2/12/16, at 7:11 a.m. an open multi dose vial of influenza (flu) vaccine was located in the medication refrigerator. The vial was dated as having been opened 10/23/15. RN-E stated multi dose flu vaccine vials are good for 30 days once opened. RN-E verified date vial was opened and that it was greater than 30 days ago.

Lakes medication room on the second floor:
During observation of the Lakes medication room on 2/12/16, at 7:58 a.m. a bottle of Calcium 600+D was noted to have expired 9/15. The bottle was dated "open 1/23/15." Trained medication aide (TMA)-C verified the bottle of Calcium 600 +D was expired. TMA-C said "I do not know who is responsible to check that here are no expired medications in the med room, but

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F 431	Continued From page 61	F 431		

whenever you take a bottle or give a medication, the person doing so, checks the expiration date at that time. I will leave it on the counter and let the nurse know."

During interview on 2/12/16, at 9:05 a.m. RN-J, nurse manager, said the nurses check the medication rooms for expired medications and the TMA's check the medication cards when they pull them. When asked how long was an open vial of flu vaccine good for RN-J replied "30 days I believe." RN-J said, "I gave flu vaccine in October of 2015. I am sure no one received the flu vaccine after it expired." RN-J verified the same vial of influenza vaccine would have been used by both Arrowhead and Boundary Waters unit because the nurse went between both units. RN-J said, "(RN-A) told me she found an expired influenza and was going to get rid of it. I thought it had been thrown away."

Requested list of vaccine dates for all residents on both third floor units. Did not receive from facility. Immunization records in the electronic health record reviewed for all residents residing on the first or third floor. One resident was identified by record review as currently residing in the facility and who received a influenza vaccine after the expiration date on the vial located in the Arrowhead medication room.

Admission Record dated 2/12/16 for R223 indicated R223 was admitted to the facility on 12/2/15, to a room on third floor. Immunization Reportdated 2/12/16, indicated R223 recieved the influenza vaccine on 12/3/15, from RN-A.

Acquisition, Receiving, Dispensing and Storage of Medications Procedure Revised 12/15,

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F 431	Continued From page 62 instructed staff: "4. Medications will be stored in a locked medication cart, drawer or cupboard.... 5. The location will routinely check for expired medications and necessary disposal will be done in accordance with state/Pharmacy regulations. 6. All medications will be stored in accordance with manufacturers' recommendations. Refer to Recommended Minimum Medication Storage Parameters and Insulin Storage Recommendations in this manual. 7. ...Refer to Vaccination Handling and Storage Parameters for specific storage of vaccinations." Vaccine Handling and Storage Parameters revised 12/15, instructed staff: "A weekly review of vaccine expiration dates and rotation of vaccine stock should be done."	F 431		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS -2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED AT VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on February 11, 2016. At the time of this survey, Good Samaritan Society-Specialty Care Community was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES TO: Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to:	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2016

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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K 000	Continued From page 1 Marian.Whitney@state.mn.us Angela. Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This 3-story building with a basement was constructed in 2012 and determined to be Type II (111) construction. The building has a garage, kitchen and mechanical equipment in the basement, long-term care and transitional care on the first floor, long-term care on the second floor and long-term care on the third floor utilizing special locking arrangements for memory care. The building is fire sprinkler protected throughout. The building 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 96 beds and had a census of 95 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly	K 050		3/23/16

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K 050	Continued From page 2 on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM a coded announcement may be used instead of audible alarms. 18.7.1.2, 19.7.1.2 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility could not provide documentation that fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 18.7.1.2. This deficient practice could affect all 94 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on February 11, 2016, the review of the fire drill documentation for the past 12 months revealed that It was observed that the fire drills for the second shift were conducted at 1530, 1600, 1615, and 1630 which are not varied in accordance with the Life Safety Code. This deficient practice was confirmed by the Director of Environmental Services at the time of discovery.	K 050	Fire drills will be conducted at unexpected, varied times. Appropriate staff were reeducated on the proper procedure for fire drills. Director of Environmental Services and/or designee will be responsible to ensure compliance through random audits. The QAPI committee will monitor audits for ongoing compliance.	
K 144 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by:	K 144		3/23/16

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K 144	Continued From page 3 Based on documentation review and staff interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110-1999 edition, Section 6-4. This deficient practice could affect all 94 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 02/11/2016, record review revealed that a generator cool down period was not documented separately from the run time. These deficient practices were verified by the Director of Environmental Services at the time of the inspection.	K 144	A separate column for generator cool down time was added to the generator run log to document cool down time on 2/11/2016. Director of Environmental Services was reeducated to proper procedure on 2/11/2016. The Administrator and/or designee will be responsible to ensure compliance through random audits. The QAPI committee will monitor audits for ongoing compliance.	

MDH
Minnesota Department of Health

Protecting, maintaining and improving the health of all Minnesotans

Electronically submitted
March 3, 2016

Ms. Nicole Mattson, Administrator
Good Samaritan Society - Specialty Care Community
3815 West Broadway
Robbinsdale, MN 55422

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5279026

Dear Ms. Mattson:

The above facility was surveyed on February 9, 2016 through February 12, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

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

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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Telephone: (651) 201-4112
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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 _____	02/12/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - SPECIALTY CA	3815 WEST BROADWAY ROBBINSDALE, MN 55422

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/9/16 through 2/12/16, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 510	MN Rule 4658.0300 Subp. 2 Use of Restraints Subp. 2. Freedom from restraints. Residents must be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess the use of a bilateral (bilat) thigh positioning device as a potential restraint for 1 of 3 residents (R97) reviewed for restraints, and who was capable of standing up from her wheel chair. Findings include: R97's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated she was severely cognitively impaired and required extensive assist of two staff for transfers. The MDS further noted R97 did not use restraints. R97's care plan dated 12/3/15, indicated risk for falls related to gait/balance problems, impulsivity and poor decision making. The care plan directed staff to apply a "bilateral thigh positioning device" while up in chair and directed staff to check the device every 30 minutes and reposition every two hours. Care planned behaviors included resistance to cares, ambulating in the hall	2 510	Corrected. No POC required.	3/23/16

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2 510	Continued From page 3 disrobed and striking out at staff. A Good Samaritan Society Specialty Care Community Progress Note dated 1/11/16, indicated R97 needed assist with mobility, assist with transfers, and "will walk short distances." The progress note further indicated R97 was using a Broda (a wheel chair that reclines) with bilat thigh pads due to "frequent standing and fall risk, not considered a restraint due to unable to transfer safely indep [independently]." During an observation on 2/9/16, at 4:28 p.m. R97 was seated in a high backed padded wheel chair. Across each of her upper thighs was a strap that extended from under her legs and attached behind and out of reach of resident. During an interview on 2/11/16, at 12:24 p.m., nursing assistant (NA)-D stated R97 had "positioning straps." NA-D stated R97 was a fall risk and the straps helped maintain position in her wheel chair. He further stated she was not able to release the device on her own. He stated if she opens it "she could fall." - At 12:39 p.m. licensed practical nurse (LPN)-B stated he thought they did an assessment prior to using the positioning device. LPN-B further stated the positioning device was used for safety due to constant falling. He stated the straps are released to reposition R97. - At 1:32 p.m., registered nurse (RN)-I stated "without those straps, [R97] would probably be on the floor." She further stated, "We are not trying to restrain her." RN-I stated an assessment was initiated on 3/11/14, but was not required because the facility did not consider the positioning device to be a restraint. Even though the device restricted R97's mobility and prevented her from rising from her chair on her own. She stated there	2 510		

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2 510	Continued From page 4 was no ongoing assessment to determine if the device continued to be appropriate. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review the resident restraint usage data to ensure residents are not restrained without proper assessments and monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 510		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to develop care planned interventions to prevent pressure ulcers for 1 of 2 residents (R97) reviewed for pressure ulcers. Findings include: During an observation on 2/11/16, at 8:22 a.m. R97's morning cares were observed. R97 was lying in bed on her right side. R97's incontinent brief was saturated with urine and soiled with	2 560	Corrected. No POC required.	3/23/16

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2 560	Continued From page 5 bowel. Following incontinent cares, R97 was noted to have a reddened coccyx area with a 1/2 inch long fissure that appeared to be open. During a subsequent observation of cares on 2/12/16, at 8:02 a.m. registered nurse (RN)-B assessed R97's skin. RN-B stated R97 had a stage one pressure ulcer (a non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) on her coccyx. She described the pressure ulcer as "a little bit open." A review of Good Samaritan Society Specialty Care Community Medication Review Report indicated, on 3/24/15, an order was received to "monitor buttocks for worsening of maceration/skin breakdown." A Review on Good Samaritan Society Special Care Community Progress Notes dated 8/2/15 through 2/12/16, indicated R97 had a history of refusing repositioning at least daily. A Pressure Ulcer Care Area Assessment (CAA) dated 8/20/15, identified R97 was at risk for impaired skin integrity related to a need for assistance for mobility, and refused to lie down. The CAA indicated R97 had "no pressure areas but has been getting excoriated from incont [incontinence], refusals to lay down, chorea [an abnormal involuntary movement disorder] pelvic thrusts." R97's care plan dated 9/4/15, indicated R97 had a self-care deficit, required assistance for all activities of daily living, and was incontinent of bowel and bladder. The care plan directed staff to	2 560		

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2 560	Continued From page 6	2 560		

provide incontinent cares every two hours and as needed. The care plan did not address R97's risk for skin impairment or identify interventions to prevent skin breakdown. A care plan addressing skin was initiated after the surveyor identified the pressure ulcer on 2/12/16.

A Progress Note dated 12/6/15, indicated R97's skin check indicated "skin is still reddened by sacral area, but this is not new." A note dated 12/20/15, indicated "sacral area slightly pink." A Progress Note dated 12/26/15, indicated "the skin on res [resident] buttocks looks good, maceration is healing." A quarterly Nursing Note dated 1/11/16, indicated "red rash intermittent on buttocks...creams applied...encourage to reposition but often refuses." A Progress Note dated 1/16/16, indicated "skin breakdown on buttocks healing." A Progress Note dated 2/10/16, indicated R97 had some reddened areas at the right side of the gluteal fold indicating some "pressure points." While the facility assessments and progress notes indicated R97 had ongoing skin issues dating back several months and continual refusals of attempts to reposition, there were no further care planned interventions implemented to reduce the risk for skin breakdown.

During an interview on 2/11/16, at 8:26 a.m. nursing assistant (NA)-D stated he did not know when R97 was last toileted or repositioned. He stated it was last done on the night shift but did not know what time. NA-D further stated he was unaware of any skin concerns regarding R97.

During an interview on 2/11/16, at 8:41 a.m. NA-E stated staff had a hard time getting R97 to lay down. NA-E stated R97 had redness to her coccyx on and off and it was "very ongoing." She

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2 560	Continued From page 7 stated staff use cream on R97's bottom and check on her every two hours. NA-E further stated when R97 sits in her chair, "all her pressure goes on her coccyx." During an interview on 2/11/16, at 12:43 a.m. licensed practical nurse (LPN)-B stated R97 had an ongoing treatment for her reddened coccyx that staff was applying cream to it. He further stated, "All the time the pressure is there." During an interview on 2/12/16, at 7:38 a.m. RN-B stated, R97 did not have any skin concerns that she was aware of. RN-B further explained even though R97's treatment record directed staff to "monitor buttocks for worsening of maceration/skin breakdown" each shift, the nurse did not look at R97's bottom daily. She stated, "The trained medication aides (TMAs) look at it and report concerns to the nurse." During an interview on 2/12/16, at 8:58 a.m. RN-I stated R97 has had some "excoriation going on." She further stated R97's skin should be addressed in the care plan, but had not been. RN-I stated R97 refused offloading, but staff continue to try to get R97 repositioned and offloaded. During an interview on 2/12/16, at 11:18 a.m. the director of nursing (DON) stated her expectation was R97's skin would have been monitored on a routine basis and with cares. She stated other interventions should have been initiated for R97 such as therapy and/or specialized mattress. A facility policy labeled Care plan, dated February 2002 indicated, "Residents will receive and be provided necessary care and services to attain or maintain the highest practicable well-being in	2 560		

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2 560	Continued From page 8 accordance with the comprehensive assessment. The policy indicated "each resident will have an individualized comprehensive care plan that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing.....needs. The resident assessment instrument and review of the physician ' s orders, any problems, needs, and concerns identified will be addressed. This plan of care will be modified to reflect the care currently required/provided for the resident." SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review and/or revise policies and procedures to ensure care plans are developed and reflect each residents current care needs including high risk medications. The DON or designee could educate all appropriate staff on the policies/procedures, and develop a monitoring system to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure staff reported	2 565	Corrected. No POC required.	3/23/16

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2 565	Continued From page 9	2 565		

pain with cares for 1 of 2 residents (R73) who experienced pain during cares. In addition, the facility staff failed to provide nail care, rolled wash cloth and range of motion (ROM) for 1 of 2 residents (R73) who required staff assistance with activities of daily living (ADLs) who were reviewed for ADLs and ROM.

Findings include:

Pain:
R73 was admitted to the facility on 5/13/10, had a cerebral vascular accident (stroke) affecting the left side in October, 2010. The facility failed to re-assess R73 for pain related to contractures of the left hand, wrist, elbow and shoulder and the facility staff did not stop providing ADLs cares when R73 experienced pain, report to the nurse, reassess and provide necessary treatment to minimize the pain experienced during morning cares.

On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room, R73's left arm rested firmly against his body with the left hand rested on his chest, wrist bent at about a 90 degrees angle at the forearm and three fingers on the left hand in a closed fist position. R73 was not able to open his clenched left hand when asked to do so.

R73 was observed during morning cares on 2/11/16, at 7:03 a.m. nursing assistant (NA)-B washed R73's face with a wash cloth and tried to pull R73's left arm away from his body to wash armpit. NA-B attempted unsuccessfully to put two different shirts on R73 before stopping cares to go get help. NA-B and NA-D unsuccessfully attempted to put on a shirt while R73 was in bed. R73 fidgeted, grimaced, moaned and yelled

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"ouch" approximately six to eight times during cares especially when staff held and pulled on R73's left arm. NA-B and NA-C did not stop providing morning cares when R73 fidgeted, grimaced, moaned and yelled "ouch" multiple times.

R73 was observed during morning cares on 2/12/16, at 8:12 a.m. NA-C was providing care to R73 under close supervision of registered nurse (RN)-D who was there to assess R73's pain during morning cares. NA-C attempted to wash R73's face with a wash cloth, R73 immediately turned his head away from NA-C, fidgeted and moaned. RN-D, who was present in the room asked NA-C to stop morning cares. RN-D stated R73's facial expressions indicated R73 was in discomfort and will need to medicate R73 with pain medication and re-attempt morning cares later. On 2/12/16, at 9:05 a.m. RN-D and NA-C returned to R73's room to complete morning cares. R73 did not seem to be any discomfort during cares but grimaced and moaned only when staff attempted to open R73's fingers on left hand.

Review R73's electronic medication administration record (EMAR) for, December 2015, January and February 2016, revealed that R73 received as needed (PRN) pain medications two times on 1/2/16, which was documented as being ineffective and on 1/11/16, which was documented as being effective on the EMAR. The medical record lacked evidence that R73's pain was assessed prior to administration of PRN pain medication and/or during cares.

R73's care plan dated 1/5/16, indicated the resident had potential for pain/discomfort related to a cerebral vascular accident, hemiplegia

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(paralysis on one side of the body) and end stage disease processes as evidenced by grinding teeth and restlessness. The goal for R73, decrease in behaviors of inadequate pain control restlessness, grimacing and grinding teeth. The facility staff were to report to nurse any signs or symptoms of non-verbal pain, changes in breathing, vocalizations, mood and behavior changes, and nursing staff to administer analgesia as per orders. Both NAs did not stop cares and report R73's pain to the nurse on 2/11/16, as the care plan directed.

During interview on 2/11/16, at 7:12 a.m. NA-B stated she heard R73 moaning and yelling "ouch" during morning cares, and continued to state whenever she assisted with R73's cares, R73 always moaned and groaned during cares and she believed R73 was "in pain" when working on his left upper extremity.

On 2/11/16, at 9:40 a.m. licensed practical nurse (LPN)-C verified R73 had a diagnosis of chronic pain for which he received pain medications. Further stated nurses administered Roxanol (a narcotic pain medication) to R73 sometimes when he was in bed or when already up in a wheelchair. LPN-C stated she would expect nursing assistants to report any pain or discomfort with residents to the nurse. LPN-C denied anyone reporting any pain or discomfort with R73 during morning cares on 2/11/16.

On 2/11/16, at 12:49 p.m. trained medication aide (TMA)-F stated R73 always groaned and clenched his teeth "like he is in pain." TMA-F further stated she administered pain medication to R73 except Roxanol that was administered by the nurse, half the time when R73 in bed and when already up in a wheelchair. TMA-F denied

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anyone reporting any pain or discomfort with R73 during morning cares on 2/11/16.

On 2/12/16, at 9:27 a.m. NA-C stated that she usually works with R73 and always moaned/ groaned sometimes yelled "ouch" when attempting to left R73's left upper extremity to wash or get R73 dressed. NA-C further stated she believed R73 was "probably in pain." NA-C stated did not report her observations to the nurse stating "it is like that every day thing with him." NA-C stated after R73 got pain medications on 2/12/16, prior to morning cares "it went better for him today" as she smiled and seemed happy.

During a joint interview on 2/11/16, at 2:35 p.m. the nurse manager of the unit RN-D and the unit's MDS coordinator RN-F were informed of surveyor observations and staff reports of pain during morning cares with R73. RN-D and RN-F both stated they were not aware of any pain issues during morning cares with R73. RN-D continued to state she expected nursing assistants to report voiced or observed pain to the nurse. RN-F verified he assessed R73's pain and R73 was assessed as to have no pain. RN-F further stated R73 was to continue with current pain regimen but he could not recall the circumstances of R73's pain assessments. RN-F acknowledged he was not aware that R73 was in pain during cares and could not recall if he ever assessed R73's pain during cares.

During interview on 2/12/16, at 8:30 a.m. after RN-D completed pain assessment on R73, she noted R73 fidgeted and moved face away when NA-C attempted to wash R73's face, indicating that R73 was in some discomfort and opted to stop morning cares. RN-D stated requested nurse to administer pain medications to R73 prior

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2 565	Continued From page 13	2 565		

to completion of morning cares from here on. On 2/12/16, at 9:38 a.m. RN-D further stated after R73 received pain medications, R73 was more relaxed during morning cares. RN-D stated she expected nursing assistants to stop cares, report voiced or observed pain to the nurse and the nurse was expected to complete a pain assessment.

During interview on 2/12/16, at 12:40 p.m. the facility's director of nursing (DON) stated the facility staff were expected to watch for nonverbal cues of pain for residents who cannot talk, if any signs or symptoms of pain are observed the facility staff are to stop cares and report to the nurse. The nurses are expected to assess resident for pain, medicate with pain medication as appropriate, review care plan and update physician for adjustment of pain medication. DON further stated that R73 might have experienced unnecessary pain on 2/11/16, during morning cares that could have been avoided.

The pain policy was requested but not provided.

ROM:
R73 was admitted to the facility on 5/13/10, had a cerebral vascular accident (stroke) affecting the left side in October, 2010. The facility failed to specialized treatments for contractures to R73 to maintain functional ROM and prevent a decline in ROM. As a result R73 developed left upper extremity contractures (including shoulder, elbow, wrist and three fingers).

On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room, R73's finger nails on both hands were observed to be long and untrimmed (approximately quarter [1/4] inch in length). There

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2 565	Continued From page 14 was no splint or rolled wash cloth placed in R73's left hand. During interview on 2/9/16, at 7:25 p.m. RN-F stated R73 had a contracture on left hand, left side hemiparesis (weakness of the entire left or right side of the body) due to a previous stroke, resident did not use any splints or received any restorative ROM. On 2/10/16, at 3:08 p.m. R73 was observed in bed awake, R73's left arm rested against his chest, finger nails on both hands were observed to be long and untrimmed. There was no rolled wash cloth placed in R73's left hand. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. provided by nursing assistant (NA)-B. NA-B did not provide any ROM services to R73 during morning cares. R73's finger nails on both hands were observed to be long and untrimmed. There was no rolled wash cloth placed in R73's left hand. At 10:23 a.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room. LPN-C verified R73's nails were long and dirty underneath. There was no rolled wash cloth placed in R73's left hand. R73 was observed during morning cares on 2/12/16, at 9:05 a.m. provided by NA-C. NA-C did not provide any ROM services to R73 during morning cares. There was rolled wash cloth placed in R73's left hand. R73's care plan dated 1/5/16, indicated R73 was dependent on staff for all ADLs. The care plan directed staff to assist R73 with all of his personal hygiene care needs and to provide gentle range of motion as tolerated to left upper and lower	2 565		

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2 565	Continued From page 15 extremities with morning and bedtime cares. Review of R73's Physician Orders dated 2/12/16, revealed a nursing order for rolled wash cloth in left hand. During interview on 2/11/16, at 12:05 p.m., NA-B stated R73 did not receive any ROM services because ROM was not indicated in the Kardex (NA assignment sheet) for NAs to complete. On 2/11/16, at 9:40 a.m. the LPN-C stated R73 had a ROM program and the care plan directed staff to provide gentle ROM to upper and lower extremities as tolerated with morning and bedtime cares. LPN-C explained that nursing assistants were responsible for the completion of ROM and nurses were responsible for ensuring completion of all cares. At 10:23 a.m. LPN-C reviewed R73's medical record and did not find any documentation of refusals of nail care by R73. LPN-C reviewed R73's medical record and verified R73 was scheduled for a bath on 1/31, 2/3, 2/7 and 2/10/16. On 2/12/16, at 8:47 a.m. LPN-C verified R73 did not have a rolled wash cloth on 2/10/16 and 2/11/16. At 11:00 a.m. the physical therapist (PT) stated she just completed a ROM assessment on R73 upper left extremity. PT stated R73 had contractures on the left upper extremity affecting the joints in the shoulder, elbow, wrist, hand and fingers. PT further stated provision of ROM services, splint devices and rolled wash cloth in palm usually helped prevent further decline in contractures. At 11:14 a.m. NA-C stated R73 did not receive any specialized treatments for contractures, tried finding Kardex and stated the Kardex did not direct the facility staff to do ROM services for R73. At 11:43 a.m. RN-D verified the	2 565		

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2 565	Continued From page 16 ROM program was not included in R73's Kardex as one of the cares for nursing assistants to provide therefore R73 had not been receiving ROM. RN-D stated she expected staff to follow resident's care plan. During interview on 2/12/16, at 12:06 p.m. the facility's DON stated she staff were expected to follow resident's care plan and the nurse managers to make sure that all cares were included in the Kardex. R73 did not receive the care and services as directed per the plan of care. The ADL policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could develop, review, and/or revise policies and procedures to ensure the facility followed care plan interventions according to the resident's individualized needs. The director of nursing could educate all appropriate staff on the policies and procedures to follow care plan interventions. The director of nursing could monitor to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and	2 830		3/23/16

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2 830	Continued From page 17 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively re-assess and provide cares and services for 1 of 3 residents (R73) reviewed for activities of daily living (ADLs) and range of motion (ROM). The facility also failed to ensure bed grab bars were safely secured to the bed frame to minimize the risk of injury for 1 of 4 residents (R38) reviewed for accidents. Findings include: R73 was admitted to the facility on 5/13/10, and experienced a cerebral vascular accident (stroke) affecting the left side in October 2010, per the Admission Record. The facility failed to re-assess R73 for pain related to contractures of the left hand, wrist, elbow and shoulder, Consequently the facility had not modified interventions to ensure comfort and pain relief prior to providing ADL cares. On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room. R73's left arm was observed to rest firmly against his body with the left hand against his chest, wrist bent at approximately a 90 degree angle at the forearm, and three fingers on the left hand held firmly in a	2 830	Corrected. No POC required.	

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2 830	Continued From page 18 closed fist position. When requested at that time, R73 was unable to open his clenched left hand. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. Nursing assistant (NA)-B was observed to attempt to pull R73's left arm away from his body enough so as to wash the resident's armpit. In addition, NA-B attempted unsuccessfully to put two different shirts on R73 before stopping cares to go get help. At approximately 7:15 a.m., NA-B and NA-D unsuccessfully attempted to put a shirt on R73 while he remained in bed. R73 fidgeted, grimaced, moaned and yelled "ouch" approximately six to eight times during cares especially when staff attempted to manipulate or move R73's left arm. NA-B and NA-D did not stop providing R73's care even when R73 fidgeted, grimaced, moaned and yelled "ouch" multiple times. At 10:23 a.m. on 2/11/16, R73 was observed sitting in a wheelchair in the common area at a table across from his room. The fingernails on R73's right hand were observed to be quite long. A licensed practical nurse (LPN)-C unsuccessfully attempted to extend the fingers on R73's left hand to check the nail length and the condition of R73's palm. R73 moaned and yelled "ouch" when LPN-C attempted to extend his fingers. LPN-C verified R73 appeared to be in discomfort during this assessment. On 2/12/16, at 8:12 a.m. registered nurse (RN)-D stated R73's facial expressions may indicate discomfort, a need to medicate with pain medication, and the need to re-attempt care later. The annual Minimum Data Set (MDS) dated 7/8/15, and quarterly MDS dated 9/23/15 &	2 830		

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2 830	Continued From page 19 12/17/15, indicated R73 demonstrated no signs of pain such as non-verbal sounds (moaning, or groaning), facial expression (grimaces, clenched teeth or jaw), protective body movements or posture (bracing, guarding, clutching or holding a body part during movement). As a result, the Care Area Assessment (CAA) for the 7/8/15 annual MDS did not trigger a need for assessment related to pain. R73's quarterly Pain Data collection dated 12/17/15, indicated that the resident had advanced dementia, was rarely/never understood, and a PAINAD (tool used to evaluate effectiveness of pain regimen for dementia residents) dated 4/5/15, 7/5/15, 9/23/15, and 12/17/15, indicated the resident's breathing was normal, no negative vocalizations, and that the resident was smiling or had inexpressive facial expression with relaxed body language. In addition, a review of the record revealed the following documentation about pain: 4/8/15- notes indicated R73 was not at high risk for pain, current medication regimen was working, and that staff should continue to follow the current plan of care for pain. 7/5/15- notes indicated R73 was not at high risk for pain, current medication regimen was working, and that staff should continue to follow the current plan of care for pain. The medical record lacked evidence as to whether staff providing direct care for R73 had been interviewed about the resident's level of pain during care, and/or whether pain assessments were completed during provision of care to ensure R73 maintained his highest functional level and comfort. Review R73's electronic medication administration record (EMAR) for December 2015	2 830		

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2 830	Continued From page 20 and January and February 2016, revealed R73 received as needed (PRN) pain medications twice on 1/2/16. Documentation for 1/2/16 indicated the PRN pain medication use was ineffective. On 1/11/16, documentation indicated the use of PRN medication was effective. The medical record lacked any evidence that R73's pain was assessed prior to administration of PRN pain medication. R73's care plan dated 1/5/16, indicated the resident had potential for pain/discomfort related to a cerebral vascular accident, hemiplegia (paralysis on one side of the body) and end stage disease processes, as evidenced by grinding teeth and restlessness. The goal was for R73 to have a decrease in behaviors indicating inadequate pain control including: restlessness, grimacing and grinding teeth. Interventions indicated staff were to report to the nurse any signs or symptoms of non-verbal pain, changes in breathing, vocalizations, mood or behavior changes, and that nursing staff were supposed to administer pain medications as ordered. R73's Physician Order Summary Report dated 2/12/16, revealed diagnoses including: cerebral vascular accident (stroke), hemiparesis (weakness of the entire left or right side of the body) and pain. Although current physician orders revealed R73 utilized the following medications for pain control: Roxanol 2.5 milligrams (mg) two times daily; Tylenol Extra Strength (ES) 1000 mg three times a day; Roxanol 10 mg every two hours as needed (PRN) for moderate to severe pain; and Roxanol 5 mg PRN for mild pain, facility staff had not identified specific criteria for when to administer (ie., before or after care), in order to assure the client received the most effective pain control.	2 830		

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2 830	Continued From page 21 During interview on 2/11/16, at 7:12 a.m. NA-B stated R73 was very stiff and it was difficult to lift his left arm to wash his armpits and to get him dressed. NA-B stated she heard R73 moaning and yelling "ouch" during morning care, and stated whenever she assisted with R73's care he moaned and groaned. NA-B said she believed R73 was "in pain" when they worked with his left upper extremity. On 2/11/16, at 9:40 a.m. licensed practical nurse (LPN)-C verified R73 had a diagnosis of chronic pain for which he received pain medications. LPN-C stated the nurses administered the Roxanol (a narcotic pain medication) to R73 sometimes while he was still in bed, and sometimes when he was already up in his wheelchair. LPN-C stated the NAs should be reporting any pain or discomfort expressed by residents to the nurse. When asked whether staff had reported R73's discomfort during care that morning, LPN-C said no. During interview on 2/11/16, at 12:39 p.m. NA-D stated she usually worked on the evening shift and was regularly assigned to take care of R73. NA-D stated R73 always moans/groans whenever staff move his left arm, and stated she believed R73 was in pain when he moaned/groaned. When asked whether she'd ever reported the pain to the nurse, NA-D said she had. However, a review of the resident's Progress Notes from 4/28/15 through 2/11/16, failed to indicate this had occurred. On 2/11/16, at 12:49 p.m. trained medication aide (TMA)-F stated R73 always groans and clenches his teeth "like he is in pain." TMA-F further stated she administered pain medication to R73, except	2 830		

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2 830	Continued From page 22	2 830		

the Roxanol which was administered by the nurse. TMA-F confirmed half the time R73 gets the medication while he's still in bed and the other half of the time when he's already up in his wheelchair.

During a joint interview on 2/11/16, at 2:35 p.m. the nurse manager of the unit, RN-D. and the unit's MDS coordinator RN-F, were informed of surveyor observations and staff reports of pain experienced by R73 during morning cares. RN-D and RN-F both stated they were unaware of any pain issues during morning cares with R73. RN-D stated she expected the nursing assistants to report voiced or observed pain to the nurse. RN-F verified he'd previously assessed R73's pain, when R73 had no pain. RN-F further stated R73 was to continue with the current pain regimen but he could not recall the circumstances of the pain assessments such as whether or not the resident had been assessed while receiving care.

During interview on 2/12/16, at 8:30 a.m. RN-D said she'd completed a pain assessment on R73 during his morning care. She verified R73 fidgeted and moved his face away even when NA-C attempted to wash R73's face, indicating R73 was in some discomfort. RN-D stated she had requested the nurse administer pain medications to R73 prior to completion of morning cares from now on. On 2/12/16, at 9:38 a.m. RN-D stated that after R73 had received the pain medication, he appeared more relaxed during his morning cares. RN-D stated she expected the nursing assistants to stop cares, report voiced or observed pain to the nurse, and for the nurse to conduct an assessment of the resident's pain.

On 2/12/16, at 9:27 a.m. NA-C stated she

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2 830	Continued From page 23	2 830		

regularly works with R73 and that he always moans and groans, and sometimes yells "ouch" when staff attempt to move his left upper extremity to wash him or get him dressed. NA-C stated she believed R73 was "probably in pain" and stated she didn't always report her observations to the nurse. NA-C stated, "it's like an every day thing with him." NA-C also said after R73 had received his medications that morning, prior to morning cares, "it went better for him" as he smiled and seemed happy.

During interview on 2/12/16, at 12:40 p.m. the facility's director of nursing (DON) stated the staff were expected to watch for nonverbal cues of pain for residents who cannot talk, to observe whether any signs or symptoms of pain are present, and for staff to stop care if the resident is in pain and report to the nurse. The DON also said the nurses are expected to assess residents for pain, medicate with pain medication as appropriate, review resident care plans for appropriateness, and update their physicians for any required adjustments of pain medication. The DON further stated R73 may have experienced unnecessary pain on 2/11/16, during his morning cares that could have been avoided.

An effort was made to call R73's primary physician on 2/16/16, at 3:00 p.m. Although a message was left for the physician, no return call was received.

The facility's policy titled "PAIN DATA COLLECTION AND ASSESSMENT" revised 9/15, directed staff to continually monitor and evaluate the pain management plan for residents with pain. The policy directed nursing assistants to make a resident who is in pain comfortable, and to verbally communicate with the nurse on

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2 830	Continued From page 24 duty regarding any observed or reported pain. The policy further directed the RN to document effectiveness of the pain management plan weekly if high risk for pain and at least monthly regarding whether the pain plan is effective and the resident is stable. Grab bars: On 2/9/16, at 3:46 p.m. when asked if resident had side rails (includes half or quarter rails) used for R38, RN-D stated resident had two grab bars for mobility. On 2/9/16, at 4:45 p.m. during room observation bed was observed with two grab bars. R38 was lying on her back in bed. The right grab bar close to the door was observed very loose and could be moved one to two inches back and forth. In addition, the bolt portion of the grab bar was loose and moved around when the grab bar was touched. On 2/10/15, at 10:00 a.m. the right grab bar remained loose. When asked if she used the grab bar resident stated she did use it to turn side to side. On 2/11/16, at 12:42 p.m. when asked if resident used the grab bar for turning side to side when in bed during cares, nursing assistant (NA)-A stated "Yes." Surveyor and NA-A went to room and verified the grab bar was very loose. When asked if she had assisted resident during morning cares to get ready, NA-A stated therapy had assisted R38. When asked how maintenance was notified of any concerns, NA-A brought surveyor to the nursing station and showed surveyor a maintenance slip then indicated was going to fill one out.	2 830		

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2 830	Continued From page 25 -At 12:51 p.m. registered nurse (RN)-B stated resident used the grab bars to turn side to side during cares or when using a bedpan. When asked if she expected staff to report any concerns with the grab bar being loose, RN-B stated, "as a matter of fact I believe [RN-C] had filled a maintenance slip for the grab bar last week." On 2/11/16, at 1:03 p.m. occupational therapist (OT) stated she had assisted resident that day with morning cares. OT indicated resident was independent with activities of daily living and did get herself dressed as she was learning to do it supine when getting on pants using a Reacher. -When asked if resident used the grab bars, OT stated resident used them when rolling side to side and OT stated she but had not noticed if the right grab bar was loose. -When asked how staff reported concerns such as loose grab bar, OT stated would fill a maintenance slip and left it at the reception desk to be picked up. -When asked if she had assisted resident on 2/10/16, OT indicated she did however had not noticed the grab bar as she worked with resident from the left side by the window. OT further she was chatting at the same time writing notes and resident never said anything regarding the grab bar. -When asked if she would expect nursing staff to have reported the issue, OT stated "I would imagine but I think she is up during day" thought the question was hard to answer. As OT was talking to surveyor, PT joined on the conversation and stated she too had worked with her but had not noticed the loose grab bar because she also was working from the left side, as this was resident preferred side.	2 830		

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2 830	Continued From page 26 On 2/11/16, at 1:12 p.m. the environmental tour was conducted with the director of facilities (DOF), administrator and Intern. DOF verified the grab bar was loose. DOF stated would expect staff to put in a work order. Surveyor requested DOF to check for a slip regarding the grab bar filled by RN-C. On 2/12/16, at approximately 10:50 a.m. the administrator stated DOF had checked and there was no slip filled for the grab bar last week. On 2/12/16, at 11:14 a.m. when asked if she expected the staff to report, any concerns with resident care equipment such as grab bars; the director of nursing (DON) stated staff was supposed to report it to maintenance immediately. When asked if the care plan was supposed to identify the grab bars for mobility, DON stated if a resident used them to be independent, she would have expected care plan to mention the grab bars. R38's diagnoses included encounter for orthopedic aftercare following surgical amputation, unspecified systolic (congestive) heart failure and acquired absence of right leg above knee obtained from electronic medication record dated February 2016. R38's care plan dated 1/12/16, indicated resident was at risk for falls related to right leg above knee amputation and deconditioning as evidenced by balance instability. Care plan directed staff educate/instruct resident and family on safe use of assistive devices(s), remind resident not to bend over to pick up dropped items and encourage to use a grabber or to ask for assistance. The care plan did not address/identify R38 used grab bars for bed mobility.	2 830		

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2 830	Continued From page 27 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could train all staff and perform audits to ensure each resident is receiving appropriate nursing care and monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 890	MN Rule 4658.0525 Subp. 2 A Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide care and services including assessment and range of motion (ROM) for 1 of 3 residents (R73) reviewed for activities of daily living (ADLs) and contractures. As a result of these failures, R73 experienced atual harm, a decline in ROM of the	2 890	Corrected. No POC required.	3/23/16

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2 890	Continued From page 28 left upper extremity, Findings include: R73 was admitted to the facility on 5/13/10, and experienced a cerebral vascular accident (stroke) affecting the left side in October 2010, per the Admission Record. The facility failed to conduct assessment and provide ROM services to R73 to maintain functional ROM and prevent a decline in ROM. As a result R73 developed left upper extremity contractures (including shoulder, elbow, wrist and fingers). During interview on 2/9/16, at 7:25 p.m. registered nurse (RN)-F stated R73 had a contracture to his left hand, left side hemiparesis (weakness of the entire left or right side of the body) due to a previous stroke, and that the resident did not use any splints or receive any restorative ROM. On 2/9/16, at 4:49 p.m. R73 was observed sitting in a wheelchair in the common area at a table across from his room. R73's left arm was observed to rest firmly against his body with the left hand against his chest, wrist bent at approximately a 90 degree angle at the forearm, and three fingers on the left hand held firmly in a closed fist position. When requested at that time, R73 was unable to open his clenched left hand. There was no splint or rolled wash cloth in place in R73's left hand. On 2/10/16, at 3:08 p.m. R73 was observed to be in bed. R73's left arm rested against his chest with the elbow bent at an angle, and three fingers on the left hand were tightly clenched into a closed fist. There was no splint or rolled wash cloth in place in the R73's left hand.	2 890		

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2 890	Continued From page 29 R73 was observed during morning cares on 2/11/16, at 7:03 a.m. Nursing assistant (NA)-B was observed to attempt to pull R73's left arm away from his body enough so as to wash the resident's armpit. In addition, NA-B attempted unsuccessfully to put two different shirts on R73 before stopping cares to go get help. At approximately 7:15 a.m., NA-B and NA-D unsuccessfully attempted to put a shirt on R73 while he remained in bed. R73 fidgeted, grimaced, moaned and yelled "ouch" approximately six to eight times during cares especially when staff attempted to manipulate or move R73's left arm. Neither NA-B or NA-D attempted to provide any ROM services to R73 during morning cares. During interview on 2/11/16, at 7:12 a.m. NA-B confirmed R73 was very stiff and it was difficult to lift his left arm to wash his armpits, and to get him dressed. NA-B stated whenever she assisted with R73's cares, R73 always moaned and groaned during cares. On 2/11/16, at 9:40 a.m. LPN-C stated R73 had a ROM program, and the care plan directed staff to provide gentle ROM to upper and lower extremities as tolerated with morning and bedtime cares. LPN-C further explained the NAs were responsible for the completion of ROM, and the nurses were responsible to ensuring overall completion of all cares. LPN-C acknowledged she did not know how long R73's contractures had been present. At 10:23 a.m. on 2/11/16, R73 was observed sitting in a wheelchair in the common area at a table across from his room. A licensed practical nurse (LPN)-C unsuccessfully attempted to	2 890		

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2 890	Continued From page 30	2 890		

extend the fingers on R73's left hand to check the nail length and the condition of R73's palm. R73 moaned and yelled "ouch" when LPN-C attempted to extend his fingers. There was no splint or rolled wash cloth in place in the R73's left hand.

During additional interview with NA-B on 2/11/16 at 12:05 p.m., NA-B stated R73 did not receive any ROM services because ROM was not indicated in the Kardex/NA assignment sheet as an intervention.

During interview on 2/12/16, at 8:47 a.m. LPN-C stated the nurses were responsible for ensuring R73 had a rolled wash cloth placed in the palm of his left hand. LPN-C verified R73 had not had a wash cloth placed in the palm of his hand on 2/10/16 or 2/11/16. However when R73's treatment administration record (TAR) was reviewed at that time, it indicated LPN-C had documented the rolled wash cloth to the palm of R73's hand had been in place. LPN-C stated she had no explanation for the discrepancy.

R73 was observed to receive assistance with morning cares from NA-C on 2/12/16, at 9:05 a.m. R73 fidgeted and moaned whenever NA-C manipulated R73's left upper extremity to wash him, or to get him dressed. NA-C did not provide any ROM services to R73 during morning cares.

During interview on 2/12/16, at 11:00 a.m. the physical therapist (PT) stated she had just completed a ROM assessment for R73's upper left extremity. The PT confirmed R73 had contractures to the left upper extremity affecting the joints in the shoulder, elbow, wrist, hand and fingers. The PT further stated provision of ROM services, use of splint devices and/or use of a

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2 890	Continued From page 31	2 890		

rolled wash cloth to the palm, would usually helped prevent further decline in contractures.

During interview on 2/12/16, at 11:14 a.m. NA-C stated she had worked with R73 regularly for years. NA-C said R73 was very contracted on the left arm which made cares and dressing difficult, and stated R73 did not receive any special treatment for the contractures. At that time, NA-C reviewed the Kardex/NA assignment sheet. NA-C verified the Kardex did not direct staff to provide ROM services for R73. NA-C further stated she had never provided ROM services for R73.

An interdisciplinary progress note dated 11/10/11, identified the first documentation related to R73's contracture. The note indicated R73 had weakness to his left hand which looked contracted, and that hospice had been notified and would bring in a splint for R73 to use.

A significant change Minimum Data Set (MDS) assessment dated 1/18/11, indicated R73 had been discharged from hospice on 12/2/10, and was totally dependent on staff for personal hygiene, toileting, bathing, needed extensive assist with bed mobility, transfers and eating. The assessment further noted R73 utilized a splint to his left wrist because it was weaker secondary to his stroke. The record lacked evidence of any assessment related to the noted contracture on the left hand and wrist.

R73's care plan dated 1/5/16, indicated the resident had limited physical mobility related to a stroke with hemiplegia (paralysis of one side of the body). The goal indicated R73 was to remain free of complications related to immobility, including contractures. Care plan interventions

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2 890	Continued From page 32 indicated nursing staff were to "Provide gentle range of motion as tolerated to (L) [left] upper and lower extremities with a.m, (morning) and hs (bedtime) cares." R73's annual and quarterly MDSs from 10/20/10 to 10/18/12, indicated R73 had no functional limitation in ROM. However subsequent annual and quarterly MDSs, from 10/18/12 to 12/17/15, inconsistently identified R73 either had functional limitation in ROM on one side, or had no functional limitation in ROM. The annual MDS dated 7/8/15, and quarterly MDSs from 9/23/15 and 12/17/15, identified R73 had diagnoses including hemiparesis related to the stroke affecting the left side. Each of these MDSs indicated R73 was totally dependent on two staff with transfers and bed mobility, and had an impairment in ROM to one side, on the upper and lower extremity. The Care Area Assessments (CAA) for the annual MDS related to impaired ROM did not trigger for completion. A medical progress note dated 2/9/16, titled Communication/Visit with Physician, indicated a discussion had occurred with the nurse practitioner regarding a decline to a contracture on R73's left arm which had gotten slightly worse, and identified a goal to ensure comfort for R73. However, review of prior progress notes, including Geriatric Services of Minnesota Progress Notes (the progress notes from R73's primary physician and nurse practitioner), dated 6/16/15, 8/10/15, 8/11/15, 8/12/15, 10/11/15 and 2/9/15 failed to identify any medical assessment or discussion about R73's contractures. On 2/12/16, at 11:43 a.m. during a joint interview with RN-D and RN-F, they verified R73 had been admitted to the facility in May 2010 and had	2 890		

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2 890	Continued From page 33	2 890		

experienced a stroke in October 2010. They stated R73 had developed the contractures after the stroke. Neither RN-D or RN-F were able to state when the staff had first identified R73's contractures. RN-D reviewed the Kardex and verified the ROM program had not been included as care the NAs were to provide. RN-D acknowledged that was likely why R73 had not been receiving any ROM. RN-D reviewed R73's care plan and stated ROM services for R73 had first been identified on the care plan on 10/30/12, but that a "K" had not been checked next to the care intervention, therefore the ROM services had not transfered to the Kardex/NA assignment sheet as an intervention for the NAs to complete. RN-D and RN-F further explained they completed functional ROM assessments at the time of quarterly and annual MDSs. They said they were then responsible to update the care plan and ensure the interventions were included on the Kardex. However, both acknowledged they had not verified whether the ROM services for R73 had been included in the Kardex for NAs to complete. RN-D acknowledged R73's decline in functional ROM had occurred while he'd resided in the facility.

During interview on 2/12/16, at 12:06 p.m. the facility's director of nursing (DON) stated staff were expected to follow each resident's care plan and the nurse managers were to make sure that all appropriate cares were included on the Kardex/NA assignment sheets. The DON also stated the facility should do everything possible to prevent further decline for any resident who has contractures. The DON was unable to state when the facility staff had first identified R73's contractures. The DON acknowledged R73's decline in functional ROM could have been related to lack of assessments and failure to

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2 890	Continued From page 34 provide care such as rolled wash cloth and ROM services. An effort was made to call R73's primary physician on 2/16/16, at 3:00 p.m. Although a message was left for the physician, no return call was received. Assessments completed since R73's contractures and were first identified by the facility staff were requested but none were provided. The facility's RANGE OF MOTION Policy dated 9/12, indicated that based on the resident's comprehensive assessment, "the facility will ensure that a resident entering the facility without a limited range of motion will not experience reduction of motion unless resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. In addition, the facility will ensure that a resident with limited range of motion receives appropriate treatment and services to increase range of motion as much as possible and to prevent further decrease in range of motion." SUGGESTED METHOD OF CORRECTION: The facility could work with the QA Committee and therapy department to identify and develop programming for residents in need of range of motion services or those at risk for decline. The facility could develop systems to audit range of motion services for completion and report to the QA Committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 890		

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2 900	Continued From page 35	2 900		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions to prevent the development of pressure ulcers for 1 of 2 residents (R97) reviewed for pressure ulcers. Findings include: During an observation on 2/11/16, at 8:22 a.m. R97's morning cares were observed. R97 was lying in bed on her right side. R97's incontinent brief was saturated with urine and soiled with bowel. Following incontinent cares, R97 was noted to have a reddened coccyx area with a 1/2 inch long fissure that appeared to be open. During a subsequent observation of cares on	2 900	Corrected. No POC required.	3/23/16

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2 900	Continued From page 36 2/12/16, at 8:02 a.m. registered nurse (RN)-B assessed R97's skin. RN-B stated R97 had a stage one pressure ulcer (a non-blanchable erythema of intact skin, the heralding lesion of skin ulceration. In individuals with darker skin, discoloration of the skin, warmth, edema, induration, or hardness may also be indicators) on her coccyx. She described the pressure ulcer as "a little bit open." A review of Good Samaritan Society Specialty Care Community Medication Review Report indicated, on 3/24/15, an order was received to "monitor buttocks for worsening of maceration/skin breakdown." A Review on Good Samaritan Society Special Care Community Progress Notes dated 8/2/15 through 2/12/16, indicated R97 had a history of refusing repositioning at least daily. A Pressure Ulcer Care Area Assessment (CAA) dated 8/20/15, identified R97 was at risk for impaired skin integrity related to a need for assistance for mobility, and refused to lie down. The CAA indicated R97 had "no pressure areas but has been getting excoriated from incont [incontinence], refusals to lay down, chorea [an abnormal involuntary movement disorder] pelvic thrusts." Although the CAA indicated R97 was non-compliant with refusals to lie down, it did not include any alternate interventions to direct staff on how to relieve pressure if R97 refused to lie down. R97's care plan dated 9/4/15, indicated R97 had a self-care deficit, required assistance for all activities of daily living, and was incontinent of bowel and bladder. The care plan directed staff to provide incontinent cares every two hours and as	2 900		

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2 900	Continued From page 37 needed. The care plan did not address R97's risk for skin impairment or identify interventions to prevent skin breakdown. A care plan addressing skin was initiated after the surveyor identified the pressure ulcer on 2/12/16. R97's quarterly Minimum Data Set (MDS) dated 11/12/15, indicated she was severely cognitively impaired and required extensive assistance of two staff for bed mobility, transfers, dressing and toileting. A Progress Note dated 12/6/15, indicated R97's skin check indicated "skin is still reddened by sacral area, but this is not new." A noted dated 12/20/15, indicated "sacral area slightly pink." A Progress Note dated 12/26/15, indicated "the skin on res [resident] buttocks looks good, maceration is healing." A quarterly Nursing Note dated 1/11/16, indicated "red rash intermittent on buttocks...creams applied...encourage to reposition but often refuses." A Progress Note dated 1/16/16, indicated "skin breakdown on buttocks healing." A Progress Note dated 2/10/16, indicated R97 had some reddened areas at the right side of the gluteal fold indicating some "pressure points." While the facility assessments and progress notes indicated R97 had ongoing skin issues dating back several months and continual refusals of attempts to reposition, there were no further care planned interventions implemented to reduce the risk for skin breakdown. During an interview on 2/11/16, at 8:26 a.m. nursing assistant (NA)-D stated he did not know when R97 was last toileted or repositioned. He stated it was last done on the night shift but did not know what time. NA-D further stated he was unaware of any skin concerns regarding R97.	2 900		

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2 900	Continued From page 38 During an interview on 2/11/16, at 8:41 a.m. NA-E stated staff had a hard time getting R97 to lay down. NA-E stated R97 had redness to her coccyx on and off and it was "very ongoing." She stated staff use cream on R97's bottom and check on her every two hours. NA-E further stated when R97 sits in her chair, "all her pressure goes on her coccyx." NA-E stated she reported R97's open area to the nurse that day. During an interview on 2/11/16, at 12:43 a.m. licensed practical nurse (LPN)-B stated R97 had an ongoing treatment for her reddened coccyx that staff was applying cream to it. He further stated, "All the time the pressure is there." He stated R97 had a small area that was being monitored and "now it is better." During an interview on 2/12/16, at 7:38 a.m. RN-B stated, R97 did not have any skin concerns that she was aware of. RN-B further explained even though R97's treatment record directed staff to "monitor buttocks for worsening of maceration/skin breakdown" each shift, the nurse did not look at R97's bottom daily. She stated, "The trained medication aides (TMAs) look at it and report concerns to the nurse." During an interview on 2/12/16, at 8:58 a.m. RN-I stated R97 has had some "excoriation going on." She further stated R97's skin should be addressed in the care plan, but had not been. RN-I stated R97 refuses offloading, but staff continue to try. She also stated R97 had a pressure redistribution mattress in her wheel chair and on her bed but stated a specialized mattress and cushion had not been tried. RN-I stated R97 was toileted and repositioned every two hours at night but she did not know what	2 900		

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2 900	Continued From page 39	2 900		

times. She stated nurses should be doing a skin check at least weekly and documenting in a progress note, however, the medical record lacked evidence of weekly skin checks were completed for R97.

During an interview on 2/12/16, at 11:18 a.m. the director of nursing (DON) stated her expectation was R97's skin would have been monitored on a routine basis and with cares. She stated other interventions should have been initiated for R97 such as therapy and/or specialized mattress.

A facility policy labeled Care plan, dated February 2002 indicated, residents will receive and be provided necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The policy indicated "each resident will have an individualized comprehensive care plan that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing.....needs. The resident assessment instrument and review of the physician's orders, any problems, needs, and concerns identified will be addressed. This plan of care will be modified to reflect the care currently required/provided for the resident."

A facility policy titled Good Samaritan Society: Pressure Ulcers, dated September 2012, was reviewed. The policy indicated its purpose was to provide appropriate assessment and prevention of pressure ulcers as well as treatment when necessary. The policy indicated residents would receive appropriate assessments and services to promote and maintain skin integrity.

SUGGESTED METHOD OF CORRECTION: The Director of Nursing or her designee could develop

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2 900	Continued From page 40 policies and procedure to ensure residents have a comprehensive assessment of the risk for developing pressure ulcers so that individualized interventions could be implemented. The Director of Nursing or her designee could educate all appropriate staff on the polices and procedures related to pressure ulcers. The Director of Nursing or her designee could develop a monitoring system to ensure residents are assessed and receive interventions to prevent the development of pressure ulcers. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	2 900		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident received grooming assistance for nail care for 1 of 4 residents (R73) reviewed for activities of daily living (ADLs). Findings include: R73's nails were observed long and soiled on 2/9/16, at 4:48 p.m. and during subsequent days of the survey, 2/10/16 and 2/11/16.	2 920	Corrected. No POC required.	3/23/16

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2 920	Continued From page 41 On 2/9/16, at 4:48 p.m. R73's finger nails on both hands were observed to be long and untrimmed (approximately quarter [1/4] inch in length). On 2/10/16, at 3:08 p.m. R73 was observed in bed awake, R73's left arm rested against his chest, finger nails on both hands were observed to be long and untrimmed. R73 was observed during morning cares on 2/11/16, at 7:03 a.m. finger nails on both hands were observed to be long and untrimmed. On 2/11/16, at 10:23 a.m., R73 was observed sitting in a wheelchair in the common area at a table across from his room. Licensed practical nurse (LPN)-C verified R73's nails were long and dirty underneath. R73's quarterly Minimum Data Set dated 12/17/15, identified R73 required total physical assist of one staff with dressing and personal hygiene needs. The CAA for Cognitive Loss/Dementia dated 7/14/15, identified R73 with confusion, forgetfulness and inability to make decisions related to end stage dementia. The care plan dated 1/5/16, identified R73 needs assistance with ADL's due to dementia and cerebral vascular accident. Goal "will maintain current level of function in bed mobility, transfers, eating, dressing, toilet use and personal hygiene..." R73's Kardex (the facility nursing assistant assignment sheet) directed R73 required total assistance with personal hygiene cares. R73's Physician Order Summary Report dated 2/12/16, revealed diagnoses included cerebral vascular accident (stroke), hemiparesis	2 920		

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2 920	Continued From page 42 (weakness of the entire left or right side of the body) and dementia. On 2/11/16, at 12:49 p.m. the trained medication aide (TMA)-F stated R73's nails were approximately quarter (1/4) inch in length. On 2/11/16, at 10:23 a.m. LPN-C stated NAs were responsible for nail care weekly on bath days and nurses are responsible to ensure it was completed. LPN-C further stated nursing assistant are to report to the nurse any time a resident refuses nail care and nurses document in the resident's record the refusals. LPN-C reviewed R73's medical record and did not find any documentation of refusals of nail care by R73. LPN-C reviewed R73's medical record and verified R73 was scheduled for a bath on 1/31, 2/3, 2/7 and 2/10/16. On 2/11/16, at 2:00 p.m. the unit's nurse manager, registered nurse (RN)-D stated she expected staff to have resident's nail care done once a week with shower/bath and if not able to be completed, the nursing assistant was expected to let the nurse know. RN-D further stated she expected nurses to document on resident's medical record whenever nail care was not completed. The nail care/ADLs/personal hygiene policy was requested but not provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could monitor for compliance with all direct care staff in providing resident assessed need for nail care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 920		

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2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed for check placement of the gastrostomy tube (G-tube) prior to administration of medication for 2 of 4 residents (R77, R2). Findings Include R77's quarterly Minimum Data Set (MDS) dated 12/23/15, identified R77's cognition was assessed by staff and his memory was ok. MDS further identified R77 was totally dependent on staff for all activities of daily living (ADLs), required a feeding tube and had diagnoses of multiple sclerosis (MS), aphasia, anxiety and depression. R77's Care Area Assessment (CAA) dated 4/21/15, identified R77 received tube feedings related to stroke and poor oral intake, and	2 930	Corrected. No POC required.	3/23/16

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2 930	Continued From page 44 precautions were taken to prevent aspiration. R77's care plan printed 2/11/16, identified R77 had end-stage MS and history of stroke. The care plan further identified R77 required a tube feeding to meet nutrition and hydration needs and R77 had no desire to eat or drink anything by mouth. R77 was to be free of side effects or complications related to tube feeding. The Medication Review Report dated 2/11/16, staff was to change the G-tube as needed if plugged or leaking and that all oral medications were to be administered by g-tube. On 2/11/16, at 7:29 a.m. registered nurse (RN-A) was observed crushing R77's individual medications R77's and emptied each crushed medication into its own 30 milliliter (ml) medication cup. RN-A proceeded to fill each medication cup to the top with water and stirred each medication with a separate plastic white spoon. RN-A then removed the cap from R77's gastric tube, inserted syringe into the tube and poured the fist medication in water into the syringe without first checking placement. RN-A added 30 ml water to the syringe after each medication and provided a total of 460 ml's of water plus a protein supplement during the course of the medication administration. RN-A stated she thought tube placement was to be checked weekly, but was not sure. She stated she was not sure when R77's tube placement had been checked, but stated she felt placement was checked in a sense several times a day because if it was not placed right, it would not work. RN-A stated she does not necessarily check tube placement every time before she administers medications, and did not instill air into	2 930		

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2 930	Continued From page 45 the tube to confirm placement. She stated she usually checks to see if it was working by adding a little bit of water to the syringe and if it drains she felt it was working. On 2/11/16, at 12:59 p.m. during follow-up interview RN-A stated the tube placement checking process is when you instill air and use a stethoscope to listen for gurgling to confirm placement. She stated she thought the night nurse who started R77's g-tube feeding should check the placement. She stated it was possible she was told at one point to check the tube placement before administering medications, but could not remember. She confirmed she did not check the placement of R77's tube today before medication administration. On 2/11/16, at 1:08 p.m. unit manager (UM)-A stated she expected the nurses to check tube placement first, and every time before they put anything in the tube. She stated she she would expect the nurses to blow air into tube and use a stethoscope to make sure the tube was where it should be and aspirate stomach contents, assess the contents and put back in. UM-A stated adding water and watching to see if it drains was not acceptable for checking tube placement. R2's diagnoses listed on the February 2015, Physician Orders included persistent vegetative state, neuromuscular dysfunction, tracheostomy, gastro esophageal reflux disease and convulsions. R2's care plan printed 2/12/16, identified R2 was in persistent vegetative state and unable to tolerate oral intake safely. The care plan further identified R2 required a tube feeding to meet	2 930		

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2 930	Continued From page 46 nutrition and hydration needs. R2 was able to tolerate tube feeding and water flushes. During medication administration observation and enteral feeding via R2's G-tube on 2/9/16, from 6:49 p.m. until 7:02 p.m. licensed practical nurse (LPN)-D was observed to flush the G-tube with 10 cubic centimeters (cc) of water without first checking placement. LPN-D then continued to administer medications via gravity through a syringe. After administering medications LPN-D flushed the G-tube with 100 cc of water and connected R2's Jevity 1.2 (a calorically dense nutritional formula for tube feeding) and turned on the tube feeding machine infused at 85 mls/hour. On 2/9/16, at 7:02 p.m. LPN-D acknowledged that he did not check the G-tube placement. LPN-G verified G-tube placement should have been checked before giving the medication and connecting the tube feeding for infusion. LPN-D stated the facility's policy required checking placement whenever giving meds and checking residuals prior to administration of G-tube feeding. Medication Administration Via Tube procedure dated 11/2013, identified the facility would administer medications through a gastric tube in a safe and appropriate manner. The policy instructed staff to: "3. Check tube placement and patency a. Observe for change in external length of the tube by determining whether the mark placed at the tubes exit site has moved. b. Remove cap from feeding tube and inject 5 -10 ml of air through the tube to clear the tube. Aspirate gastric contents to be sure the tube is in the stomach. c. Check the pH of the gastric contents and	2 930		

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2 930	Continued From page 47 refer to pH strip for exact values." SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have the placement of the tube feeding properly checked and medications are administered separately. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21565	MN Rule 4658.1325 Subp. 4 Administration of Medications Self Admin Subp. 4. Self-administration. A resident may self-administer medications if the comprehensive resident assessment and comprehensive plan of care as required in parts 4658.0400 and 4658.0405 indicate this practice is safe and there is a written order from the attending physician. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete self-administration of medication assessments and ensure safe administration of nebulizer and inhalers medications for 2 of 2 residents (R122, R74) who self-administered medication. Findings include: R122's medication administration was observed on 2/11/16, at 8:44 a.m. registered nurse (RN)-A	21565	Corrected. No POC required.	3/23/16

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21565	Continued From page 48	21565		

entered R122's room, assessed R122's lung sounds and heart rate. RN-A emptied the Duo-neb vial into nebulizer (a medication delivery system that administers medication in a mist that is inhaled into the lungs) cup. RN-A attached the nebulizer cup to face mask and RN-A applied the nebulizer mask to R122 and left room. At 8:51 a.m. RN-A returned and look into R122's room. The nebulizer was still running. R122 was lying in bed with the head of the bed elevated and mask on face. Nebulizer was still running. At 8:59 a.m. RN-A entered room removed face mask and turned off the nebulizer. There was no medication left in the cup. After washing the nebulizer cup, RN-A checked R122 lung sounds and heart rate.

The Cognitive Care Area Assessment (CAA) dated 9/15/15, was triggered information on the 9/3/15, annual MDS indicated R122 had severely impaired cognition, verbal and physical behaviors, rejection of cares and wandered one to three times during the assessment reference period. The CAA also indicated resident had Parkinson's and dementia with the overall objective of addressing cognition on the care plan to minimize risks to R122.

R122 quarterly Minimum Data Set (MDS) dated 11/26/15, indicated R122 was severely cognitively impaired, requires assistance with all ADL's including eating. R122's diagnoses on quarterly MDS included dementia, Parkinson's, depression, and respiratory failure.

R122's care plan printed 2/12/16, did not address self-administration of any medications.

R122's Medication Review Report dated 2/12/16, included DuoNeb solution 0.5 to 2.5 (3) milligrams/3 milliliters (a medication that improves

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21565	Continued From page 49 breathing), one vial inhale orally three times a day for shortness of breath. The staff were to document the pulse and lung sounds pre- and post-administration and record the total time nursing spent with resident. There was no order for self-administration of medications was on the medication review report. Review of the medical record did not include evidence of an assessment related to R122's ability to self-administer medications. During interview on 2/12/16, at 9:12 a.m. RN-J stated, "No, they [the nurses] should be staying in there with him because he could pull it [the mask] off. That is what our procedure is. Nobody gives their own medications up here." RN-J verified R122 did not have a self-administration of medication assessment, care plan or order. During interview on 2/12/16, at 10:52 a.m. pharmacist said, "If the resident does not have an order for self-administration of nebs [neb treatments] the staff should administer the neb medication or get an order for self-administration. Before getting the order they do need to do an assessment to make sure it is safe for them [the resident] to self-administer the neb." Procedure Nebulizer revised 9/15, instructed staff: "If resident is cognitively impaired, stay with the resident during the treatment." Procedure Resident Self-Administration of Medication Revised 7/14, instructed staff: "1. Complete the Resident Self-Administration of Medications UDA (user defined assessment) to determine if the resident can safely administer medications and to create a plan to assist the resident to be successful in this process.... 6. The interdisciplinary team's determination that	21565		

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21565	Continued From page 50 the resident can safely self-administer medications must be documented in the medical record... 7. A physician's order must be obtained prior to the resident self-administering medications. The order must be specific to the medications being self-administered... 8. The care plan must indicate which medications the resident is self-administering, where they are kept, who will document the medication and the location of the administration, if applicable..." R74's medication administration was observed on 2/12/16, at 7:32 a.m. The trained medication aide (TMA)-B gave R74 a Proair 90 mcg (microgram) inhaler without shaking the inhaler. TMA-B did not give any instructions to R74 and turned back toward Electronic Medication Administration Record. R74 inhaled one puff and gave inhaler back to TMA. R122 did not breathe out deeply before taking a puff from the inhaler or hold breath for 10 seconds after taking a puff. R74's care plan revised 10/8/13, indicated "The resident has impaired cognitive function/ dementia or impaired thought processes R/T [related to] Huntington's Disease E/B [evidence by] needs assistance with decision making. Wife assists with all decision making. Res. [resident] does not self-administer medications." R74's quarterly MDS dated 11/5/15, indicated R74 was cognitively intact, able to understand others, requires supervision with eating, dressing and hygiene. R74's diagnoses on quarterly MDS included dementia, Huntington's, depression, and asthma. R74's Medication Review Report dated 2/12/16, included Albuterol Sulfate HFA aerosol solution	21565		

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21565	Continued From page 51 108 (90 Base) MCG one dose inhale orally in the morning for shortness of breath/wheeze. There was no order for self-administration of medications was on the medication review report. The review of the medical record did not include evidence of an assessment related to R74's ability to self-administer medications. During interview on 2/12/16, at 9:19 a.m. RN-I said we would assess if it is appropriate for a resident to self-administer their own medications including inhalers. "Up here it would be a real stretch, [R74] is here because of his lack of medication set up. I would expect that the inhaler would be handed to a resident. If I know the resident I do not necessarily repeat the instructions." RN-I verified R74 did not have a self-administration of medication assessment, order or care plan. During interview on 2/12/16, at 9:25 a.m. TMA-B said, "Yes for the inhaler [R74] does have a self-administration order. If they [residents] do not have an order I would tell the resident what to do, open mouth, use one puff or two puffs." TMA-B verified turning back to the medication drawer before resident used the inhaler. During interview on 2/12/16, at 10:52 a.m. pharmacist said, "They (the nurse) should be shaking inhalers before administering the inhaler. If a resident does not have an order for self-administration of inhalers staff should administer the inhaler. They need to hold the inhaler. Before getting the order the facility staff do need to do an assessment to make sure it is safe for the resident to self-administer the inhaler." Procedure Inhalant Medication Metered Dose	21565		

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21565	Continued From page 52 Inhalers revised 9/15, instructed staff: "3. Have resident sit up if condition permits or elevate head of bed 30 to 45 degrees. 4. Listen to breath sounds and observe respiratory pattern. 5. Shake the container well. 6. Remove the mouthpiece cover and position canister upright (nozzle down). 7. Spacers are often used in the elderly when there is Trouble coordinating the actuation of the canister with inhalation; ass the spacer if indicated. 8. Instruct resident to take a deep breath and the exhale completely. Have him or her place the mouthpiece in his or her mouth and close his or her lips around the mouthpiece. 9. As you firmly push the device ask the resident to inhale slowly and to continue inhaling until his or her lungs feel full. 10. Ask the resident to try to hold breath for several seconds to help medications reach deep into lungs. Ask resident to exhale out as slowly as possible through pursed lips." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee ensure the appropriate assessments are conducted to ensure the safe administration of medications. The DON could ensure the staff were educated on the importance of the assessment process. The DON or designee could randomly audit resident records to ensure adequate monitoring and documentation was in place. The DON could could random audits to ensure medication is not left with residents unless deemed safe by the interdisciplinary team. Results of these audits could then be presented at the quarterly QA&A meetings. TIME PERIOD FOR CORRECTION: Twenty-one	21565		

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21565	Continued From page 53 (21) days.	21565		
21630	MN Rule 4658.1350 Subp. 2 A.B. Disposition of Medications; Destruction Subp. 2. Destruction of medications. A. Unused portions of controlled substances remaining in the nursing home after death or discharge of a resident for whom they were prescribed, or any controlled substance discontinued permanently must be destroyed in a manner recommended by the Board of Pharmacy or the consultant pharmacist. The board or the pharmacist must furnish the necessary instructions and forms, a copy of which must be kept on file in the nursing home for two years. B. Unused portions of other prescription drugs remaining in the nursing home after the death or discharge of the resident for whom they were prescribed or any prescriptions discontinued permanently, must be destroyed according to part 6800.6500, subpart 3, or must be returned to the pharmacy according to part 6800.2700, subpart 2. A notation of the destruction listing the date, quantity, name of medication, prescription number, signature of the person destroying the drugs, and signature of the witness to the destruction must be recorded on the clinical record. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, facility failed to ensure expired medications were properly disposed off for 3 of 6 units. In addition, the facility failed to ensure 1 of 6 medication refrigerators was kept clean and sanitary.	21630	Corrected. No POC required.	3/23/16

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21630	Continued From page 54 Findings include: Bluff Country medication room: During observation of the Bluff Country medication room on 2/11/2016, at 9:40 a.m. an open multi dose vial of influenza (flu) vaccine was located in the medication refrigerator. The vial was dated as having been opened 10/7/15, the licensed practical nurse (LPN)-C stated multi dose flu vaccine vials are good for 30 days once opened. LPN-C verified date vial was opened on 10/7/15, and that it was greater than 30 days. In addition the top shelve of the refrigerator was noted with pinkish-whitish stains. LPN-C verified that the refrigerator was not kept clean and sanitary. LPN-C further stated the nurses on night shift were supposed to be cleaning the refrigerator and freezer once a week. During interview on 2/12/16, at 11:55 a.m. the unit's nurse manager, registered nurse (RN)-D stated she expected medications to be properly disposed off when expired and the refrigerator to be kept clean and sanitary. Boundary Waters medication room on the third floor: During observation of the Boundary Waters medication room on 2/12/16, at 6:56 a.m. an open bottle of milk of magnesia (MOM-a medication for constipation) was noted to have expired on 10/15. RN-E verified the MOM had expired in October of 2015. RN-E was unable to say who had received the MOM but that it most likely had been used after it had expired.	21630		

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21630	Continued From page 55 Arrowhead medication room on the third floor: During observation of the Arrowhead medication room on 2/12/16, at 7:11 a.m. an open multi dose vial of influenza (flu) vaccine was located in the medication refrigerator. The vial was dated as having been opened 10/23/15. RN-E stated multi dose flu vaccine vials are good for 30 days once opened. RN-E verified date vial was opened and that it was greater than 30 days ago. Lakes medication room on the second floor: During observation of the Lakes medication room on 2/12/16, at 7:58 a.m. a bottle of Calcium 600+D was noted to have expired 9/15. The bottle was dated "open 1/23/15." Trained medication aide (TMA)-C verified the bottle of Calcium 600 +D was expired. TMA-C said "I do not know who is responsible to check that here are no expired medications in the med room, but whenever you take a bottle or give a medication, the person doing so, checks the expiration date at that time. I will leave it on the counter and let the nurse know." During interview on 2/12/16, at 9:05 a.m. RN-J, nurse manager, said the nurses check the medication rooms for expired medications and the TMA's check the medication cards when they pull them. When asked how long was an open vial of flu vaccine good for RN-J replied "30 days I believe." RN-J said, "I gave flu vaccine in October of 2015. I am sure no one received the flu vaccine after it expired." RN-J verified the same vial of influenza vaccine would have been used by both Arrowhead and Boundary Waters unit because the nurse went between both units. RN-J said, "(RN-A) told me she found an expired influenza and was going to get rid of it. I thought it had been thrown away."	21630		

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21630	Continued From page 56 Requested list of vaccine dates for all residents on both third floor units. Did not receive from facility. Immunization records in the electronic health record reviewed for all residents residing on the first or third floor. One resident was identified by record review as currently residing in the facility and who received a influenza vaccine after the expiration date on the vial located in the Arrowhead medication room. Admission Record dated 2/12/16 for R223 indicated R223 was admitted to the facility on 12/2/15, to a room on third floor. Immunization Reportdated 2/12/16, indicated R223 recieved the influenza vaccine on 12/3/15, from RN-A. Acquisition, Receiving, Dispensing and Storage of Medications Procedure Revised 12/15, instructed staff: "4. Medications will be stored in a locked medication cart, drawer or cupboard.... 5. The location will routinely check for expired medications and necessary disposal will be done in accordance with state/Pharmacy regulations. 6. All medications will be stored in accordance with manufacturers' recommendations. Refer to Recommended Minimum Medication Storage Parameters and Insulin Storage Recommendations in this manual. 7. ...Refer to Vaccination Handling and Storage Parameters for specific storage of vaccinations." Vaccine Handling and Storage Parameters revised 12/15, instructed staff: "A weekly review of vaccine expiration dates and rotation of vaccine stock should be done." SUGGESTED METHOD OF CORRECTION: The director of nursing and pharmacist could educate	21630		

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21630	Continued From page 57 staff in the disposal of expired medications and monitor for the medication for cleanliness. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21630		
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 review, the facility failed to ensure 1 of 2 residents (R37) wheelchair was maintained in good repair reviewed for environmental concerns. Findings include: On 2/9/16, at 4:13 p.m. during resident room observation, the Broda wheelchair (specialized wheelchair) handles were observed wrapped with peeling black electrical tape around the gray porous foam type of material. In addition, the pink vinyl covering on the wheelchair frame to the left back was observed ripped exposing the mesh cloth underneath not making it a cleanable surface. When asked about the porous foam and electrical tape that was peeling exposing the adhesive part, trained medication aide (TMA)-A stated it was wrapped to protect the environment,	21685	Corrected. No POC required.	3/23/16

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21685	Continued From page 58	21685		

such as the walls to prevent gouges. TMA-A verified the concerns and stated tore up pink vinyl was due to being hit on the edges of the door jam.

On 2/11/16, at 1:20 p.m. the environmental tour was conducted with the director of facilities (DOF), administrator and intern. DOF brought the wheelchair out of the room both him and the administration verified the tape was peeling and was exposing the foam underneath making it not a cleanable surface. In addition, both verified the tore up vinyl on the side. When asked who checked the W/C's to make sure they were in good repair, the administrator stated staff was supposed to put a work order and the chairs were looked at by therapy.

R37's quarterly Minimum Data Set (MDS) dated 1/14/16, indicated R37 had severely impaired cognition, required extensive physical assistance of one staff with transfers from bed to wheelchair, un-steady and used a wheelchair for mobility.

R37's care plan dated 10/6/14, indicated resident had limited physical mobility related to cerebrovascular accident (CVA) with hemiplegia, supranucular palsy as manifested by altered standing and sitting balance and gait disturbance. Care plan indicated resident used a Broda chair with front side and rear tip bars bilateral thigh positioning device.

Wheel Chair and Walker Cleaning Procedure revised 3/2013, directed staff, "All chairs and walkers requiring repair will be identified and work orders will be filled out and distributed for repair."

SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could

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21685	Continued From page 59 develop a maintenance program to ensure damaged walls and wheelchairs are repaired to maintain a safe, clean, homelike environment. The DON or designee could educate all appropriate staff on the program, and could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) Days.	21685		
21810	MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, facility failed to ensure 1 of 1 resident's (R252) call light was in reach for a resident who was capable of using the call light. Findings include: On 2/10/16, at 10:41 a.m. during interview R252 asked surveyor for help locating the call light. At 10:42 a.m. the licensed practical nurse (LPN)-A entered R252's room, located the call light and handed the call light to R252. The call light was	21810	Corrected. No POC required.	3/23/16

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21810	Continued From page 60 observed on the night stand that was located behind R252 and not within reach. On 2/10/16, at 10:43 a.m. LPN-A verified R252 was able to use call light and call light was not within reach. LPN-A stated all call lights should be within reach for residents who were capable of using call lights. On 2/10/16, at 10:44 a.m. nursing assistant (NA)-A stated R252 was capable of using call light. R252's fall care plan dated 2/9/16, indicated R252 was at risk for falls related to partial amputation of right foot due to osteomyelitis as evidenced by deconditioning and gait/balance problems. The goal was noted to be "Resident will be free of falls through the review date." The care plan directed staff to remind resident not to bend over to pick up dropped items. Encourage to use grabber or to ask for assistance. The care plan did not address call light accessibility even though it directed staff to encourage to ask for assistance. On 2/11/16, at 2:00 p.m. registered nurse (RN)-D, the Prairie unit nurse manager, stated the expectation was call lights should be within reach of residents capable of using them. - At 1:11 p.m. during the environmental tour the administrator stated, "Yes" when asked if the call light was supposed to be in reach for residents who was capable of using a call light. The facility's call light policy dated 9/12, directed staff to ensure that a resident has a method of calling for assistance and further directed staff to place call light with reach of a resident. SUGGESTED METHOD OF CORRECTION: The	21810		

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21810	Continued From page 61 director of nursing or designee could review and / or revise policies and procedures for ensuring appropriate table height for all residents. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21810		