DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART 1 - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID:	BZJW
Eng	1ity ID: 00000

	IAKI I-	TO BE COMIT	DETED DI	IIIE SIAI	ESURVETAGENCI		racinty ID. 00090
1. MEDICARE/MEDICAID PROVID NO.(L 1) 245279	DER	3. NAME AND AI (L3) GOOD SAM			PECIALTY CARE COMMU	4. TYPE OF ACTIO	ON: 7 (L8) 2. Recertification
2. STATE VENDOR OR MEDICAL	NO.	(L4) 3815 WEST	BROADWAY			3. Termination	4. CHOW
(L 2) 138218700		(L5) ROBBINSD	ALE, MN		(L6) 55422	5. Validation 7. On-Site Visit	6. Complaint9. Other
5. EFFECTIVE DATE CHANGE OF	OWNERSHIP	7. PROVIDER/SU	JPPLIER CATEO	GORY	<u>02</u> (L7)	8. Full Survey Afte	r Complaint
(L9)		01 Hospital	05 HHA	09 ESRD	13 PTIP 22 CLIA	6. Full Survey Afte	r Compianit
6. DATE OF SURVEY 03/3	31/2016 (L34)	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR END	ING DATE: (L35)
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC		ING DATE. (L33)
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/31	
11LTC PERIOD OF CERTIFICATIO	N	10.THE FACILITY	IS CERTIFIED	AS:			
From (a):		A. In Complia	ance With		And/Or Approved Waivers Of	The Following Requirem	nents:
To (b):		~	equirements		2. Technical Personnel	6. Scope of S	ervices Limit
		Compliance	e Based On:		3. 24 Hour RN	7. Medical D	irector
12. Total Facility Beds	96 (L18)	1. A	cceptable POC		4. 7-Day RN (Rural SN	VF) 8. Patient Roo	om Size
13.Total Certified Beds	96 (L17)	X B. Not in Con	nnliance with Pro	aram	5. Life Safety Code	9. Beds/Room	1
13. Total Certified Beds) (E17)		and/or Applied	0	* Code: A	(L12)	
14. LTC CERTIFIED BED BREAKDO	OWN				15. FACILITY MEETS		
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)	
96							
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	IARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	APPROVAL	Date:
Rebecca Wong, HFE N	E II		04/04/2016	(L19)	Kamala Fiske-Downing, En	nforcement Specialist	05/04/2016 _(L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
19. DETERMINATION OF ELIGIBI			MPLIANCE WIT	H CIVIL	 Statement of Final Ownership/Control 	ncial Solvency (HCFA-25 ol Interest Disclosure Stm	
1. Facility is Eligible to	Participate				3. Both of the Above	e:	
2. Facility is not Eligible	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREE!	MENT	26. TERMINATION ACTION:	:	(L30)
OF PARTICIPATION	BEGINNING	DATE	ENDING DA	TE	VOLUNTARY 00	<u>INVOLU</u>	NTARY_
04/01/1985					01-Merger, Closure	05-Fail to	Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburse	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS	(E23)		03-Risk of Involuntary Termination	on OTHER	
23. EIC EXTENSION DATE.		n of Admissions:			04-Other Reason for Withdrawal	· · · · · · · · · · · · · · · · · · ·	ler Status Change
	71. Suspension	i or ramissions.	(L44)			00-Active	-
(L27)	B. Rescind St	uspension Date:	,				
			(L45)				
28. TERMINATION DATE:	29	. INTERMEDIARY	/CARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	N OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APPI	ROVAI	
	(L32)			(233)	DETERMINATION AT I	INO VAL	



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697



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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Health Regulation Division

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Good Samaritan Society - Specialty Care Community April 4, 2016 Page 2

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION			DATE OF REVISIT	ī
IDENTIFICATION NUMBER	A. Building **PI	ease note this form has been revis	ed to reflect		
245279 _{Y1}	B. Wing a cl	ange in the Correction Completed	Date. Y2	3/31/2016	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STAT	E, ZIP CODE		
GOOD SAMARITAN SOCIETY	- SPECIALTY CARE COMMU	IITY 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).

ITE	М	DATE	ITEM			DATE	ITEM			DATE
Y4		Y5	Y4			Y5	Y4			Y5
ID Prefix	F0176	Correction	ID Prefix F	0221		Correctir .	ו∟ ?refix	F0246		Correction
Reg. #	483.10(n)	Completed	Reg. #	33.13(a)	Craplet '	Reg :	483.15(e)(1)		Completed
LSC		03/23/2016	LSC _			03/23/2 16	٦C			03/23/2016
ID Prefix	F0253	Correction	ID Prefix F	0278		Con on	ID Prefix	F0279		Correction
Reg. #	483.15(h)(2)	Completed	Reg. #	33.20(á, - (ì)	ompleted	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 . efix Fo	030ა		Correction	ID Prefix	F0312		Correction
Reg. #	483.20(k)(3)(ii)	Completed	, g, 48	33.25		Completed	Reg. #	483.25(a)(3)		Completed
LSC		03/23/2′ ،6	LSC			03/23/2016	LSC			03/23/2016
ID Prefix	F0314	Correctic	ID Prefix F	0318		Correction	ID Prefix	F0322		Correction
Reg. #	483.25(c)	Completed	Reg. # 48	33.25(e)(2)	Completed	Reg. #	483.25(g)(2)		Completed
LSC		03/23/2016	LSC _			03/23/2016	LSC			03/23/2016
ID Prefix		Correction	ID Prefix F			Correction	ID Prefix			Correction
Reg. #	483.25(h)	Completed	Reg. #	33.60(b), (d), (e)	Completed	Reg. #			Completed
LSC		03/23/2016	LSC			03/23/2016	LSC			
REVIEWE		REVIEWED BY (INITIALS)	DATE		SIGNATURE OF	SURVEYOR			DATE	
STATE AC	GENCY 🗀	GD/kfd	05/02/20	016		3095	1		03/3	1/2016
REVIEWE CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE		TITLE				DATE	
FOLLOW 2/12/201		Y COMPLETED ON		_	ANY UNCORRECTED DEFICIENCI	_			☐ YE	s 🗆 no

Completed

Correction

Completed

Correction

Completed

Correction

Completed

REVIEWED BY

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

DATE

LSC

LSC

LSC

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

REVIEWED BY

STATE AGENCY

LSC

LSC

LSC

LSC

		POST-0	CERT	IFICATIO	N REVISIT F	REPORT			
	ER / SUPPLIER / CLIA / ICATION NUMBER	MULTIPLE CON A. Building 02 B. Wing		-			Y2	DATE OF RE\ 3/29/2016	
NAME O	NAME OF FACILITY GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422								Y3
program correcte provisio	n, to show those deficed and the date such	encies previously corrective action	y reported was accor	on the CMS-256 nplished. Each c	Medicaid and/or Clinica 7, Statement of Defic deficiency should be fi the CMS-2567 (prefix	iencies and Plan of ully identified using	Correct either the	tion, that have ne regulation o	or LSC
ITE	EM .	DATE	ITEI	М	DATE	ITEM		DAT	E
Y4	ļ	Y5	Y4		Y5	Y4		Y5	5
ID Prefix		Correction	ID Prefix	«	Correction	ID Prefix		Corre	ection
Reg. #	NFPA 101	Completed	Reg. #	NFPA 101	Completed	Reg. #		Com	pleted
LSC	K0050	03/23/2016	LSC	K0144	03/23/2016	LSC			
ID Prefix		Correction	ID Prefix	(Correction	ID Prefix		Corre	ection

Completed

Correction

Completed

Correction

Completed

Correction

Completed

SIGNATURE OF SURVEYOR

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

ID Prefix

Reg. #

LSC

LSC

LSC

LSC

Completed

Correction

Completed

Correction

Completed

Correction

Completed

DATE



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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

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									
	ER / SUPPLIER / CLIA / CATION NUMBER	MULTIPLE CON A. Building B. Wing	*	**Please note	this form has b			DATE OF REVISIT 3/31/2016 y3		
NAME OF	13									
correctiv identifica	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).									
ITE	М	DATE	ITEM	1	DATE	ITEM		DATE		
Y4		Y5	Y4		Y5	Y4		Y5		
ID Prefix	ID Prefix 20510 Correction ID Prefix 20560 Correction ID Prefix 20565							Correction		
Reg. #	MN Rule 4658.0300 Subp. 2	Completed	Reg. #	MN Rule 4658.04 Subp. 2	05 Completed	Reg. #	MN Rule 4658.04 Subp. 3	Completed		
LSC		03/23/2016	LSC		03/23/2016	LSC	-	03/23/2016		

Page 1 of 1 EVENT ID: BZJW12

			STAT	TE FORM: REV	ISIT REPORT				
_	ER / SUPPLIER / CLIA / ICATION NUMBER	MULTIPLE CON	NSTRUCTIO	ON				DATE OF RE	VISIT
00890	Y	D Wing					Y2	3/31/2016	Y3
NAME O	F FACILITY				STREET ADDRESS, (CITY, STATE	, ZIP CODE		
GOOD	SAMARITAN SOCIET	Y - SPECIALTY (CARE COM	VIIVIOIVIII	3815 WEST BROADV				
					ROBBINSDALE, MN 5	55422			
	\	,		barvey rieport (pre	efix codes shown to	ine leit of e	acii requiremen	t on the surve	У
report fo	,	DATE	ITEN		DATE	ITEM	acii requiremen	DA	
	· ·		_			1	acti requiremen		ΓE
ITE Y4	· M	DATE Y5	ITEN Y4	1	DATE Y5	ITEM Y4		DA `	ΓΕ
ITE	20510	DATE	ITEN	20560	DATE Y5 Correction	ITEM	20565	DA' Y Corr	ΓE
ITE Y4	· M	DATE Y5	ITEN Y4	1	DATE Y5 Correction	ITEM Y4		DA' Y Corr	rE 5 rection
ITE Y4	20510 MN Rule 4658.0300	DATE Y5 Correction	Y4 ID Prefix	20560 MN Rule 4658.040	DATE Y5 Correction	ITEM Y4 ID Prefix	20565 MN Rule 4658.04	Corr	ΓΕ
ITE Y4 ID Prefix Reg. #	20510 MN Rule 4658.0300 Subp. 2	DATE Y5 Correction Completed	ITEN Y4 ID Prefix Reg. #	20560 MN Rule 4658.040 Subp. 2	DATE Y5 Correction Completed	ITEM Y4 ID Prefix Reg. #	20565 MN Rule 4658.04 Subp. 3	DA' Y Corr 405 Com 03/3	rE 5 rection

POST-CERTIFICATION REVISIT REPORT

	MULTIPLE CONSTRUCTION A. Building			DATE OF REV	/ISIT
	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).

ITE Y4		DATE Y5	ITEM Y4		DATE Y5	ITEM Y4			DATE Y5
ID Prefix		Correction	ID Prefix F022		Correction	ID Prefix	-		Correction
Reg. #	483.10(n)	Completed	Reg. #	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 F027	78	Correction	ID Prefix	F0279		Correction
Reg. #	483.15(h)(2)	Completed	Reg. # 483.2	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 F030	09	Correction	ID Prefix	F0312		Correction
Reg. #	483.20(k)(3)(ii)	Completed	Reg. #	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 F03	18	Correction	ID Prefix	F0322		Correction
Reg. #	483.25(c)	Completed	Reg. #	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 483.25(h)	Correction	ID Prefix F043	31 60(b), (d), (e)	Correction	ID Prefix			Correction
Reg. #	403.23(11)	Completed	Reg. #	50(b), (d), (e)	Completed	Reg. #			Completed
LSC		03/31/2016	LSC		03/31/2016	LSC			
REVIEWI STATE A		REVIEWED BY (INITIALS) GD/kfd	DATE 4/4/2016	SIGNATURE (OF SURVEYOR	951		DATE 03/3	31/2016
REVIEWI CMS RO	ED BY	REVIEWED BY (INITIALS)	DATE	TITLE				DATE	
FOLLOW 2/12/201		COMPLETED ON			RECTED DEFICIEN NCIES (CMS-2567)		IE EAGULIEVO	☐ YES	в 🗆 по

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: BZJW Facility ID: 00890

		TO DE COMIT			E SCH (ET HOEL (CT		raemey 15. 00090
MEDICARE/MEDICAID PROVID NO.(L 1) 245279	ER	3. NAME AND AI (L3) GOOD SAM			PECIALTY CARE COMMU	4. TYPE OF ACTIO	ON: <u>2 (L8)</u> 2. Recertification
2. STATE VENDOR OR MEDICAID (L 2) 138218700	NO.	(L4) 3815 WEST (L5) ROBBINSD			(L6) 55422	3. Termination 5. Validation	4. CHOW6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEO	GORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 8. Full Survey Afte	9. Other r Complaint
6. DATE OF SURVEY 02/1 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	2/2016 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDI	NG DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	96 (L18) 96 (L17)	Compliance1. A X B. Not in Con	equirements e Based On: cceptable POC	gram	And/Or Approved Waivers Of 2. Technical Personnel 3. 24 Hour RN 4. 7-Day RN (Rural SN 5. Life Safety Code * Code: * R	6. Scope of So 7. Medical Di	ervices Limit rector m Size
		requirements	ина/от гърпеа	vuiveis.		(EIZ)	
14. LTC CERTIFIED BED BREAKDO 18 SNF 18/19 SNF 96	WN 19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)	
(L37) (L38)	(L39)	(L42)	(L43)				
16. STATE SURVEY AGENCY REM	ARKS (IF APPLICA	ABLE SHOW LTC CA	ANCELLATION :	DATE):			
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY	' APPROVAL	Date:
Magdalene Jares, HFE	NE II		03/15/2016	(L19)	Kamala Fiske-Downing, Er	nforcement Specialist	03/25/2016 (L20)
PA	RT II - TO BE	COMPLETED I	BY HCFA RI	EGIONAL	OFFICE OR SINGLE S	TATE AGENCY	
DETERMINATION OF ELIGIBIE 1. Facility is Eligible to I 2. Facility is not Eligible	Participate		IPLIANCE WITI ITS ACT:	H CIVIL	21. 1. Statement of Fina2. Ownership/Contr3. Both of the Above	ol Interest Disclosure Stmt	
2. Tacinty is not English	(L21)						
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	:	(L30)
OF PARTICIPATION 04/01/1985	BEGINNING	G DATE	ENDING DA	TE	VOLUNTARY 00 01-Merger, Closure	05-Fail to	NTARY Meet Health/Safety
(L24)	(L41)		(L25)		02-Dissatisfaction W/ Reimburs	ement 06-Fail to	Meet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:			03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	07-Provid	er Status Change
(L27)	B. Rescind So	uspension Date:	(L44) (L45)			00-Active	
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS		
		00140					
	(L28)			(L31)			
31. RO RECEIPT OF CMS-1539	32	. DETERMINATION	OF APPROVAL	L DATE			
	(L32)			(L33)	DETERMINATION APP	ROVAL	



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:

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

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

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

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

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

Good Samaritan Society - Specialty Care Community March 3, 2016 Page 2

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.

Good Samaritan Society - Specialty Care Community March 3, 2016 Page 4

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

Good Samaritan Society - Specialty Care Community March 3, 2016 Page 5

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, Program Specialist

Licensing and Certification Program Health Regulation Division

Kumala Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ATE SURVEY OMPLETED
		245279	B. WING _		2/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENT	-s	F 00	00	
	as your allegation on Department's accept enrolled in ePOC, y at the bottom of the	of correction (POC) will serve for compliance upon the otance. Because you are our signature is not required first page of the CMS-2567 ic submission of the POC will ion of compliance.			
F 176 SS=D	on-site revisit of you validate that substa regulations has bee your verification.	acceptable electronic POC, an ir facility may be conducted to ntial compliance with the an attained in accordance with NT SELF-ADMINISTER D SAFE	F 17	76	3/23/16
	the interdisciplinary	nt may self-administer drugs if team, as defined by as determined that this			
	by: Based on observat review, the facility fa self-administration of and ensure safe ad inhalers medication R74) who self-admi Findings include: R122's medication on 2/11/16, at 8:44 entered R122's roo	ion, interview and document ailed to complete of medication assessments ministration of nebulizer and s for 2 of 2 residents (R122, nistered medication. administration was observed a.m. registered nurse (RN)-Am, assessed R122's lung ate. RN-A emptied the		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 we federal requirements of participation, this response and plan of correction	he ith
ABORATOR	L / DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

BORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE 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.

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING			02/ ⁻	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	38	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY COBBINSDALE, MN 55422	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 176	Duo-neb vial into no system that adminisis inhaled into the lunebulizer cup to face nebulizer mask to Fa.m. RN-A returned. The nebulizer was shed with the head on face. Nebulizer on RN-A entered room turned off the nebulieft in the cup. After RN-A checked R12 The Cognitive Caredated 9/15/15, was 9/3/15, annual Minimindicated R122 had verbal and physical and wandered one assessment referent indicated resident havith the overall objeon the care plan to R122 quarterly MDR R122 was severely assistance with all diagnoses on quart Parkinson's, depresent R122's care plan proceeding and self-administration R122's Medication included DuoNeb similligrams/3 millilited breathing), one vial	ge 1 abulizer (a medication delivery sters medication in a mist that lings) cup. RN-A attached the seemask and RN-A applied the R122 and left room. At 8:51 and look into R122's room. Still running. R122 was lying in of the bed elevated and mask was still running. At 8:59 a.m. a removed face mask and lizer. There was no medication washing the nebulizer cup, 2 lung sounds and heart rate. Area Assessment (CAA) triggered information on the mum Data Set (MDS) severely impaired cognition, behaviors, rejection of cares to three times during the nece period. The CAA also had Parkinson's and dementia active of addressing cognition minimize risks to R122. So dated 11/26/15, indicated cognitively impaired, requires ADLs including eating. R122's erly MDS included dementia, asion, and respiratory failure. Finted 2/12/16, did not address of any medications. Review Report dated 2/12/16, olution 0.5 to 2.5 (3) are (a medication that improves inhale orally three times a day eath. The staff were to	F 1	76	constitutes the center's allegation of compliance in accordance with sec 7305 of the State Operations Manual Resident R122 is incident occurred because staff did not follow policy. Was re-educated on 2/16/2016 to for policy regarding nebulizer treatment residents with cognitive impairment which states that staff are to stay we resident during treatment. Resident R74 care plan was review TMA-B was re-educated on 3/8/20 follow policy regarding inhalant ment treatments for residents that do not an order for self-administration. Care plans for all residents with ordination and order for self-administration. Care plans for all residents with ordination and addressed on curred plan, if appropriate, were completed and addressed on curred plan, if appropriate staff were reeducated nebulizer, inhaler and self-administ procedures. The Director of Nursing Services and/or designee will be responsible to ensure compliance to random monthly audits. The QAPI committee will monitor audits for or compliance.	tion tal. RN-A pllow tts for tts, tith red. 16 to dication t have ders for ere tion that care and on ration through	

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245279	B. WING _		02	02/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 176	post-administration nursing spent with for self-administration medication review or record did not inclurelated to R122's a medications. During interview on stated, "No, they [th there with him becard off. That is what out their own medication R122 did not have medication assessing interview on pharmacist said, "If order for self-admin treatments] the starmedication or get a Before getting the cassessment to make resident] to self-administresident] to self-administresident during R74's medication a 2/12/16, at 7:32 a.m (TMA)-B gave R74 inhaler without shall give any instruction toward Electronic MRecord. R74 inhale back to TMA. R122	and lung sounds pre- and and record the total time resident. There was no order on of medications was on the report. Review of the medical de evidence of an assessment bility to self-administer 2/12/16, at 9:12 a.m. RN-J ne nurses] should be staying in ause he could pull it [the mask] r procedure is. Nobody gives ons up here." RN-J verified a self-administration of ment, care plan or order. 2/12/16, at 10:52 a.m. the resident does not have an instration of nebs [neb ff should administer the neb in order for self-administration. Order they do need to do an accessive it is safe for them [the minister the neb."		76			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		245279	B. WING		02	02/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, 3815 WEST BROADWAY ROBBINSDALE, MN 55422	ZIP CODE	, , =, = 0 . 0	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 176	breath for 10 second R74's care plan reviewed resident has impaired fementia or impaired [related to] Hunting by] needs assistant assists with all decidoes not self-admired R74's quarterly MD R74 was cognitively others, requires sugand hygiene. R74's included dementia, asthma. R74's Medication R included the Albuter was to adminsiter of for shortness of breorder for self-admired on the medication rethe medical record assessment related self-administer medical would assert resident to self-admired including inhalers. "stretch, [R74] is her medication set up. I would be handed to resident I do not ne instructions." RN-I would self-admired resident I do not ne instructions." RN-I would self-admired resident I do not ne instructions." RN-I would self-admired resident I do not ne instructions." RN-I would self-admired resident I do not ne instructions." RN-I would self-admired resident I do not ne instructions."	ds after taking a puff. ised 10/8/13, indicated "The ed cognitive function/ ed thought processes R/T ton's Disease E/B [evidence to with decision making. Wife sion making. Res. [resident] hister medications." S dated 11/5/15, indicated intact, able to understand pervision with eating, dressing diagnoses on quarterly MDS Huntington's, depression, and eview Report dated 2/12/16, rol Sulfate inhaler and staff the dose orally in the morning eath/wheeze. There was no histration of medications was eview report. The review of did not include evidence of an I to R74's ability to	F 1	76			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED	
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, Z 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 176	said, "Yes for the in self-administration have an order I wo open mouth, use of verified turning back before resident use." During interview or pharmacist said, "shaking inhalers be If a resident does in self-administration administer the inhal inhaler. Before get do need to do an a safe for the resident inhaler." Procedure Inhalan Inhalers revised 9/"3. Have resident selevate head of be 4. Listen to breath respiratory pattern 5. Shake the conticulation of the canister upright (no 7. Spacers are off there is Trouble concanister with inhala indicated. 8. Instruct resident exhale completely mouthpiece in his of her lips around the 9. As you firmly put the selevation of	n 2/12/16, at 9:25 a.m. TMA-B haler [R74] does have a order. If they [residents] do not uld tell the resident what to do, ne puff or two puffs." TMA-B ex to the medication drawer ed the inhaler. n 2/12/16, at 10:52 a.m. They (the nurse) should be efore administering the inhaler. not have an order for of inhalers staff should eller. They need to hold the ting the order the facility staff ssessment to make sure it is not to self-administer the t Medication Metered Dose 15, instructed staff: sit up if condition permits or d 30 to 45 degrees. sounds and observe eainer well. Southpiece cover and position or dinating the actuation of the ation; ass the spacer if to take a deep breath and the Have him or her place the or her mouth and close his or mouthpiece. Ush the device ask the resident d to continue inhaling until his	F 1	76		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	ELE CONSTRUCTION (.	(X3) DATE SURVEY COMPLETED		
		245279	B. WING		02/12/2016	
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	,	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 176	several seconds to into lungs. Ask residences possible through pure through pure the procedure Residence Medication Revised	t to try to hold breath for help medications reach deep dent to exhale out as slowly as ursed lips." t Self-Administration of 17/14, instructed staff:	F 170	5		
F 221 SS=D	"1. Complete the Re Medications UDA (Le determine if the res medications and to resident to be succe 6. The interdiscipling the resident can sa medications must be record 7. A physician's ord the resident self-ad order must be specification self-ad order must be specification of the admitted the resident is self-akept, who will document to the admitted the self-admitted the self-admi	esident Self-Administration of user defined assessment) to ident can safely administer create a plan to assist the essful in this process nary team's determination that fely self-administer be documented in the medical er must be obtained prior to ministering medications. The cific to the medications being sust indicate which medications administering, where they are ment the medication and the inistration, if applicable" O BE FREE FROM AINTS The right to be free from any mposed for purposes of nience, and not required to	F 22		3/23/16	
	by: Based on observat review, the facility fa	NT is not met as evidenced tion, interview and document ailed to assess the use of a positioning device as a		Resident R97 had a restraint assess completed on 3/11/2014 and again of 3/9/2016 and care plan was amended	n	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245279	245279 B. WING		02/-	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	, :	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		. = / = 0 . 0
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETION DATE
F 221	reviewed for restra standing up from h Findings include: R97's quarterly Mir 11/12/15, indicated impaired and requistaff for transfers. not use restraints. R97's care plan da falls related to gait/ and poor decision is staff to apply a "bila while up in chair ar device every 30 mi hours. Care planneresistance to cares disrobed and strikin An Occupation The 3/17/14, indicated I chair management R97 was able to sit latching positioning was no evidence Rsince 2014. A Good Samaritan Community Progreindicated R97 need with transfers, and The progress note using a Broda (a w bilateral thigh pads fall risk, not consid	or 1 of 3 residents (R97) ints, and who was capable of er wheel chair. nimum Data Set (MDS) dated she was severely cognitively red extensive assist of two The MDS further noted R97 did ted 12/3/15, indicated risk for balance problems, impulsivity making. The care plan directed ateral thigh positioning device and directed staff to check the nutes and reposition every two ed behaviors included a mbulating in the hall	F 221	Resident R97 was picked up on Cload on 3/10/16. All residents with bilateral thigh st were reviewed and reassessed. The policy & procedure for Physic Restraints was reviewed with the appropriate staff. The Director of Services and/or designee will be responsible to ensure compliance random monthly audits. The QAF committee will monitor audits for compliance.	raps al Nursing through	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	IPLE CONSTRUCTION IG	COMPLETED		
		245279	B. WING _		0;	2/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 221	R97 was seated in chair. Across each strap that extended attached behind an During an interview nursing assistant (I "positioning straps. risk and the straps wheel chair. He fur release the device opens it "she could - At 12:39 p.m. lice stated he thought t using the positioning dev constant falling. He to reposition R97 At 1:32 p.m. regis "without those strap the floor." She furth to restrain her." RN initiated on 3/11/14 the facility did not coto be a restraint. Expressing from her chair was no ongoing as	ion on 2/9/16, at 4:28 p.m. a high backed padded wheel of her upper thighs was a from under her legs and id out of reach of resident. You on 2/11/16, at 12:24 p.m., NA)-D stated R97 had "NA-D stated R97 was a fall helped maintain position in her ther stated she was not able to on her own. He stated if she fall." Insed practical nurse (LPN)-B hey did an assessment prior to a device. LPN-B further stated ice was used for safety due to a stated the straps are released tered nurse (RN)-I stated on, [R97] would probably be on her stated, "We are not trying I-I stated an assessment was but was not required because consider the positioning device wen though the device obbility and prevented her from ir on her own. She stated there sessment to determine if the		,		
	Physical, dated 8/2 free from physical purposes of discipl required to treat the symptoms. The fact	I Samaritan Society Restraints: 014 indicated "residents will be restraints imposed for ine or convenience and not e resident's medical cilities procedure titled Physical 0/13, identified a physical				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	, 3	STREET ADDRESS, CITY, STATE, ZIP CODE 8815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 246 SS=D	mechanical device, attached or adjacer the individual cannot physical restraints of documentation of restraint review quaindicated staff to correstraint review quaindicated the use of physical restraint, the was properly assess restraint, nor was the device was attempted 483.15(e)(1) REAS OF NEEDS/PREFE A resident has the reservices in the facil accommodations of preferences, excepthe individual or othendangered.	anual method or physical or material or equipment at to the resident's body that of remove." The procedure for directed staff to complete esponse to previous pted and continually monitor se of the restraint and pursue device. The procedure further applete a physical device and arterly. While the facility policy f bilateral thigh restraints as a nere was no evidence R97 sed for use of a physical nere evidence a less restrictive and since March 2014. ONABLE ACCOMMODATION ERENCES right to reside and receive ity with reasonable f individual needs and t when the health or safety of her residents would be	F 246			3/23/16
	by: Based on observative review, facility failed (R252) call light was at risk for falls. Findings include:	NT is not met as evidenced tion, interview, and document d to ensure 1 of 3 resident's s in reach for a resident who		Call light for resident R252 was pla within reach on 2/10/16. Staff on Prairie unit, including LPN- were reeducated to follow policy re- call light placement for all residents are capable of using call lights on 2/10/2016 and 2/11/2016.	·A, garding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	,	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 246	10:42 a.m. the licer entered R252's roo handed the call ligh observed on the nig behind R252 and n On 2/10/16, at 10:4 was able to use cal within reach. LPN-/within reach for resusing call lights. On 2/10/16, at 10:4 (NA)-A stated R252 light. R252's fall care pla was at risk for falls right foot due to ost deconditioning and goal was noted to be through the review staff to remind residup dropped items. To ask for assistance address call light addirected staff to end on 2/11/16, at 2:00 the Prairie unit nurse expectation was call of residents capables. At 1:11 p.m. during administrator stated.	help locating the call light. At a sed practical nurse (LPN)-A m, located the call light and at to R252. The call light was ght stand that was located of within reach. 3 a.m. LPN-A verified R252 Il light and call light was not a stated all call lights should be idents who were capable of the a.m. nursing assistant are was capable of using call and the analysis as evidenced by gait/balance problems. The per "Resident will be free of falls date." The care plan directed dent not to bend over to pick encourage to use grabber or the are plan did not accessibility even though it courage to ask for assistance. p.m. registered nurse (RN)-D, see manager, stated the lights should be within reach e of using them. g the environmental tour the d, "Yes" when asked if the call to be in reach for residents	F 246	All staff were reeducated or procedure. The Director of Services and/or designee were responsible to ensure comparandom monthly audits. The committee will monitor audit compliance.	Nursing vill be bliance through the QAPI		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	PLE CONSTRUCTION G	COMPLETED		
		245279	B. WING _		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 253 SS=D	staff to ensure that calling for assistant place call light with 483.15(h)(2) HOUS MAINTENANCE SET The facility must promaintenance service sanitary, orderly, and This REQUIREMENT by: Based on observative review, the facility for facility	a resident has a method of the and further directed staff to reach of a resident. SEKEEPING & SERVICES Dovide housekeeping and these necessary to maintain a and comfortable interior. NT is not met as evidenced the side of the side o	F 24		ent, roda ent / ector of will be through	
		-				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245279	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRECTION ((EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPRIED TO T	D BE	(X5) COMPLETION DATE
F 253	(DOF), administrator wheelchair out of the administration verification verification was exposing the form a cleanable surface tore up vinyl on the checked the W/C's good repair, the administration was proposed to put a vince looked at by the put a vince looked at by the raper R37's quarterly Min 1/14/16, indicated F cognition, required of one staff with traun-steady and used R37's care plan dath had limited physication cerebrovascular ac supranucular palsy standing and sitting Care plan indicated	in the director of facilities or and intern. DOF brought the per common both him and the led the tape was peeling and pam underneath making it not e. In addition, both verified the side. When asked who to make sure they were in ministrator stated staff was work order and the chairs were y. Immum Data Set (MDS) dated and severely impaired extensive physical assistance in sfers from bed to wheelchair, if a wheelchair for mobility.	F 2	53		
F 278 SS=D	revised 3/2013, dire walkers requiring re orders will be filled 483.20(g) - (j) ASSI ACCURACY/COOF	Valker Cleaning Procedure ected staff, "All chairs and epair will be identified and work out and distributed for repair." ESSMENT RDINATION/CERTIFIED ust accurately reflect the	F 2	78		3/23/16
	A registered nurse	must conduct or coordinate				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	v 3	ROBBINSDALE, MN 55422	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 278	assessment is come Each individual who assessment must see that portion of the about that portion of the about that portion of the about the portion of the about the subject to a civil most subject	with the appropriate lth professionals. must sign and certify that the upleted. completes a portion of the sign and certify the accuracy of assessment. d Medicaid, an individual who gly certifies a material and a resident assessment is oney penalty of not more than sessment; or an individual who gly causes another individual and false statement in a nt is subject to a civil money than \$5,000 for each	F 278	,		
	review, the facility f status was accurate Data Set (MDS) for reviewed for dental Findings include: During morning car	res observation on 2/11/16, at observed with missing and		This coding error occurred due to individual employee not following procedure. Employee was reeduc 2/12/16. An oral assessment of Resident R done on 7/8/2015 but was not accureflected on the last annual MDS. Resident R73 last annual MDS was corrected via a "significant correctilast comprehensive assessment" N with an ARD date of 3/10/16. Resident to the last comprehensive assessment.	73 was urately son to MDS	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		245279	B. WING			02/12/2016		
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	38	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY COBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 278	Review of R73's me Apple Tree Dental I Assessment Form had obvious or likel teeth, had root tips, bleeding gums or lodirect staff assistant No oral assessment completion of annu R73's annual MDS did not have any debut not limited to bright partial denture, no infragments, abnorm or loose natural teemouth or facial pair chewing, unable to above" option had a dental section Care not trigger for compound MDS verifies assessment was con 7/8/15 and state optional. RN-D reving 3.0 Oral/Dental Assigned State of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for contact of the entered in the annual have triggered for the entered in the entered in the annual have triggered for the entered in the entered i	edical record revealed the MDS 3.0 Oral/Dental dated 6/12/15, indicated R73 y cavity or broken natural missing teeth, inflamed or cose natural teeth and required are with oral cares. It was found in the record for al MDS on 7/8/15. dated 7/8/15, indicated R73 ental concerns which included oken or loosely fitting full or natural teeth or tooth al mouth tissue, obvious cavity th, inflamed or bleeding gums, n, discomfort or difficulty with examine with "None of the been checked. In addition, the examine with "None of the been checked. In addition, the examine with "None of the objection on 7/8/15. p.m. registered nurse (RN)-D ho also completed the R73's difficulty or annual oral completed for the annual MDS difficulty difficulty with the examine with "None of the example of the annual MDS difficulty or annual oral completed for the annual MDS difficulty or annual oral completed for the annual MDS difficulty or annual matural teeth, had root tips, med or bleeding gums or loose annual MDS. RN-D definition on 7/8/15, and there should be an oral care	F 2	78	MDS' s for all residents will be revior oral dental status and modified needed. All appropriate staff were re-educathe proper MDS coding procedure. Director of Nursing Services will be responsible to ensure compliance random monthly audits. QAPI will raudits monthly.	iewed as ted on The through		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		02/	12/2016	
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNITY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 278	Resident Assessment version 3.0 last revision 3.0 last resident opens his moves when the redentulous or lacks teeth. " -"Check L0200 B, fragment(s) (edentulous or lacks teeth." -"Check L0200 C, amasses, oral lesion or oral lesion is not or oral lesion is not or oral lesion is not or oral lesion." -"Check L0200 B, is loose natural teeth; seen." - "Check L0200 E, is loose natural teeth; swollen, or bleeding they readily move with a fingertip." - "Check L0200F, in discomfort with che any pain in the mouchewing." - "Check L0200G, it resident's mouth of seed and seed are seed as the seed as the seed are seed as the seed as the seed are seed as the seed as the seed as the seed as the seed are seed as the seed as t	ang Term Care Facility ent Instrument User's Manual ised on October 2015, dental ed on the MDS when all of the e met: broken or loosely fitting full or e denture or partial is chipped ole, or loose. A denture is he resident complains that it is visibly moves when the or her mouth, or the denture sident tries to talk." no natural teeth or tooth ulous): if the resident is all natural teeth or parts of abnormal mouth tissue (ulcers, es): Select if any ulcer, mass, ed on any oral surface." bobvious or likely cavity or he if any cavity or broken tooth inflamed or bleeding gums or if gums appear irritated, red, g. Teeth are coded as loose if when light pressure is applied mouth or facial pain or ewing: if the resident reports of the resident reports of the above: if none of the spresent"	F 27			3/23/16	
F 279 SS=D	483.20(d), 483.20(k COMPREHENSIVE		F 27	/9		3/23/16	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	у 3	ROBBINSDALE, MN 55422	,	_,
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 279	Continued From pa	age 15 the results of the assessment	F 279			
		and revise the resident's				
	plan for each reside objectives and time medical, nursing, a	evelop a comprehensive care ent that includes measurable etables to meet a resident's nd mental and psychosocial etified in the comprehensive				
	to be furnished to a highest practicable psychosocial well-b §483.25; and any s be required under § due to the resident	t describe the services that are attain or maintain the resident's physical, mental, and being as required under ervices that would otherwise §483.25 but are not provided s exercise of rights under the right to refuse treatment.				
	by: Based on observareview, the facility finterventions to pre	NT is not met as evidenced tion, interview, and document ailed to develop care planned vent pressure ulcers for 1 of 2 riewed for pressure ulcers.		Resident R97 s care plan was re on 2/12/2016 and skin integrity foc and corresponding interventions w added. Resident R97 was picked OT caseload on 3/10/2016.	us, goal ere up on	
	R97's morning care lying in bed on her brief was saturated bowel. Following in noted to have a recommendation	ion on 2/11/16, at 8:22 a.m., es were observed. R97 was right side. R97's incontinent with urine and soiled with continent cares, R97 was dened coccyx area with a 1/2 at appeared to be open.		Care plans for all residents with po for skin integrity issues were review modified as needed on 3/9/2016. Policy for Care Plans and Procedu Skin Assessments, Pressure Ulcer Prevention and Documentation Requirements and Weekly Skin Ch	res for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	/ - SPECIALTY CARE COMMUNIT	, :	STREET ADDRESS, CITY, STATE, ZIP CODI 8815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 279	During a subseque 2/12/16, at 8:02 a. assessed R97's sk stage one pressure erythema of intact skin ulceration. In discoloration of the induration, or hard on her coccyx. She as "a little bit open A review of Good S Care Community Nindicated, on 3/24/"monitor buttocks maceration/skin br A Review on Good Care Community Pathrough 2/12/16, ir refusing reposition A Pressure Ulcer C dated 8/20/15, idea impaired skin integrassistance for most The CAA indicated but has been getting [incontinence], refusion a self-care deficit, activities of daily libowel and bladder provide incontinence.	ent observation of cares on m. registered nurse (RN)-B kin. RN-B stated R97 had a e ulcer (a non-blanchable skin, the heralding lesion of individuals with darker skin, e skin, warmth, edema, ness may also be indicators) e described the pressure ulcer." Samaritan Society Specialty Medication Review Report 15, an order was received to for worsening of reakdown." I Samaritan Society Special Progress Notes dated 8/2/15 indicated R97 had a history of	F 279	were reviewed with all appropring The Director of Nursing Service designee will be responsible to compliance through random maudits. The QAPI committee waudits for ongoing compliance.	es and/or ensure onthly vill monitor	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02	/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CO X (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 279	for skin impairment prevent skin breakd skin was initiated a pressure ulcer on 2 A Progress Note daskin check indicated sacral area, but this 12/20/15, indicated Progress Note date on res [resident] but is healing." A quarted 1/11/16, indicated "buttockscreams a reposition but often dated 1/16/16, indicated R97 had right side of the glu "pressure points." Vand progress notes skin issues dating the continual refusals of were no further car implemented to recommend to recommend to the stated it was last do not know what time unaware of any skin During an interview stated staff had a hadown. NA-E stated coccyx on and off as	t or identify interventions to down. A care plan addressing fter the surveyor identified the		279			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING			02/-	12/2016	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY			Υ	STREET ADDRESS, CITY, ST. 3815 WEST BROADWAY ROBBINSDALE, MN 55				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD ID TO THE APPROP ICIENCY	BE	(X5) COMPLETION DATE	
F 279	stated when R97 si pressure goes on him pressure go	two hours. NA-E further its in her chair, "all her her coccyx." on 2/11/16, at 12:43 a.m. hurse (LPN)-B stated R97 had ent for her reddened coccyx ring cream to it. He further it the pressure is there." on 2/12/16, at 7:38 a.m. hid not have any skin concerns it of. RN-B further explained treatment record directed staff is for worsening of eakdown" each shift, the nurse is bottom daily. She stated, ation aides (TMAs) look at it	F 2	279				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION ((X3) DATE COMP	SURVEY LETED
		245279	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	y 3	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY ROBBINSDALE, MN 55422	32 , 1	_, _ 0
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE
F 282 SS=D	individualized compinclude measurable toward achieving an optimal medical, nu assessment instrumphysician's orders concerns identified care will be modified required/provided for 483.20(k)(3)(ii) SEFPERSONS/PER CATThe services provided by the ser	d "each resident will have an brehensive care plan that will a goals and timetables directed and maintaining the resident's ursingneeds. The resident nent and review of the , any problems, needs, and will be addressed. This plan of d to reflect the care currently or the resident."	F 279			3/23/16
	by: Based on observate review, the facility for pain with cares for experienced unnect addition, the facility care, rolled wash of (ROM) for 1 of 2 restaff assistance with (ADLs) who were restaff as a single with (ADLs) who were r	cion, interview and document ailed to ensure staff reported of 2 residents (R73) who essary pain during cares. In staff failed to provide nail oth and range of motion sidents (R73) who required the activities of daily living eviewed for ADLs and ROM. To the facility on 5/13/10, had a accident (stroke) affecting the 2010. The facility failed to pain related to contractures of		Resident R73 s pain was reassess 2/12/2016 and care plan modified as appropriate. NA-B and TMA-F were reeducated or 2/11/2016, NA-C was reeducated or 3/10/2016 about stopping cares and reporting to the nurse if they observe signs and symptoms of verbal or non-verbal pain. Range of motion was discussed with nurse practitioner and ROM order w clarified on 3/1/2016. Physical theracompleted a range of motion assess with resident R73 on 2/12/2016. Ramotion tasks were added to R73 s	on in the any aspy sment	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY MPLETED
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STAT 3815 WEST BROADWAY ROBBINSDALE, MN 5542	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE CROSS-REFERENCED DEFICE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 282	the left hand, wrist, facility staff did not when R73 experier reassess and proving minimize the pain of cares. On 2/9/16, at 4:49 in a wheelchair in the across from his root against his body with chest, wrist bent at the forearm and the closed fist position clenched left hand. R73 was observed 2/11/16, at 7:03 a.r washed R73's face pull R73's left arm armpit. NA-B attempted to put on R73 fidgeted, grim "ouch" approximate cares especially with R73's left arm. NA-B attempted to put on R73 fidgeted, grim "ouch" approximate cares especially with R73's left arm. NA-B attempted to put on R73 fidgeted, grim "ouch" approximate cares especially with R73's left arm. NA-B attempted to put on R73 fidgeted, grim "ouch" approximate cares especially with R73's left arm. NA-B attempted to put on R73 fidgeted, grim "ouch" approximate cares especially with R73's left arm. NA-B attempted to put on R73 fidgeted, grim "ouch" approximate cares especially with R73's left arm. NA-B attempted to put on R73's left arm.	age 20 a elbow and shoulder and the stop providing ADLs cares need pain, report to the nurse, ide necessary treatment to experienced during morning p.m. R73 was observed sitting he common area at a table om, R73's left arm rested firmly ith the left hand rested on his about a 90 degrees angle at ree fingers on the left hand in a and a left hand in	F 2	Kardex assignment stare (POC) documen 2/15/2016. Resident R73 s rolle order dated 12/30/20 contracture managem integrity was not follow Individual employees to be following this order 2/12/2016. Resident R73 s nails 2/11/2016. Care plans for all resicontractures were revas needed on 3/10/20 Policies for Care Plan Management-Resider Non-Pharmacological and Range of Motion Pain Data Collection, Range of Motion and Range of Motion Exeruith all appropriate st Nursing Services and responsible to ensure random monthly audit committee will monitor compliance.	atation schedule on and wash cloth nursing 15 for purposes of ment and skin wed as directed. Who were found not der were reeducated as were trimmed on idents with viewed and modified on the Assistance, I Pain Interventions and Procedures for Nail Care and Guidelines for roises were reviewed aff. The Director of lor designee will be a compliance through its. The QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
F 282	moaned. RN-D, wh asked NA-C to stop R73's facial expres discomfort and will pain medication and later. On 2/12/16, a returned to R73's rocares. R73 did not a during cares but gri when staff attempte hand. Review R73's elect administration reco 2015, January and R73 received as net two times on 1/2/16 being ineffective and documented as bei medical record lack was assessed prior medication and/or of R73's care plan dat resident had potent to a cerebral vascu (paralysis on one sidisease processes teeth and restlessness, grima facility staff were to symptoms of non-v breathing, vocalizat changes, and nursi analgesia as per or	o was present in the room of morning cares. RN-D stated sions indicated R73 was in need to medicate R73 with different results and re-attempt morning cares to 9:05 a.m. RN-D and NA-C common to complete morning seem to be any discomfort maced and moaned only red to open R73's fingers on left ronic medication rd (EMAR) for, December February 2016, revealed that reded (PRN) pain medications of, which was documented as red on 1/11/16, which was ng effective on the EMAR. The red evidence that R73's pain reto administration of PRN pain during cares. The december of the body) and end stage as evidenced by grinding ress. The goal for R73, rors of inadequate pain control acing and grinding teeth. The report to nurse any signs or rebal pain, changes in the control of the sign of the december of the sign of the pain, changes in the sign of the pain to the nurse on the pain to the nurse on	F 28	2		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION		TE SURVEY MPLETED		
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER	7 - SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, 2 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 282	stated she heard F during morning cal whenever she ass always moaned are she believed R73 whis left upper extree. On 2/11/16, at 9:40 (LPN)-C verified R pain for which he refurther stated nursurancotic pain medi when he was in bewheelchair. LPN-C nursing assistants discomfort with residenied anyone repwith R73 during morning as teeth further stated she to R73 except Rox the nurse, half the when already up in anyone reporting a during morning calculation. On 2/12/16, at 9:20 usually works with groaned sometime attempting to left F wash or get R73 dishe believed R73 stated did not reponurse stating "it is	n 2/11/16, at 7:12 a.m. NA-B R73 moaning and yelling "ouch" res, and continued to state isted with R73's cares, R73 and groaned during cares and was "in pain" when working on mity. D a.m. licensed practical nurse 73 had a diagnosis of chronic eceived pain medications. Sees administered Roxanol (a cation) to R73 sometimes and or when already up in a continuent to report any pain or sidents to the nurse. LPN-C corting any pain or discomfort forning cares on 2/11/16. By p.m. trained medication aide ray always groaned and "like he is in pain." TMA-F administered pain medication and that was administered by time when R73 in bed and a wheelchair. TMA-F denied any pain or discomfort with R73	F 2	282		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(E SURVEY PLETED
		245279	B. WING _			02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD E E APPROPRI		(X5) COMPLETION DATE
F 282	on 2/12/16, prior to for him today" as shaped on 2/12/16, prior to for him today" as shaped on 2/12/16, at 9:38 a.n. R73 received pain in relaxed during morning cares nurse to administer to completion of morning cares.	morning cares "it went better ne smiled and seemed happy." Fiew on 2/11/16, at 2:35 p.m. of the unit RN-D and the unit's N-F were informed of surveyor taff reports of pain during R73. RN-D and RN-F both of aware of any pain issues as with R73. RN-D continued and nursing assistants to report pain to the nurse. RN-F d R73's pain and R73 was are no pain. RN-F further stated a with current pain regimen call the circumstances of R73's RN-F acknowledged he was was in pain during cares and are ever assessed R73's pain. 2/12/16, at 8:30 a.m. after an assessment on R73, she and moved face away when wash R73's face, indicating the discomfort and opted to an RN-D stated requested pain medications to R73 prior forning cares from here on. On the RN-D further stated after medications, R73 was more thing cares. RN-D stated she sesistants to stop cares, report pain to the nurse and the discomplete a pain.	F 28	32			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245279	B. WING			02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, Z 3815 WEST BROADWAY ROBBINSDALE, MN 55422	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 282	facility staff were excues of pain for ressigns or symptoms facility staff are to some successions. The nurses resident for pain, mas appropriate, reventures further stated that funnecessary pain of cares that could has the facility's policy COLLECTION AND 19/15, directed staff evaluate the pain movith pain. The policy assistants to make comfortable and venurse on duty obserpolicy further direct effectiveness of the weekly if high risk for pain plan is effective. ROM/rolled washeld R73 was admitted cerebral vascular a left side in October specialized treatment maintain functional ROM. As a result feather wrist and three fing. On 2/9/16, at 4:49 in a wheelchair in the across from his rock.	spected to watch for nonverbal sidents who cannot talk, if any of pain are observed the stop cares and report to the are expected to assess redicate with pain medication iew care plan and update tment of pain medication. DON R73 might have experienced on 2/11/16, during morning we been avoided. Ititled "PAIN DATA DASSESSMENT" revised to continually monitor and management plan for residents by directed the nursing a resident who is in pain erbally communicate with the erved or reported pain. The red the RN to document er pain management plan or pain and at least monthly if the and resident is stable. Oth and nail care: to the facility on 5/13/10, had a accident (stroke) affecting the pain for contractures to R73 to ROM and prevent a decline in R73 developed left upper res (including shoulder, elbow,	F2	82			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 282	(approximately quawas no splint or rolleft hand. During interview or stated R73 had a cide hemiparesis (vight side of the boresident did not use restorative ROM. On 2/10/16, at 3:08 bed awake, R73's Ichest, finger nails to be long and untrivial common area at a LPN-C verified R73 was observed sittin common area at a LPN-C verified R73 underneath. There placed in R73's left R73 was observed 2/12/16, at 9:05 a.r not provide any RC morning cares. The placed in R73's left R73's care plan dadependent on staff	arter [1/4] inch in length). There led wash cloth placed in R73's a 2/9/16, at 7:25 p.m. RN-F contracture on left hand, left weakness of the entire left or dy) due to a previous stroke, any splints or received any a p.m. R73 was observed in left arm rested against his on both hands were observed immed. There was no rolled in R73's left hand. during morning cares on n. provided by nursing IA-B did not provide any ROM ring morning cares. R73's hands were observed to be d. There was no rolled wash it's left hand. At 10:23 a.m. R73 in a wheelchair in the table across from his room. B's nails were long and dirty was no rolled wash cloth thand. during morning cares on m. provided by NA-C. NA-C did of the services to R73 during ere was rolled wash cloth	F 2	32		

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG			E SURVEY PLETED
		245279	B. WING			02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE ADDITIONAL DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 282	hygiene care needs of motion as tolerat extremities with mo Review of R73's Phrevealed a nursing left hand. During interview on stated R73 did not because ROM was (NA assignment should be assignment should be assignment should be assignment should be a ROM program staff to provide genextremities as tolerabedtime cares. LPN assistants were res ROM and nurses we completion of all careviewed R73's meany documentation R73. LPN-C review verified R73 was so 2/3, 2/7 and 2/10/16. On 2/12/16, at 8:47 not have a rolled was 2/11/16. At 11:00 a. stated she just com R73 upper left extracontractures on the the joints in the shoftingers. PT further a services, splint dev palm usually helped contractures. At 11:	s and to provide gentle range sed to left upper and lower brining and bedtime cares. Inysician Orders dated 2/12/16, order for rolled wash cloth in 2/11/16, at 12:05 p.m., NA-B receive any ROM services not indicated in the Kardex eet) for NAs to complete. a.m. the LPN-C stated R73 m and the care plan directed tle ROM to upper and lower ated with morning and N-C explained that nursing sponsible for the completion of rere responsible for ensuring upon the care by red R73's medical record and cheduled for a bath on 1/31,	F 2	82			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	v 3	ROBBINSDALE, MN 55422	, 32	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 309 SS=D	contractures, tried of Kardex did not direservices for R73. A ROM program was as one of the caresprovide therefore ROM. RN-D stated resident's care pland During interview on facility's DON state follow resident's camanagers to make included in the Kard care and services a care. The facility's policy 11/13, directed staff and trimmed to proof The facility's policy LIVING revised 6/1 residents who are undaily living and ensinecessary services hygiene. 483.25 PROVIDE CHIGHEST WELL B Each resident must provide the necess or maintain the highmental, and psychology as well as the provide the necess or maintain the highmental, and psychological services for ROME and ROME an	finding Kardex and stated the ct the facility staff to do ROM to 11:43 a.m. RN-D verified the not included in R73's Kardex for nursing assistants to 173 had not been receiving she expected staff to follow a. 2/12/16, at 12:06 p.m. the dishe staff were expected to re plan and the nurse sure that all cares were dex. R73 did not receive the as directed per the plan of titled NAIL CARE revised for to keep resident's nails clean mote well-being. titled ACTIVITIES OF DAILY 4, directed staff to assist unable to carry out activities of ure that they receive to maintain good personal CARE/SERVICES FOR	F 282			3/23/16

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION		SURVEY PLETED
		245279	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNITY	v 3	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY ROBBINSDALE, MN 55422	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309		age 28 NT is not met as evidenced	F 309			
	review, the facility fassess, and provid residents (R73) resof daily living (ADLs Findings include: R73 was admitted experienced a cereaffecting the left sid Admission Record. R73 for pain related hand, wrist, elbows the facility had not ensure comfort and ADL cares. On 2/9/16, at 4:49 in a wheelchair in tha across from his rocobserved to rest fir left hand against his approximately a 90 and three fingers of closed fist position. R73 was unable to R73 was observed to at away from his body resident's armpit. It unsuccessfully to pefore stopping care	tion, interview and document railed to comprehensively e pain management for 1 of 3 sidents reviewed for activities is) and range of motion (ROM). To the facility on 5/13/10, and abral vascular accident (stroke) de in October 2010, per the The facility failed to re-assess document to domain relief prior to providing the common area at a table of pain relief prior to providing the common area at a table of the common area at the forearm, in the left hand held firmly in a component of the common area at the forearm, in the left hand held firmly in a component of the common assistant (NA)-B thempt to pull R73's left arm of the common assistant (NA)-B thempt to pull R73's left arm of the addition, NA-B attempted out two different shirts on R73 ares to go get help. At the a.m., NA-B and NA-D		Resident R73 s pain was reasses 2/12/2016 and care plan modified a appropriate. NA-B and TMA-F were reeducated 2/11/2016, NA-C was reeducated o 2/12/2016, NA-D was reeducated o 3/10/2016 about stopping cares and reporting to the nurse if they observ signs and symptoms of verbal or non-verbal pain. Care plans for all residents were refor pain management and modified needed. Policies for Care Plans, Pain Management-Resident Assistance, Non-Pharmacological Pain Interven and Range of Motion and Procedur Pain Data Collection, and Range of Motion Exercises were reviewed wi appropriate staff. The Director of N Services and/or designee will be responsible to ensure compliance to random monthly audits. The QAPI committee will monitor audits for on compliance.	on on on d ve any viewed as ntions es for f th all lursing	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL	TIPLE CONSTRUCTION ING			E SURVEY PLETED
		245279	B. WING			02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE 3815 WEST BROADWAY ROBBINSDALE, MN 5542			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN (X (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD O THE APPROPI	BE	(X5) COMPLETION DATE
F 309	while he remained grimaced, moaned approximately six to especially when star move R73's left arm providing R73's car grimaced, moaned times. At 10:23 a.m. on 2/sitting in a wheelch table across from h R73's right hand we A licensed practical attempted to extend hand to check their R73's palm. R73 m LPN-C attempted to verified R73 appear this assessment. On 2/12/16, at 8:12 stated R73's facial discomfort, a need medication, and the The annual Minimu 7/8/15, and quarter 12/17/15, indicated pain such as non-vegroaning), facial exteeth or jaw), proteen posture (bracing, groody part during medication and processing), group body part during medication and the posture (bracing, groody part during medication).	impted to put a shirt on R73 in bed. R73 fidgeted, and yelled "ouch" or eight times during cares off attempted to manipulate or in. NA-B and NA-D did not stop to even when R73 fidgeted, and yelled "ouch" multiple are even when R73 fidgeted, and yelled "ouch" multiple are observed to be quite long. In recommendate to the fingers on R73's left hail length and the condition of oaned and yelled "ouch" when to extend his fingers. LPN-C ared to be in discomfort during are as a considered to re-attempt care later. In Data Set (MDS) dated by MDS dated 9/23/15 & R73 demonstrated no signs of erbal sounds (moaning, or pression (grimaces, clenched cive body movements or uarding, clutching or holding a povement). As a result, the nent (CAA) for the 7/8/15 trigger a need for	F3	009			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	RIPLE CONSTRUCTION NG		ATE SURVEY OMPLETED
		245279	B. WING		O	2/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP COL 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR ((EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 309	R73's quarterly Pai 12/17/15, indicated advanced dementia understood, and a effectiveness of pa residents) dated 4/12/17/15, indicated normal, no negative resident was smilin expression with reliaddition, a review of following document 4/8/15- notes indicated for pain, current me working, and that sethe current plan of 7/5/15- notes indicated for pain, current me working, and that sethe current plan of The medical record whether staff provides the resident were care to ensure R73 functional level and Review R73's elect administration recound January and Foreceived as needed twice on 1/2/16. Defindicated the PRN ineffective. On 1/1 the use of PRN me medical record lackets.	In Data collection dated that the resident had a, was rarely/never PAINAD (tool used to evaluate in regimen for dementia 5/15, 7/5/15, 9/23/15, and the resident's breathing was a vocalizations, and that the g or had inexpressive facial axed body language. In of the record revealed the tation about pain: ated R73 was not at high risk adication regimen was taff should continue to follow care for pain. At the resident's level of ind/or whether pain completed during provision of a maintained his highest it comfort.	F3	09		

	OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			COMPLETED			
		245279	B. WING _		02	2/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 309	resident had potent to a cerebral vascu (paralysis on one sidisease processes teeth and restless in have a decrease in inadequate pain cogrimacing and grinding and grinding and grinding are signs or symptoms breathing, vocalizate changes, and that administer pain med. R73's Physician Or 2/12/16, revealed or vascular accident (weakness of the ebody) and pain. Alt revealed R73 utilize for pain control: Rotimes daily; Tylenol three times a day; hours as needed (Fpain; and Roxanol staff had not identifiadminister (ie., befassure the client recontrol. During interview or stated R73 was very his left arm to wash dressed. NA-B state and yelling "ouch" of stated whenever shad in the state of	ted 1/5/16, indicated the tial for pain/discomfort related allar accident, hemiplegia ide of the body) and end stage, as evidenced by grinding tess. The goal was for R73 to behaviors indicating antrol including: restlessness, ding teeth. Interventions to report to the nurse any of non-verbal pain, changes in tions, mood or behavior nursing staff were supposed to edications as ordered. The Summary Report dated diagnoses including: cerebral stroke), hemiparesis entire left or right side of the hough current physician orders and the following medications exanol 2.5 milligrams (mg) two Extra Strength (ES) 1000 mg. Roxanol 10 mg every two PRN) for moderate to severe 5 mg PRN for mild pain, facility fied specific criteria for when to one or after care), in order to be ceived the most effective pain and 12/11/16, at 7:12 a.m. NA-B ry stiff and it was difficult to lift in his armpits and to get him ted she heard R73 moaning during morning care, and the assisted with R73's care he and NA-B said she believed		09			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG	()		SURVEY
		245279	B. WING			02/1	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422	ODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD B		(X5) COMPLETION DATE
F 309	upper extremity. On 2/11/16, at 9:40 (LPN)-C verified R7 pain for which he re LPN-C stated the n Roxanol (a narcotic sometimes while he sometimes when he wheelchair. LPN-C reporting any pain or residents to the nur had reported R73's morning, LPN-C sa During interview on stated she usually w and was regularly a NA-D stated R73 al whenever staff mov believed R73 was in moaned/groaned. W ever reported the pa she had. However, Progress Notes fron failed to indicate thi On 2/11/16, at 12:44 (TMA)-F stated R73 his teeth "like he is she administered pa the Roxanol which w nurse. TMA-F conf the medication whill half of the time whe wheelchair.	a.m. licensed practical nurse is had a diagnosis of chronic received pain medications. The pain medication is the was already up in his stated the NAs should be or discomfort expressed by se. When asked whether staff discomfort during care that id no. 2/11/16, at 12:39 p.m. NA-D worked on the evening shift ssigned to take care of R73. ways moans/groans re his left arm, and stated she in pain when he When asked whether she'd ain to the nurse, NA-D said a review of the resident's m 4/28/15 through 2/11/16,	F3	09			

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP CO 3815 WEST BROADWAY ROBBINSDALE, MN 55422		,12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 309	the nurse manager unit's MDS coordin surveyor observative experienced by R7 and RN-F both starpain issues during stated she expecter report voiced or obverified he'd previous when R73 had no pure was to continue with e could not recall assessments such had been assessed. During interview or said she'd complet during his morning fidgeted and move NA-C attempted to R73 was in some of had requested the medications to R73 morning cares from a.m. RN-D stated to pain medication, he during his morning expected the nursi report voiced or obfor the nurse to corresident's pain. On 2/12/16, at 9:27 regularly works with moans and groans when staff attempt extremity to wash is stated she believed.	age 33 If of the unit, RN-D. and the ator RN-F, were informed of ons and staff reports of pain 3 during morning cares. RN-D ted they were unaware of any morning cares with R73. RN-D and the nursing assistants to served pain to the nurse. RN-F usly assessed R73's pain, pain. RN-F further stated R73 the current pain regimen but the circumstances of the pain as whether or not the resident district while receiving care. In 2/12/16, at 8:30 a.m. RN-D and a pain assessment on R73 care. She verified R73 district his face away even when wash R73's face, indicating discomfort. RN-D stated she nurse administer pain 3 prior to completion of a now on. On 2/12/16, at 9:38 hat after R73 had received the appeared more relaxed cares. RN-D stated she ng assistants to stop cares, served pain to the nurse, and anduct an assessment of the rank of the rank of the left upper him or get him dressed. NA-C di R73 was "probably in pain" in talways report her	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION NG	(X3)) DATE SURVEY COMPLETED
		245279	B. WING			02/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP COD 3815 WEST BROADWAY ROBBINSDALE, MN 55422	Æ	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION E DATE
F 309	an every day thing of R73 had received he prior to morning can he smiled and seem. During interview on facility's director of were expected to we pain for residents we whether any signs of present, and for stain pain and report to said the nurses are for pain, medicate we appropriate, review appropriateness, and any required adjust DON further stated unnecessary pain of cares that could had an effort was made physician on 2/16/1 message was left for was received. The facility's policy COLLECTION AND 9/15, directed staff evaluate the pain me with pain. The policity to make a resident and to verbally come duty regarding any the policy further deffectiveness of the weekly if high risk for the smile and to the pain of the weekly if high risk for the smile and to the pain of the weekly if high risk for the smile and to the pain of the weekly if high risk for the smile and to the pain of the policy further deffectiveness of the weekly if high risk for the prior to make a resident and to the pain of the policy further deffectiveness of the weekly if high risk for the prior to make a resident and to the pain of	nurse. NA-C stated, "it's like with him." NA-C also said after is medications that morning, res, "it went better for him" as ned happy. 2/12/16, at 12:40 p.m. the nursing (DON) stated the staff atch for nonverbal cues of the cannot talk, to observe or symptoms of pain are ff to stop care if the resident is to the nurse. The DON also expected to assess residents with pain medication as resident care plans for and update their physicians for ments of pain medication. The R73 may have experienced in 2/11/16, during his morning we been avoided. to call R73's primary 6, at 3:00 p.m. Although a or the physician, no return call	F3	09		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY IPLETED
		245279	B. WING _		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON SHOUNDERSON SHOUNDERSON SHOWN SHO	LD BE	(X5) COMPLETION DATE
F 309 F 312 SS=D	DEPENDENT RES A resident who is ur daily living receives	e. ARE PROVIDED FOR	F 30			3/23/16
	by: Based on observat review, the facility fa received grooming a of 4 residents (R73) living (ADLs). Findings include: R73's nails were ob 2/9/16, at 4:48 p.m. of the survey, 2/10/ On 2/9/16, at 4:48 p hands were observed (approximately qual On 2/10/16, at 3:08 bed awake, R73's le chest, finger nails o to be long and untri R73 was observed 2/11/16, at 7:03 a.m were observed to be	o.m. R73's finger nails on both ed to be long and untrimmed rter [1/4] inch in length). p.m. R73 was observed in eft arm rested against his n both hands were observed		Resident R73 s nails were trim 2/11/2016. Fingernails of all residents were for appropriate length. Procedure for Nail Care was rew with all appropriate staff. The Di Nursing Services and/or designer responsible to ensure compliance random monthly audits. The QA committee will monitor audits for compliance.	reviewed ewed rector of e will be e through PI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	12/2016	
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	., 3	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 312	Continued From pa	age 36	F 312				
	across from his roo (LPN)-C verified R underneath. R73's quarterly Mir 12/17/15, identified assist of one staff of hygiene needs. The	he common area at a table om. Licensed practical nurse 73's nails were long and dirty nimum Data Set dated I R73 required total physical with dressing and personal e CAA for Cognitive					
	confusion, forgetfu	ted 7/14/15, identified R73 with Iness and inability to make or end stage dementia.					
	assistance with AD cerebral vascular a current level of fun eating, dressing, to hygiene" R73's K assistant assignments	d 1/5/16, identified R73 needs L's due to dementia and accident. Goal "will maintain ction in bed mobility, transfers, pilet use and personal cardex (the facility nursing ent sheet) directed R73 stance with personal hygiene					
	2/12/16, revealed of vascular accident (rder Summary Report dated diagnoses included cerebral stroke), hemiparesis entire left or right side of the a.					
	aide (TMA)-F state	19 p.m. the trained medication of R73's nails were rter (1/4) inch in length.					
	were responsible for days and nurses at completed. LPN-C assistant are to rep	23 a.m. LPN-C stated NAs or nail care weekly on bath re responsible to ensure it was further stated nursing port to the nurse any time a ail care and nurses document					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	гү	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 312	in the resident's recreviewed R73's me any documentation R73. LPN-C review verified R73 was so 2/3, 2/7 and 2/10/16 On 2/11/16, at 2:00 manager, registered expected staff to have once a week with some completed, the stated she expected resident's medical runot completed. The facility's policy	cord the refusals. LPN-C dical record and did not find of refusals of nail care by ed R73's medical record and cheduled for a bath on 1/31,	F3	12		
F 314 SS=D	and trimmed to produce the produce of the facility's policy LIVING revised 6/12 residents who are udaily living and ensunecessary services hygiene. 483.25(c) TREATM PREVENT/HEAL P Based on the compresident, the facility who enters the facility who enters the facility does not develop prindividual's clinical of they were unavoidal pressure sores received.	titled ACTIVITIES OF DAILY 4, directed staff to assist unable to carry out activities of ure that they receive to maintain good personal	F 3	14		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245279	B. WING _		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 314	This REQUIREMENT by: Based on observation review, the facility finterventions to prepressure ulcers for reviewed for pressure ulcers for reviewed for pressure ulcers for reviewed for pressure lying include: During an observation R97's morning care lying in bed on her brief was saturated bowel. Following innoted to have a redinch long fissure that During a subseque 2/12/16, at 8:02 a.n assessed R97's ski stage one pressure erythema of intact skin ulceration. In indiscoloration of the induration, or hardron her coccyx. She as "a little bit open." A review of Good S Care Community Mindicated, on 3/24/1	from developing. NT is not met as evidenced tion, interview and document ailed to implement vent the development of 1 of 2 residents (R97) are ulcers. ion on 2/11/16, at 8:22 a.m. as were observed. R97 was right side. R97's incontinent with urine and soiled with continent cares, R97 was addened coccyx area with a 1/2 at appeared to be open. Int observation of cares on the registered nurse (RN)-B and the later (a non-blanchable skin, the heralding lesion of adividuals with darker skin, skin, warmth, edema, the sess may also be indicators) described the pressure ulcer amaritan Society Specialty ledication Review Report 5, an order was received to	F 3:	Resident R97 s care plan on 2/12/2016 and skin integ and corresponding intervent added. Resident R97 was pOT caseload on 3/10/2016. Care plans for all residents for skin integrity issues were modified as needed on 3/9/2016. Policy for Care Plans and PSkin Assessments, Pressur Prevention and Documentar Requirements and Weekly were reviewed with all approach the Director of Nursing Ser designee will be responsible compliance through random audits. The QAPI committee audits for ongoing compliant	rity focus, goal tions were bicked up on with potential e reviewed and 2016. rocedures for e Ulcer tion Skin Checks opriate staff. vices and/or e to ensure in monthly se will monitor	
	on her coccyx. She as "a little bit open." A review of Good S Care Community M indicated, on 3/24/1 "monitor buttocks for maceration/skin bree.	amaritan Society Specialty ledication Review Report 5, an order was received to or worsening of				

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRU			X3) DATE SURVEY COMPLETED		
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, 3815 WEST BROADWAY ROBBINSDALE, MN 55422	ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE OTHE APPROPRIATE	(X5) COMPLETION DATE
F 314	through 2/12/16, in refusing reposition A Pressure Ulcer of dated 8/20/15, idea impaired skin integrassistance for most The CAA indicated but has been getting [incontinence], refusion abnormal involuntation thrusts." Although non-compliant with include any alternation how to relieve provide and bladder provide incontinent needed. The care for skin impairment prevent skin break skin was initiated apressure ulcer on a R97's quarterly Min 11/12/15, indicated impaired and requitive staff for bed mit toileting. A Progress Note of skin check indicated sacral area, but the	Progress Notes dated 8/2/15 indicated R97 had a history of ing at least daily. Care Area Assessment (CAA) intified R97 was at risk for grity related to a need for bility, and refused to lie down. I R97 had "no pressure areasing excoriated from incont usals to lay down, chorea [an ary movement disorder] pelvice the CAA indicated R97 was a refusals to lie down, it did not atte interventions to direct staff pressure if R97 refused to lie with the care plan directed staff to the care plan directed staff to the care severy two hours and as plan did not address R97's risk at or identify interventions to down. A care plan addressing after the surveyor identified the	F3	314		

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING) DATE SURVEY COMPLETED			
		245279	B. WING		***	02/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, S 3815 WEST BROADWAY ROBBINSDALE, MN 5		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	LAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIA FICIENCY)	
F 314	Progress Note date on res [resident] but is healing." A quarte 1/11/16, indicated "buttockscreams a reposition but often dated 1/16/16, indicated 1/16/16, indicated R97 had right side of the glu "pressure points." Vand progress notes skin issues dating a continual refusals owere no further car implemented to recibreakdown. During an interview nursing assistant (Nahen R97 was last stated it was last do not know what time unaware of any skin buring an interview stated staff had a hadown. NA-E stated coccyx on and off a stated staff use crecheck on her every stated when R97 si pressure goes on hereorted R97's ope	age 40 and 12/26/15, indicated "the skin attocks looks good, maceration erly Nursing Note dated red rash intermittent on appliedencourage to refuses." A Progress Note cated "skin breakdown on A Progress Note dated 2/10/16, some reddened areas at the teal fold indicating some While the facility assessments indicated R97 had ongoing back several months and of attempts to reposition, there e planned interventions fluce the risk for skin If on 2/11/16, at 8:26 a.m. NA)-D stated he did not know to to the night shift but did at NA-D further stated he was an concerns regarding R97. If on 2/11/16, at 8:41 a.m. NA-E and time getting R97 to lay R97 had redness to her and it was "very ongoing." She am on R97's bottom and two hours. NA-E further the coccyx." NA-E stated she in area to the nurse that day. If on 2/11/16, at 12:43 a.m. hurse (LPN)-B stated R97 had ent for her reddened coccyx ring cream to it. He further	F3	114		

-	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245279	B. WING _		02	/12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422		= / = 3 . 0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO ((EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 314	stated, "All the time stated R97 had a s monitored and "now RN-B stated, R97 of that she was aware even though R97's to "monitor buttocks maceration/skin bredid not look at R97' "The trained medic and report concern During an interview stated R97 has had She further stated I addressed in the car RN-I stated R97 recontinue to try. She pressure redistribution chair and on her be mattress and cushi stated R97 was toil two hours at night be times. She stated in the car check at least week progress note, how lacked evidence of completed for R97. During an interview director of nursing of was R97's skin wor routine basis and was reasonable to the state of the state	e the pressure is there." He mall area that was being wit is better." on 2/12/16, at 7:38 a.m. did not have any skin concerns of. RN-B further explained treatment record directed staff for worsening of eakdown" each shift, the nurse is bottom daily. She stated, ation aides (TMAs) look at it is to the nurse." on 2/12/16, at 8:58 a.m. RN-I disome "excoriation going on." R97's skin should be are plan, but had not been. If the stated a specialized on had not been tried. RN-I eted and repositioned every out she did not know what hurses should be doing a skin kly and documenting in a rever, the medical record weekly skin checks were	F3	14		
		d/or specialized mattress. eled Care plan, dated February				

-	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		E SURVEY MPLETED
		245279	B. WING _		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 314	2002 indicated, resprovided necessary maintain the highest accordance with the The policy indicated individualized compinclude measurable toward achieving aroptimal medical, nuassessment instrunt physician's orders, concerns identified care will be modified required/provided for A facility policy titled Pressure Ulcers, dareviewed. The policy provide appropriate of pressure ulcers anecessary. The policy	idents will receive and be care and services to attain or at practicable well-being in a comprehensive assessment. It is each resident will have an orehensive care plan that will a goals and timetables directed and maintaining the resident's arisingneeds. The resident ment and review of the any problems, needs, and will be addressed. This plan of the to reflect the care currently or the resident." If Good Samaritan Society: a ded September 2012, was by indicated its purpose was to a ssessment and prevention as well as treatment when icy indicated residents would assessments and services to	F 31	4		

, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	` /	E SURVEY PLETED
		245279	B. WING _		02 /-	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	Continued From pa	ge 43	F 31	4		
F 318 SS=G	Based on the compresident, the facility with a limited range appropriate treatments	rehensive assessment of a must ensure that a resident of motion receives ent and services to increase d/or to prevent further	F 31	8		3/23/16
	by: Based on observate review, the facility for services including a motion (ROM) for reviewed for activitic contractures. As a experienced atual helft upper extremity Findings include: R73 was admitted to	ion, interview and document ailed to provide care and assessment and range of I of 3 residents (R73) es of daily living (ADLs) and result of these failures, R73 aarm, a decline in ROM of the other than the facility on 5/13/10, and bral vascular accident (stroke)		Resident R73 s pain was reasses 2/12/2016 and care plan modified a appropriate. NA-B and TMA-F were reeducated 2/11/2016, NA-C was reeducated o 2/12/2016, NA-D was reeducated o 3/10/2016 regarding stopping cares reporting to the nurse if they observings and symptoms of verbal or non-verbal pain. Range of motion was discussed with	on n n s and ve any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION NG		E SURVEY PLETED
		245279	B. WING _		02/-	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP (3815 WEST BROADWAY ROBBINSDALE, MN 55422	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 318	Admission Record assessment and p maintain functional ROM. As a result fextremity contracturist and fingers). During interview or registered nurse (Feontracture to his I (weakness of the ebody) due to a prevesident did not us restorative ROM. On 2/9/16, at 4:49 in a wheelchair in the across from his root observed to rest fill left hand against heapproximately a 90 and three fingers of closed fist position R73 was unable to There was no splir in R73's left hand. On 2/10/16, at 3:00 in bed. R73's left hand we closed fist. There cloth in place in the R73 was observed to a was observed to a was observed to a was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a contraction of the left hand we closed fist. There cloth in place in the R73 was observed to a contraction of the left hand we closed fist.	de in October 2010, per the The facility failed to conduct rovide ROM services to R73 to ROM and prevent a decline in R73 developed left upper pares (including shoulder, elbow, an 2/9/16, at 7:25 p.m. RN)-F stated R73 had a reft hand, left side hemiparesis rentire left or right side of the vious stroke, and that the reany splints or receive any p.m. R73 was observed sitting the common area at a table per many against his body with the ris chest, wrist bent at the degree angle at the forearm, on the left hand held firmly in a then requested at that time, open his clenched left hand. It or rolled wash cloth in place are tightly clenched into a was no splint or rolled wash	F 3 ⁻¹	nurse practitioner and ROM clarified on 3/1/2016. Physicompleted a range of motion with resident R73 on 2/12/2 motion tasks were added to Kardex assignment sheet a care (POC) documentation 2/15/2016. Resident R73 is rolled was order dated 12/30/2015 for contracture management a integrity was not followed a Individual employees who will to be following this order will on 2/12/2016. Resident R73 is nails were 2/11/2016. Resident R73 is nails were 2/11/2016. Care plans for all residents contractures were reviewed as needed on 3/10/2016. Policies for Care Plans, Pa Management-Resident Assistant Non-Pharmacological Pain and Range of Motion and Fain Data Collection, and Find Data Collection and Guidelines for Indianal Collection and Guidelines for Indianal Collection, and Find Data Collection, and Find Data Collection, and Find Data Collection and Guidelines for Indianal Collection and Guidelines for Indianal Collection, and Find Data Collection Dat	sical therapy on assessment 2016. Range of o R73 s and point of o schedule on sh cloth nursing r purposes of and skin as directed. were found not ere reeducated etrimmed on sistance, Interventions Procedures for Range of iewed with all ector of Nursing will be pliance through ne QAPI	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZI 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF (X (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 318	unsuccessfully to perfore stopping cate approximately 7:15 unsuccessfully attending the performanced, moaned approximately six especially when stopped approximately six especially she are stopped approximately six especially approximately six especially approximately six especially she are stopped approximately six especially attending approximately six especially she are stopped approximately six especially stopped approximately six especially approximately six especially she are stopped approximately she a	n addition, NA-B attempted out two different shirts on R73 ares to go get help. At 5 a.m., NA-B and NA-D empted to put a shirt on R73 in bed. R73 fidgeted, I and yelled "ouch" to eight times during cares aff attempted to manipulate or m. Neither NA-B or NA-D de any ROM services to R73	F3	18		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02 /	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 318	splint or rolled wash hand. During additional in at 12:05 p.m., NA-E any ROM services lindicated in the Kar an intervention. During interview on stated the nurses w R73 had a rolled wash cloth placed in 2/10/16 or 2/11/16. treatment administr reviewed at that tim documented the rol R73's hand had been had no explanation R73 was observed morning cares from a.m. R73 fidgeted a manipulated R73's him, or to get him dany ROM services from any ROM services from the joints in the shofingers. The PT furt services, use of spl rolled wash cloth to	ge 46 In cloth in place in the R73's left Iterview with NA-B on 2/11/16 Is stated R73 did not receive Decause ROM was not Decause ROM not had a not he palm of Decause R73's was Decause R73's Decause ROM was not Decause ROM was	F3	18		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION ING		TE SURVEY MPLETED
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER	7 - SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, Z 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 318	stated she had wo years. NA-C said the left arm which difficult, and stated special treatment it time, NA-C review sheet. NA-C verification for the provide RC further stated she services for R73. An interdisciplinary identified the first of contracture. The noweakness to his left contracture, and the and would bring in the services for R73. Assignificant change assessment dated been discharged from the waste to the left with bed more assessment further his left wrist becauth his stroke. The reconstruction and work is stroke. The reconstruction and work is stroke with hemiple the body). The goal free of complication including contraction including con	n 2/12/16, at 11:14 a.m. NA-C rked with R73 regularly for R73 was very contracted on made cares and dressing R73 did not receive any for the contractures. At that ed the Kardex/NA assignment ed the Kardex did not direct DM services for R73. NA-C had never provided ROM If progress note dated 11/10/11, documentation related to R73's ote indicated R73 had at hospice had been notified a splint for R73 to use. If e Minimum Data Set (MDS) 1/18/11, indicated R73 had rom hospice on 12/2/10, and lent on staff for personal bathing, needed extensive obility, transfers and eating. The er noted R73 utilized a splint to use it was weaker secondary to cord lacked evidence of any did to the noted contracture on	F3	18		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	TIPLE CONSTRUCTION ING	(X3 _.	COMPLETED	
		245279	B. WING			02/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	гү	STREET ADDRESS, CITY, STATE, Z 3815 WEST BROADWAY ROBBINSDALE, MN 55422	IP CODE	02/12/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		TION SHOULD BE THE APPROPRIAT	(X5) COMPLETION DATE
F 318	lower extremities w (bedtime) cares." R73's annual and q to 10/18/12, indicat limitation in ROM. I and quarterly MDSs inconsistently ident limitation in ROM of functional limitation dated 7/8/15, and q and 12/17/15, ident including hemipare affecting the left significated R73 was with transfers and be impairment in ROM lower extremity. The (CAA) for the annual ROM did not trigger A medical progress Communication/Visid discussion had occupractitioner regarding on R73's left arm whand identified a goal However, review of including Geriatric Strogress Notes (the primary physician and 6/16/15, 8/10/15, 8/2/9/15 failed to iden or discussion about On 2/12/16, at 11:4 with RN-D and RN-admitted to the facility and the facility of the same content of the facility of the same content of the facility of the facil	ith a.m, (morning) and hs quarterly MDSs from 10/20/10 ed R73 had no functional However subsequent annual s, from 10/18/12 to 12/17/15, ified R73 either had functional n one side, or had no in ROM. The annual MDS quarterly MDSs from 9/23/15 ified R73 had diagnoses sis related to the stroke le. Each of these MDSs totally dependent on two staff ped mobility, and had an I to one side, on the upper and e Care Area Assessments al MDS related to impaired		18		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		245279	B. WING			02/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP COD 3815 WEST BROADWAY ROBBINSDALE, MN 55422	Æ		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 318	the stroke. Neither state when the staff contractures. RN-D verified the ROM properties and state first been receiving any care plan and state first been identified but that a "K" had not transfered to sheet as an interver RN-D and RN-F fur functional ROM assignarterly and annual then responsible to ensure the interven Kardex. However, knot verified whether had been included complete. RN-D actunctional ROM had in the facility.	ge 49 reloped the contractures after RN-D or RN-F were able to had first identified R73's reviewed the Kardex and rogram had not been included are to provide. RN-D was likely why R73 had not ROM. RN-D reviewed R73's d ROM services for R73 had on the care plan on 10/30/12, ot been checked next to the herefore the ROM services to the Kardex/NA assignment antion for the NAs to complete. The explained they completed bessments at the time of all MDSs. They said they were update the care plan and tions were included on the both acknowledged they had the ROM services for R73 in the Kardex for NAs to knowledged R73's decline in discourred while he'd resided	F3	18			
	facility's director of were expected to for and the nurse mana all appropriate care Kardex/NA assignmented the facility shapevent further decicontractures. The Extremely staff had contractures. The Expectage of the facility staff had contractures. The Expectage of the facility staff had contractures. The Expectage of the facility staff had contractures and the facility staff had contractures.	nursing (DON) stated staff ollow each resident's care plan agers were to make sure that is were included on the ment sheets. The DON also could do everything possible to ine for any resident who has DON was unable to state when first identified R73's DON acknowledged R73's I ROM could have been assessments and failure to					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING	COMPLETED
245279 B. WING	02/12/2016
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF COMPLETE ACTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE DEFICIENCY OF TH	ON SHOULD BE COMPLÉTION DATE
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 322 483.25(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	3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING			02/-	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	38	TREET ADDRESS, CITY, STATE, ZIP CODE B15 WEST BROADWAY OBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 322	treatment and serv pneumonia, diarrhe metabolic abnorma	age 51 eceives the appropriate ices to prevent aspiration ea, vomiting, dehydration, lities, and nasal-pharyngeal re, if possible, normal eating	F 3	22			
	by: Based on observareview the facility fathe gastrostomy tul administration of m (R77, R2). Findings Include R77's quarterly Mir 12/23/15, identified by staff and his meidentified R77 was all activities of daily feeding tube and his sclerosis (MS), aph R77's Care Area As 4/21/15, identified I related to stroke ar precautions were ta R77's care plan prihad end-stage MS	tion, interview and document ailed for check placement of the (G-tube) prior to edication for 2 of 4 residents a sessed mory was ok. MDS further totally dependent on staff for a living (ADLs), required a aid diagnoses of multiple trasia, anxiety and depression. Seessment (CAA) dated R77 received tube feedings and poor oral intake, and aken to prevent aspiration.			Incidents occurred due to two staff properly following procedure. RN-ALPN-D were reeducated to the proportion of the procedure on 2/16/2016 and 2/11/2 respectively. The Medication Administration via Procedure was reviewed with all appropriate staff. The Director of New Services and/or designee will be responsible to ensure compliance trandom monthly audits. The QAPI committee will monitor audits for or compliance.	A and per 2016 Tube Jursing hrough	

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	TIPLE CONSTRUCTION NG		TE SURVEY MPLETED
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422	.	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 322	had no desire to ea R77 was to be free complications related. The Medication Restaff was to change plugged or leaking were to be adminis. On 2/11/16, at 7:29 was observed crush medications R77's medication into its of medication cup. RN medication cup to the each medication wispoon. RN-A then regastric tube, inserted poured the fist medication and prowater plus a protein course of the medication and	at or drink anything by mouth. of side effects or ed to tube feeding. view Report dated 2/11/16, the G-tube as needed if and that all oral medications tered by g-tube. a.m. registered nurse (RN-A) hing R77's individual and emptied each crushed own 30 milliliter (ml) I-A proceeded to fill each he top with water and stirred th a separate plastic white removed the cap from R77's ed syringe into the tube and lication in water into the checking placement. RN-A to the syringe after each vided a total of 460 ml's of a supplement during the cation administration. At the tion, RN-A stated she thought is to be checked weekly, but estated she was not sure when ent had been checked, but ement was checked in a sense of because if it was not placed ork. RN-A stated she does not ube placement every time ters medications, and did not one to confirm placement. She checks to see if it was working of water to the syringe and if it	F3	22		

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02	2/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP O 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 322	checking process is stethoscope to listed placement. She state nurse who started is check the placement before a could not remember check the placement before a could not remember check the placement medication administrated she expected placement first, and anything in the tube expect the nurses it stethoscope to make should be and aspit the contents and placements and placemen	ted the tube placement is when you instill air and use a sen for gurgling to confirm ated she thought the night R77's g-tube feeding should int. She stated it was possible is point to check the tube administering medications, but it is she confirmed she did not int of R77's tube today before stration. If p.m. unit manager (UM)-A is the nurses to check tube it is she stated she she would to blow air into tube and use a ke sure the tube was where it rate stomach contents, assess it back in. UM-A stated watching to see if it drains was checking tube placement. The don'the February 2015, included persistent vegetative lar dysfunction, tracheostomy, reflux disease and the december of the safely. The care plan further are december of the safely and water flushes. The administration observation and administration observation and and interest and unable to a safely. The care plan further are december of the safely and water flushes.	F3	22		
		R2's G-tube on 2/9/16, from p.m. licensed practical nurse				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNITY	,	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 322	cubic centimeters (checking placement administer medicat syringe. After administer medicat syringe. After administer medicat syringe. After administer medicat connected R2's Jewnutritional formula f	ved to flush the G-tube with 10 cc) of water without first it. LPN-D then continued to ions via gravity through a histering medications LPN-D with 100 cc of water and vity 1.2 (a calorically dense or tube feeding) and turned on achine infused at 85 mls/hour. D.m. LPN-D acknowledged ck the G-tube placement. The placement should have re giving the medication and refeeding for infusion. LPN-D policy required checking er giving meds and checking deministration of G-tube described the facility would into the facility would into the facility would into the manner. The policy change in external length of ning whether the mark abbes exit site has moved. If from feeding tube and inject 5 the the tube to clear the tube. In the tube to clear the tube in the facility to be sure the tube is in the of the gastric contents and exact values."	F 322			
F 323 SS=D	483.25(h) FREE OI HAZARDS/SUPER		F 320	3		3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	у 3	TREET ADDRESS, CITY, STATE, ZIP CODE 815 WEST BROADWAY ROBBINSDALE, MN 55422	0=,1=,000	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION	
F 323	The facility must en environment remain as is possible; and adequate supervising prevent accidents.	ge 55 Issure that the resident Ins as free of accident hazards each resident receives on and assistance devices to	F 323			
	by: Based on observative review, the facility for were safely secured the risk of injury for reviewed for accident Findings include:	tion, interview and document ailed to ensure bed grab bars d to the bed frame to minimize 1 of 4 residents (R38) ents.		The right pivoting assist bar on res R38 s bed was tightened on 2/11/2 Resident R38 discharged on 2/26/2 All pivoting assist grab bars attacher resident beds were inspected on 3/1/2016.	2016. 2016. ed to	
	had side rails (inclufor R38, RN-D state for mobility. On 2/9/16, at 4:45 pbed was observed lying on her back into the door was observed one to two in addition, the bolt policing and moved at touched. On 2/10/15, at 10:0 remained loose. W	o.m. when asked if resident des half or quarter rails) used ed resident had two grab bars o.m. during room observation with two grab bars. R38 was bed. The right grab bar close served very loose and could be nothes back and forth. In ortion of the grab bar was round when the grab bar was 0 a.m. the right grab bar hen asked if she used the		Procedures for reporting equipmen issues and completion of work orde were reviewed with all appropriate. The Director of Nursing Services at designee will be responsible to ens compliance through random month audits. The QAPI committee will maudits for ongoing compliance	ers staff. nd/or ure ly	
	to side.	ated she did use it to turn side				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02 /	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	4	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	,	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 323	bed during cares, n "Yes." Surveyor and verified the grab ba if she had assisted to get ready, NA-A R38. When asked I of any concerns, N nursing station and maintenance slip th one outAt 12:51 p.m. regis resident used the g during cares or whe asked if she expect concerns with the g stated, "as a matter filled a maintenance week." On 2/11/16, at 1:03	or turning side to side when in ursing assistant (NA)-A stated d NA-A went to room and r was very loose. When asked resident during morning cares stated therapy had assisted now maintenance was notified A-A brought surveyor to the showed surveyor a ren indicated was going to fill stered nurse (RN)-B stated rab bars to turn side to side en using a bedpan. When red staff to report any rab bar being loose, RN-B of fact I believe [RN-C] had a slip for the grab bar last	F3	23		
	with morning cares independent with a get herself dressed supine when getting. When asked if res stated resident use side and OT stated right grab bar was I. When asked how as loose grab bar, a maintenance slip at to be picked up. When asked if she 2/10/16, OT indicat noticed the grab ba from the left side by	d assisted resident that day OT indicated resident was ctivities of daily living and did as she was learning to do it g on pants using a Reacher. ident used the grab bars, OT d them when rolling side to she but had not noticed if the oose. staff reported concerns such OT stated would fill a and left it at the reception desk had assisted resident on ed she did however had not r as she worked with resident of the window. OT further she same time writing notes and				

	OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION (X3) MULTIPLE CONSTRUCTION (X4) MULTIPLE CONSTRUCTION (X5) MULTIPLE CONSTRUCTION (X6) MULTIPLE CONSTRUCTION (X7) MULTIPLE CONSTRUCTION			TE SURVEY MPLETED		
		245279	B. WING		02	/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP C 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	barWhen asked if she have reported the i imagine but I think the question was h talking to surveyor, and stated she too not noticed the loos was working from t resident preferred some staff to put in a wor DOF, administrate grab bar was loose staff to put in a wor DOF to check for a filled by RN-C. On 2/12/16, at app administrator state was no slip filled for the care equipal director of nursing supposed to report immediately. When supposed to identif DON stated if a resindependent, she was month of the grab R38's diagnoses in R38's diagnoses in the staff of the care equipal to the care equipal	anything regarding the grab would expect nursing staff to ssue, OT stated "I would she is up during day" thought ard to answer. As OT was PT joined on the conversation had worked with her but had se grab bar because she also he left side, as this was side. p.m. the environmental tour in the director of facilities or and Intern. DOF verified the p. DOF stated would expect the order. Surveyor requested a slip regarding the grab bar roximately 10:50 a.m. the d DOF had checked and there in the grab bar last week. 4 a.m. when asked if she to report, any concerns with oment such as grab bars; the (DON) stated staff was it to maintenance in asked if the care plan was by the grab bars for mobility, sident used them to be would have expected care plan	F3	23		
	amputation, unspec	e following surgical cified systolic (congestive) cquired absence of right leg				

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		E SURVEY IPLETED
		245279	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO ((EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 431 SS=E	R38's care plan dat was at risk for falls amputation and dec balance instability. Geducate/instruct resof assistive devices bend over to pick upencourage to use a assistance. The car R38 used grab bars 483.60(b), (d), (e) ELABEL/STORE DR The facility must emalicensed pharmacof records of receip controlled drugs in accurate reconciliate records are in order controlled drugs is reconciled. Drugs and biological abeled in accordan professional princip appropriate accessinstructions, and the applicable. In accordance with facility must store a locked compartment.	ed from electronic medication ary 2016. ed 1/12/16, indicated resident related to right leg above knee conditioning as evidenced by Care plan directed staff sident and family on safe use (s), remind resident not to or dropped items and grabber or to ask for re plan did not address/identify of for bed mobility. PRUG RECORDS, UGS & BIOLOGICALS Inploy or obtain the services of sist who establishes a system to and disposition of all sufficient detail to enable an ion; and determines that drug reand that an account of all maintained and periodically als used in the facility must be ce with currently accepted les, and include the ory and cautionary expiration date when State and Federal laws, the ll drugs and biologicals in ints under proper temperature to only authorized personnel to	F 4			3/23/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245279	B. WING		02/12	/2016	
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	у 3	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		1 02/12/2010	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETION DATE	
F 431	permanently affixed controlled drugs lis Comprehensive Dr Control Act of 1976 abuse, except whe package drug distriquantity stored is in be readily detected. This REQUIREMED by: Based on observareview, facility faile medications were punits. In addition, the medication refrigured sanitary. Findings include: Bluff Country medic During observation medication room of open multi dose via located in the medicated in the medicated in the medicated in the medicated practical in dose flu vaccine via opened. LPN-C ver 10/7/15, and that it in addition the top so noted with pinkishthat the refrigerator sanitary. LPN-C fur	ovide separately locked, d compartments for storage of ted in Schedule II of the ug Abuse Prevention and and other drugs subject to the facility uses single unit ibution systems in which the minimal and a missing dose can be. NT is not met as evidenced tion, interview and document d to ensure expired properly disposed off for 3 of 6 the facility failed to ensure 1 of the erators was kept clean and	F 431	All expired medication/vaccines on disposed of on 2/12/2016. The refrigerator on Bluff was cleaned or 2/12/2016. All medication rooms were inspecte expired medications and refrigerate checked for cleanliness on 2/12/20 Nurse Manager for 3rd floor unit gate of vaccination dates to surveyor on 2/12/2016. Procedures for Disposition of Medicand Vaccine Handling Storage Parameters will be reviewed with a appropriate staff. The Director of Nervices and/or designee will be responsible to ensure compliance to trandom monthly audits. The QAPI committee will monitor audits for or compliance	ed for ors 16. we list cation		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		` '	(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02/	12/2016	
_	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	1	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOUND CROSS-REFERENCED TO THE APPRINTED DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 431	unit's nurse managestated she expected disposed off when expected disposed off when expected disposed off when expected disposed off when expected on the second of the se	ezer once a week. 2/12/16, at 11:55 a.m. the er, registered nurse (RN)-D d medications to be properly expired and the refrigerator to canitary. nedication room on the third of the Boundary Waters n 2/12/16, at 6:56 a.m. an of magnesia (MOM-a stipation) was noted to have MOM had expired in October of nable to say who had received most likely had been used tion room on the third floor: of the Arrowhead medication to 7:11 a.m. an open multi dose of the vaccine was located in the lator. The vial was dated as decorated to 10/23/15. RN-E stated multiples are good for 30 days once ied date vial was opened and	F 4	31			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		245279	B. WING		02	/12/2016	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNIT	Υ	STREET ADDRESS, CITY, STATE, ZIP (3815 WEST BROADWAY ROBBINSDALE, MN 55422			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE	
F 431	the person doing so that time. I will leave nurse know." During interview or nurse manager, sa medication rooms to the TMA's check the pull them. When as vial of flu vaccine good believe." RN-J said of 2015. I am sure vaccine after it expension of influenza and was a had been thrown as Requested list of vaccine on both third floor up facility. Immunization	a bottle or give a medication, o, checks the expiration date at e it on the counter and let the a 2/12/16, at 9:05 a.m. RN-J, id the nurses check the for expired medications and the medication cards when they sked how long was an open good for RN-J replied "30 days I I," I gave flu vaccine in October no one received the flu ired." RN-J verified the same become would have been used by d Boundary Waters unit went between both units. Told me she found an expired going to get rid of it. I thought it way."	F 4	31			
	on the first or third identified by record the facility and who after the expiration Arrowhead medica Admission Record indicated R223 was 12/2/15, to a room Reportdated 2/12/1 influenza vaccine of Acquisition, Receiv	wed for all residents residing floor. One resident was review as currently residing in received a influenza vaccine date on the vial located in the tion room. dated 2/12/16 for R223 and admitted to the facility on on third floor. Immunization 6, indicated R223 recieved the in 12/3/15, from RN-A. ing, Dispensing and Storage cedure Revised 12/15,					

	PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		245279	B. WING		0	2/12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNI	тү	STREET ADDRESS, CITY, STATE, ZIP 3815 WEST BROADWAY ROBBINSDALE, MN 55422		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETION DATE
F 431	medication cart, dra 5. The location will medications and ne in accordance with 6. All medications v with manufacturers Recommended Mir Parameters and Ins Recommendations 7Refer to Vaccir Parameters for spe Vaccine Handling a revised 12/15, instr	be stored in a locked awer or cupboard routinely check for expired ecessary disposal will be done state/Pharmacy regulations. will be stored in accordance recommendations. Refer to minum Medication Storage in this manual. The manual hation Handling and Storage cific storage of vaccinations." and Storage Parameters ucted staff: "A weekly review n dates and rotation of	F 4	31		

5279026

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING 02 - MAIN BLDG B. WING 245279 02/11/2016 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **3815 WEST BROADWAY** GOOD SAMARITAN SOCIETY - SPECIALTY CARE COMMUNITY **ROBBINSDALE, MN 55422** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES ID (X4) ID COMPLETION EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX **PREFIX** CROSS-REFERENCED TO THE APPROPRIATE DATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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:

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.

Facility ID: 00890

	T OF DEFICIENCIES DF CORRECTION				COMPLETED		
		245279	B. WING		02	/11/2016	
	PROVIDER OR SUPPLIER	- SPECIALTY CARE COMMUNIT	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422		,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 000	DEFICIENCY MUS FOLLOWING INFO 1. A description of to correct the defice 2. The actual, or properties of the correct the defice 3. The name and/oresponsible for comprevent a reoccurrent a reoccurrent and recomprevent and recomprevent and long-term special locking arrathe building is fire the building has a detection in the concorridors that is modepartment notifical capacity of 96 beds time of the survey.	state.mn.us an@state.mn.us ana@state.mn.us ana@state.mn.us ana@state.mn.us ana@state.mn.us ana.cor title of the person and title of the person and title of the person and the deficiency. and with a basement was and determined to be Type II and the building has a garage, anical equipment in the and care and transitional care ang-term care on the second and care on the third floor utilizing angements for memory care. angements for automatic fire ation. The facility has a and had a census of 95 at the at 42 CFR, Subpart 483.70(a) is	K 00				
K 050 SS=F	NFPA 101 LIFE SA Fire drills include the signal and simulatic conditions. Fire dri	ne transmission of a fire alarm on of emergency fire alls are held at unexpected g conditions, at least quarterly	K 0	50	580	3/23/16	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

PRINTED: 03/15/2016 FORM APPROVED OMB NO. 0938-0391
(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	TIPLE CONSTRUCTION NG 02 - MAIN BLDG	(X3) DATE SURVEY COMPLETED	
-		245279	B. WING		02/	11/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CARE COMMUNITY	Y	STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	, •=-	988
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 050	and is aware that d routine. Responsible conducting drills is persons who are quere where drills are conducted and are conducted as a coded at instead of audible at 18.7.1.2, 19.7.1.2. This STANDARD is Based on document interview, the facility documentation that once per shift per quarying times and conducted as a condu	staff is familiar with procedures rills are part of established lity for planning and assigned only to competent palified to exercise leadership, and anouncement may be used plarms. Is not met as evidenced by: another than the provide fire drills were conducted uarter for all staff under onditions as required by 2000 18.7.1.2. This deficient	K 0	Fire drills will be conducted at unexpected, varied times. Appropr staff were reeducated on the prope procedure for fire drills. Director of Environmental Services and/or des will be responsible to ensure comp through random audits. The QAPI committee will monitor audits for o compliance.	er f signee liance	
K 144 SS=F	February 11, 2016, documentation for that It was observed second shift were conformation 1630 white accordance with the This deficient practic Director of Environmentation of Environment	reen 9:30 AM and 1:30 PM on the review of the fire drill he past 12 months revealed that the fire drills for the onducted at 1530, 1600, ich are not varied in a Life Safety Code. ce was confirmed by the mental Services at the time of FETY CODE STANDARD and weekly and exercised inutes per month and shall be NFPA 99 and NFPA 110. NFPA 99), Chapter 6 (NFPA	K 14	44	±:	3/23/16

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - MAIN BLDG		(X3) DATE SURVEY COMPLETED				
		245279	B. WING			02/1	11/2016
NAME OF PROVIDER OR		- SPECIALTY CARE COMMUNITY	v	38	REET ADDRESS, CITY, STATE, ZIP CODE		
OOOD OAMAKTAN		- or Edizer Foate dominoter		R	OBBINSDALE, MN 55422		
PREFIX (EACH	DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ď	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 144 Continued	From pa	ige 3	K 14	44			
Based on interview, emergence requirements. 6-4. This contents in the content of	documenthe facility general ints of NF deficient proclude: tour between tour between cool down from the ficient praff Environr	ntation review and staff by failed to maintain the tor in accordance with the FPA 110-1999 edition, Section practice could affect all 94 ween 9:30 AM and 1:30 PM on review revealed that a m period was not documented	K 14	44	A separate column for generator of down time was added to the gener log to document cool down time or 2/11/2016. Director of Environment Services was reeducated to proper procedure on 2/11/2016. The Administrator and/or designee will responsible to ensure compliance random audits. The QAPI committed monitor audits for ongoing compliance of the complex of the compl	ator run ital be through ee will	



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 <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at 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.

Good Samaritan Society - Specialty Care Community March 3, 2016 Page 2

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

Kamala Fiske Downing

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

PRINTED: 03/15/2016 **FORM APPROVED** Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: ___ B. WING 00890 02/12/2016 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY **GOOD SAMARITAN SOCIETY - SPECIALTY CA ROBBINSDALE, MN 55422** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****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

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/inf obul.htm The State licensing orders are delineated on the attached Minnesota

orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 03/11/16

(X6) DATE

TITLE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		00890	B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALLY CA	ST BROADW SDALE, MN(
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 000	you electronically. A is necessary for State enter the word "cortext. You must then State licensure procompletion date, the corrected prior to e Minnesota Department's staff, the following correction that you and identify the data. Minnesota Department be state Licensing federal software. To assigned to Minnesota Department he State Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To assigned to Minnesota Department be state Licensing federal software. To state and replaces the "Incorrection order. The assigned the "Incorrection order. The statement be statement by the statement by the Suggested Time period for Country Provider's PLA APPLIES TO FEDERAL TO FEDERAL TO FEDERAL TO STATE TO ST	alth orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for indicate in the electronic cess, under the heading le date your orders will be electronically submitting to the ment of Health. 2/12/16, surveyors of this visited the above provider and ction orders are issued. Your electronic plan of have reviewed these orders, the when they will be completed. The ent of Health is documenting agr numbers have been sota state statutes/rules for the ent of Deficiencies" column for Comply" portion of the his column also includes the in violation of the state statute for the surveyors findings method of Correction and rection. ARD THE HEADING OF THE	2 000			

Minnesota Department of Health STATE FORM

BZJW11 If continuation sheet 2 of 62

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			SURVEY LETED
		00890	B. WING		02/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 2	2 000			
	PLAN OF CORREC	QUIREMENT TO SUBMIT A CTION FOR VIOLATIONS OF E STATUTES/RULES.				
2 510	MN Rule 4658.0300	O Subp. 2 Use of Restraints	2 510			3/23/16
	must be free from a restraints imposed	from restraints. Residents any physical or chemical for purposes of discipline or not required to treat the symptoms.				
	by: Based on observati review, the facility fa bilateral (bilat) thigh potential restraint fo	on, interview and document ailed to assess the use of a positioning device as a por 1 of 3 residents (R97) er wheel chair.		Corrected. No POC required.		
	Findings include:					
	11/12/15, indicated impaired and requir	imum Data Set (MDS) dated she was severely cognitively red extensive assist of two The MDS further noted R97 did				
	falls related to gait/b and poor decision n staff to apply a "bila while up in chair an device every 30 mir hours. Care planne	ted 12/3/15, indicated risk for balance problems, impulsivity making. The care plan directed ateral thigh positioning device" d directed staff to check the nutes and reposition every two d behaviors included, ambulating in the hall				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
_	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S T BROADW DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 510	disrobed and striking A Good Samaritan a Community Progresindicated R97 need with transfers, and The progress note of using a Broda (a whollat thigh pads duerisk, not considered transfer safely index During an observating R97 was seated in chair. Across each strap that extended attached behind and During an interview nursing assistant (N "positioning straps." risk and the straps wheel chair. He furt release the device opens it "she could - At 12:39 p.m. licer stated he thought the using the positioning deviconstant falling. He to reposition R97 At 1:32 p.m., regis "without those strap the floor." She furth to restrain her." RN initiated on 3/11/14, the facility did not coto be a restraint. Everestricted R97's mo	ag out at staff. Society Specialty Cars Note dated 1/11/16 led assist with mobilit "will walk short distant further indicated R97 neel chair that recline to "frequent standing a restraint due to un p [independently]." ion on 2/9/16, at 4:28 a high backed padde of her upper thighs w from under her legs d out of reach of resident of the control of t	p.m., d wheel ras a and dent. p.m., d sa a fall tion in her ot able to d if she (LPN)-B nt prior to her stated ty due to e released atted ably be on by trying ent was a g device ener from	2 510			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 4 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00890		B. WING		02/1	02/12/2016	
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S BT BROADW DALE, MN				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE	
2 510	was no ongoing assisted device continued to SUGGESTED MET administrator or despendent resident restraint us are not restrained wand monitoring. TIME PERIOD FOR (21) days.	sessment to determine be appropriate. THOD OF CORRECT signee could review to sage data to ensure revithout proper assess a CORRECTION: Two	TION: The he residents sments renty-one	2 510				
2 560	Plan of Care; Contents comprehensive plan objectives and time long- and short-term and mental and psylidentified in the comassessment. The comust include the increquired by Minness subdivision 14, para This MN Requirements: Based on observation review, the facility for subdivision 14.	of plan of care. The n of care must list me tables to meet the ren goals for medical, rychosocial needs that apprehensive resident comprehensive plan of dividual abuse prevenota Statutes, section agraph (b). ent is not met as eviction, interview, and do ailed to develop care	easurable sident's nursing, t are of care ntion plan 626.557, denced cument planned	2 560	Corrected. No POC required.		3/23/16	
	residents (R97) rev Findings include: During an observati R97's morning care lying in bed on her i	vent pressure ulcers iewed for pressure u ion on 2/11/16, at 8:2 is were observed. R9 right side. R97's inco with urine and soiled	Icers. 2 a.m. 97 was ntinent					

Minnesota Department of Health

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00890	B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE		-,
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	T BROADW			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	DALE, MN 5	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	COMPLETE DATE
2 560	Continued From pa	ge 5	2 560			
	noted to have a red	continent cares, R97 was dened coccyx area with a 1/2 at appeared to be open.				
	2/12/16, at 8:02 a.n assessed R97's ski stage one pressure erythema of intact skin ulceration. In ir discoloration of the induration, or hardn	nt observation of cares on n. registered nurse (RN)-B n. RN-B stated R97 had a ulcer (a non-blanchable skin, the heralding lesion of ndividuals with darker skin, skin, warmth, edema, less may also be indicators) described the pressure ulcer				
	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.					
	dated 8/20/15, iden impaired skin integrassistance for mobour The CAA indicated but has been gettin [incontinence], refusions.	are Area Assessment (CAA) tified R97 was at risk for rity related to a need for illity, and refused to lie down. R97 had "no pressure areas g excoriated from incont sals to lay down, chorea [an ry movement disorder] pelvic				
	a self-care deficit, r activities of daily liv	ed 9/4/15, indicated R97 had equired assistance for all ing, and was incontinent of The care plan directed staff to				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 6 of 62

Minnesota Department of Health

	(X3) DATE SURVEY COMPLETED	
00890 B. WING 02/12/2		
00890 B. WING 02/12/2	2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY - SPECIALTY CA ROBBINSDALE, MN 55422		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) X4) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 560 Continued From page 6 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 buttockscreams appliedencourage 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 B97 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 whit 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 staff had a hard time getting R97 to lay down. NA-E stated staff had a hard time getting R97 to lay down. NA-E stated staff had a hard time getting R97 to lay		

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 7 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER		REET ADDRESS, CITY			
GOOD S	AMARITAN SOCIETY	- SPECIΔΕΓΥ (:Δ	15 WEST BROAD BBINSDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 560	stated staff use crecheck on her every stated when R97 si pressure goes on h During an interview licensed practical n an ongoing treatmethat staff was apply stated, "All the time During an interview RN-B stated, R97 of that she was aware even though R97's to "monitor buttocks maceration/skin bredid not look at R97." "The trained medica and report concerns. During an interview stated R97 has had She further stated R97 has had She further stated R97 ref continue to try to ge offloaded. During an interview director of nursing (was R97's skin wour routine basis and winterventions should such as therapy and	am on R97's bottom and two hours. NA-E further its in her chair, "all her er coccyx." on 2/11/16, at 12:43 a.m. urse (LPN)-B stated R97 nt for her reddened coccing cream to it. He further the pressure is there." on 2/12/16, at 7:38 a.m. id not have any skin con of. RN-B further explain treatment record directed for worsening of eakdown" each shift, the statement record directed is to the nurse." on 2/12/16, at 8:58 a.m. is some "excoriation going R97's skin should be ure plan, but had not been used offloading, but staff at R97 repositioned and on 2/12/16, at 11:18 a.m. DON) stated her expectable have been monitored ith cares. She stated oth thave been initiated for its door specialized mattress led Care plan, dated February in the care i	n. ' had cyx er cerns ed d staff nurse d, at it RN-I g on." n. f n. the ation on a er R97 s. bruary			
	provided necessary	sidents will receive and I care and services to atta t practicable well-being i	ain or			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 8 of 62

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	LTIPLE CONSTRUCTION DING:		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/1	2/2016	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ITEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICIENCY)	D BE	(X5) COMPLETE DATE	
2 560	The policy indicated individualized compinclude measurable toward achieving ar optimal medical, nu assessment instrum physician 's orders concerns identified care will be modified required/provided for SUGGESTED MET DON or designee concerns are developed current care needs medications. The Deducate all appropriodicies/procedures system to ensure or	e comprehensive assessment. d "each resident will have an orehensive care plan that will e goals and timetables directed and maintaining the resident's ursingneeds. The resident ment and review of the equation, any problems, needs, and will be addressed. This plan of d to reflect the care currently or the resident." THOD OF CORRECTION: The ould develop, review and/or procedures to ensure care d and reflect each residents including high risk oon or designee could	2 560				
2 565	Plan of Care; Use Subp. 3. Use. A co	5 Subp. 3 Comprehensive omprehensive plan of care personnel involved in the incomprehensive plan of care in the incomprehensive plan of ca	2 565			3/23/16	
	by: Based on observati	ent is not met as evidenced ion, interview and document ailed to ensure staff reported		Corrected. No POC required.			

Minnesota Department of Health STATE FORM

FORM BZJW11 If continuation sheet 9 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 565	pain with cares for experienced pain of facility staff failed to cloth and range of residents (R73) who with activities of dair reviewed for ADLs at Findings include: Pain: R73 was admitted to cerebral vascular at left side in October, re-assess R73 for puthe left hand, wrist, facility staff did not when R73 experient reassess and provides.	1 of 2 residents (R73 luring cares. In addit provide nail care, re notion (ROM) for 1 of prequired staff assistly living (ADLs) who	ion, the olled wash of 2 stance were /10, had a cting the alled to actures of and the cares ne nurse, ent to	2 565			
	in a wheelchair in the across from his roo against his body with chest, wrist bent at the forearm and three closed fist position. Clenched left hand with the forearm and three closed fist position. Clenched left hand with the forearm and the closed fist position. Clenched left hand with the closed fist position. Clenched left hand with the closed fist position. Clenched left hand with the cl	o.m. R73 was observate common area at a m, R73's left arm reach the left hand rester about a 90 degrees ee fingers on the left R73 was not able to when asked to do so during morning care in a many from his body to pted unsuccessfully 173 before stopping and NA-D unsuccessing a shirt while R73 was a shirt while R73 was aced, moaned and years.	a table sted firmly ed on his angle at thand in a open his o. s on (NA)-B and tried to owash to put two cares to sfully as in bed.				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 10 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING	····	02/	12/2016
	GOOD SAMARITAN SOCIETY - SPECIALTY CA 3815 WE			DRESS, CITY, S ST BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 565	"ouch" approximate cares especially wh R73's left arm. NA-providing morning or grimaced, moaned times. R73 was observed 2/12/16, at 8:12 a.n R73 under close su (RN)-D who was the during morning care R73's face with a weare turned his head awe moaned. RN-D, who asked NA-C to stop R73's facial express discomfort and will pain medication and later. On 2/12/16, a returned to R73's recares. R73 did not a during cares but griwhen staff attempted hand. Review R73's elect administration reco 2015, January and R73 received as netwo times on 1/2/16 being ineffective and documented as bein medical record lack was assessed prior medication and/or of R73's care plan dat resident had potent	ely six to eight times aren staff held and purity is and NA-C did not cares when R73 fidgrand yelled "ouch" must be and yelled "ouch" must be a seen to assess R73's es. NA-C attempted as has cloth, R73 immoral from NA-C, fidger of the was present in the property of the pr	lled on stop eted, ultiple es on eg care to ed nurse pain to wash ediately ted and room -D stated was in 73 with g cares id NA-C rning omfort lonly gers on left edications ented as was EMAR. The 73's pain PRN pain the ort related				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			SURVEY LETED	
		00890	B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	T BROADW DALE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
2 565	(paralysis on one signs disease processes teeth and restlessin decrease in behaviorestlessness, grimal facility staff were to symptoms of non-vibreathing, vocalizationanges, and nursi analgesia as per or cares and report Ri 2/11/16, as the care During interview on stated she heard Riduring morning care whenever she assistalways moaned and she believed R73 whis left upper extremate on 2/11/16, at 9:40 (LPN)-C verified R7 pain for which he refurther stated nursing assistants of the discomfort with residenced anyone repowith R73 during model on 2/11/16, at 12:4 (TMA)-F stated R73 clenched his teeth further stated she as to R73 except Roxathe nurse, half the filter stated she for the stated she as to R73 except Roxathe nurse, half the state	ide of the body) and end stage as evidenced by grinding ess. The goal for R73, ors of inadequate pain control acing and grinding teeth. The report to nurse any signs or erbal pain, changes in tions, mood and behavior ng staff to administer ders. Both NAs did not stop 73's pain to the nurse on e plan directed. 2/11/16, at 7:12 a.m. NA-B 73 moaning and yelling "ouch" es, and continued to state sted with R73's cares, R73 di groaned during cares and vas "in pain" when working on	2 565			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 12 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CA 3815 WE ROBBIN						
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 565	anyone reporting ar during morning care on 2/12/16, at 9:27 usually works with I groaned sometimes attempting to left R' wash or get R73 dr she believed R73 w stated did not repornurse stating "it is li him." NA-C stated a on 2/12/16, prior to for him today" as shouring a joint intervithe nurse manager MDS coordinator R observations and si morning cares with stated they were not during morning care to state she expectivoiced or observed verified he assesse assessed as to hav R73 was to continu but he could not recipain assessments. Not aware that R73 could not recall if he during cares. During interview on RN-D completed panoted R73 fidgeted NA-C attempted to that R73 was in sor stop morning cares	ny pain or discomfort	nity to stated." NA-C of the edications ent better ed happy. 35 p.m. of the unit's of surveyor uring. F both is sues continued is to report. N-F. '3 was her stated egimen es of R73's he was ares and B's pain. after 173, she ay when dicating of the dica				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 13 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER	3815 WES	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 13	2 565			
	2/12/16, at 9:38 a.n R73 received pain relaxed during more expected nursing a voiced or observed nurse was expected 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.					
	ROM: R73 was admitted to cerebral vascular a left side in October specialized treatmer maintain functional ROM. As a result Fextremity contractury wrist and three fing	,				
	in a wheelchair in the across from his roo hands were observ	o.m. R73 was observed sitting ne common area at a table m, R73's finger nails on both ed to be long and untrimmed rter [1/4] inch in length). There				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 14 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00890	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 565	was no splint or roll left hand. During interview on stated R73 had a consider hemiparesis (wright side of the booresident did not use restorative ROM. On 2/10/16, at 3:08 bed awake, R73's lochest, finger nails of to be long and untri wash cloth placed in R73 was observed 2/11/16, at 7:03 a.m assistant (NA)-B. Note services to R73 duratinger nails on both long and untrimmed cloth placed in R73 was observed sitting common area at at LPN-C verified R73 underneath. There placed in R73's left R73 was observed 2/12/16, at 9:05 a.m not provide any RO morning cares. The placed in R73's left R73's care plan dat dependent on staff directed staff to assing hygiene care needs	ed wash cloth placed in R73's 2/9/16, at 7:25 p.m. RN-F contracture on left hand, left veakness of the entire left or dy) due to a previous stroke, e any splints or received any p.m. R73 was observed in eft arm rested against his n both hands were observed mmed. There was no rolled n R73's left hand. during morning cares on n. provided by nursing A-B did not provide any ROM ing morning cares. R73's hands were observed to be d. There was no rolled wash 's left hand. At 10:23 a.m. R73 g in a wheelchair in the table across from his room. 's nails were long and dirty was no rolled wash cloth hand. during morning cares on n. provided by NA-C. NA-C did M services to R73 during were was rolled wash cloth	2 565			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 15 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		o. '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00890	B. WING _		02/	12/2016
NAME OF	PROVIDER OR SUPPLIER	9779	REET ADDRESS, CITY	STATE ZIP CODE		12/2010
		38:	15 WEST BROAD			
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	BBINSDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION		PROVIDER'S PLAN C (EACH CORRECTIVE AI CROSS-REFERENCED TO DEFICIE!	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 15	2 565			
	extremities with mo	rning and bedtime cares				
		ysician Orders dated 2/1 order for rolled wash clo				
	stated R73 did not a because ROM was	2/11/16, at 12:05 p.m., freceive any ROM service not indicated in the Kardeet) for NAs to complete	es lex			
	had a ROM prograr staff to provide gentextremities as tolerabedtime cares. LPN assistants were res ROM and nurses work completion of all careviewed R73's meany documentation R73. LPN-C review	a.m. the LPN-C stated Fin and the care plan directle ROM to upper and located with morning and I-C explained that nursin ponsible for the complet ere responsible for ensures. At 10:23 a.m. LPN-C dical record and did not a for fefusals of nail care bed R73's medical record sheduled for a bath on 1/5.	eted wer g ion of ring C iind y and			
	not have a rolled wa 2/11/16. At 11:00 a. stated she just com R73 upper left extre contractures on the the joints in the sho fingers. PT further s services, splint devipalm usually helped contractures. At 11: not receive any spe contractures, tried f Kardex did not direct	a.m. LPN-C verified R73 ash cloth on 2/10/16 and m. the physical therapist pleted a ROM assessmenty. PT stated R73 had left upper extremity affeulder, elbow, wrist, hand stated provision of ROM ices and rolled wash clot prevent further decline 14 a.m. NA-C stated R7 cialized treatments for inding Kardex and stated the facility staff to do Ft 11:43 a.m. RN-D verifie	(PT) ent on toting and h in in 3 did d the ROM			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 16 of 62

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED	
		00890	B. WING		02/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 565	Continued From pa	ge 16	2 565			
	as one of the cares provide therefore R	not included in R73's Kardex for nursing assistants to 73 had not been receiving she expected staff to follow				
	facility's DON stated follow resident's call managers to make included in the Karo	2/12/16, at 12:06 p.m. the d she staff were expected to re plan and the nurse sure that all cares were dex. R73 did not receive the as directed per the plan of				
	The ADL policy was	requested but not provided.				
	The director of nurs and/or revise policie the facility followed according to the res The director of nurs appropriate staff on to follow care plan i	THOD OF CORRECTION: sing could develop, review, es and procedures to ensure care plan interventions sident's individualized needs. sing could educate all the policies and procedures nterventions. The director of tor to ensure ongoing				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 830	MN Rule 4658.0520 Proper Nursing Car	O Subp. 1 Adequate and re; General	2 830			3/23/16
	receive nursing car- custodial care, and individual needs an the comprehensive	general. A resident must e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 830	4658.0405. A nursi of bed as much as written order from the	ng home resident m possible unless then ne attending physicia in in bed or the resic	re is a an that the	2 830			
	by: Based on observati review, the facility for re-assess and prov 3 residents (R73) re living (ADLs) and ra facility also failed to safely secured to the	ent is not met as evi on, interview and do ailed to comprehens ide cares and servic eviewed for activities ange of motion (ROM ensure bed grab bate bed frame to mining f 4 residents (R38) re	cument ively es for 1 of of daily 1). The irs were mize the		Corrected. No POC required.		
	experienced a cere affecting the left sid Admission Record. R73 for pain related hand, wrist, elbow athe facility had not related to the second secon	o the facility on 5/13, bral vascular accide e in October 2010, p The facility failed to d to contractures of the and shoulder, Conse modified intervention pain relief prior to p	nt (stroke) per the re-assess he left equently s to				
	in a wheelchair in the across from his roo observed to rest firm left hand against his approximately a 90	o.m. R73 was observate common area at a m. R73's left arm wanly against his body s chest, wrist bent at degree angle at the n the left hand held f	a table as with the forearm,				

Minnesota Department of Health

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION		SURVEY PLETED		
		00890		B. WING		02/	12/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALLY CA		ST BROADW DALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	closed fist position. R73 was unable to R73 was observed 2/11/16, at 7:03 a.n was observed to at away from his body resident's armpit. Ir unsuccessfully to p before stopping car approximately 7:15 unsuccessfully atte while he remained grimaced, moaned approximately six to especially when stamove R73's left arr providing R73's car grimaced, moaned times. At 10:23 a.m. on 2/sitting in a wheelch table across from h R73's right hand we A licensed practical attempted to extendand to check their R73's palm. R73 m LPN-C attempted to verified R73 appear this assessment. On 2/12/16, at 8:12 stated R73's facial discomfort, a need medication, and the	When requested at the open his clenched left during morning cares in. Nursing assistant (Notempt to pull R73's left of enough so as to was in addition, NA-B attempt two different shirts of the automorphism of the computation of the computati	on NA)-B t arm h the on R73 on	2 830			
		ly MDS dated 9/23/15					

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02 /	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	12/17/15, indicated pain such as non-vegroaning), facial exteeth or jaw), protect posture (bracing, growth body part during modern Care Area Assessmannual MDS did not assessment related advanced demential understood, and a leffectiveness of pair residents) dated 4/5 12/17/15, indicated normal, no negative resident was smilling expression with related addition, a review of following document 4/8/15- notes indicated for pain, current memorking, and that sith the current plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memorking, and that sith ecurrent plan of 67/5/15- notes indicated for pain, current memory for pain, current plan of 67/5/15- notes indicated normal plan of	R73 demonstrated rerbal sounds (moanipression (grimaces, ctive body movement uarding, clutching or ovement). As a resurent (CAA) for the 7/st trigger a need for d to pain. In Data collection data that the resident had a, was rarely/never PAINAD (tool used to in regimen for dement of the resident's breather over the resident's breather over the record revealed at the record regimen was the resident's lend or whether pain. I lacked evidence as ding direct care for Repout the resident's lend or whether pain completed during promaintained his high comfort.	ng, or clenched ts or holding a alt, the 8/15 ed d co evaluate ntia and ning was that the e facial and the high risk as to follow to 73 had evel of covision of est				

6899

Minnesota Department of Health
STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA 3815 W	ADDRESS, CITY, S EST BROADW ISDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 830	and January and Fereceived as needed twice on 1/2/16. Do indicated the PRN prineffective. On 1/11 the use of PRN memodical record lack pain was assessed pain medication. R73's care plan dat resident had potent to a cerebral vascul (paralysis on one sidisease processes, teeth and restless in inadequate pain congrimacing and grindindicated staff were signs or symptoms breathing, vocalizat changes, and that readminister pain memory and pain. Althrevealed R73 utilize for pain control: Rottimes daily; Tylenol three times a day; Fhours as needed (Fpain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain; and Roxanol Staff had not identification and reference to the pain	ge 20 ebruary 2016, revealed R73 I (PRN) pain medications becumentation for 1/2/16 beain medication use was I/16, documentation indicated dication was effective. The led any evidence that R73's prior to administration of PRI ed 1/5/16, indicated the lial for pain/discomfort related lar accident, hemiplegia de of the body) and end stag as evidenced by grinding less. The goal was for R73 to behaviors indicating ntrol including: restlessness, ling teeth. Interventions to report to the nurse any of non-verbal pain, changes ions, mood or behavior nursing staff were supposed to dications as ordered. der Summary Report dated diagnoses including: cerebral stroke), hemiparesis ntire left or right side of the hough current physician order det the following medications exanol 2.5 milligrams (mg) two Roxanol 10 mg every two re mg PRN for mild pain, facilities are or after care), in order to ceived the most effective pair	n c			

6899

Minnesota Department of Health STATE FORM

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		E CONSTRUCTION		E SURVEY PLETED
		00890	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3819	EET ADDRESS, CITY, S 5 WEST BROADW BBINSDALE, MN !	AY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	During interview on stated R73 was ver his left arm to wash dressed. NA-B state and yelling "ouch" of stated whenever she moaned and groane R73 was "in pain" wupper extremity. On 2/11/16, at 9:40 (LPN)-C verified R7 pain for which he read the new left and the sometimes when he wheelchair. LPN-C reporting any pain of residents to the nur had reported R73's morning, LPN-C sated she usually wand was regularly and regularly	2/11/16, at 7:12 a.m. NA-y stiff and it was difficult to his armpits and to get hir ed she heard R73 moaning during morning care, and he assisted with R73's cared. NA-B said she believe when they worked with his a.m. licensed practical nurses administered the expain medications. The was still in bed, and he was already up in his stated the NAs should be are discomfort expressed by the se. When asked whether discomfort during care the discomfort duri	o lift m lig e he ed left urse onic y staff at A-D ift 73. she d id 6, aide ches ated			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 22 of 62

Minnesota Department of Health

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00890	B. WING		02/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 22	2 830			
2 830	the Roxanol which nurse. TMA-F confithe medication while half of the time when wheelchair. During a joint intervitie nurse manager unit's MDS coordinasurveyor observation experienced by R73 and RN-F both state pain issues during is stated she expected report voiced or observation when R73 had no play was to continue with the could not recall assessments such had been assessed. During interview on said she'd completed during his morning fidgeted and moved NA-C attempted to	was administered by the firmed half the time R73 gets e he's still in bed and the other en he's already up in his view on 2/11/16, at 2:35 p.m. of the unit, RN-D. and the ator RN-F, were informed of ons and staff reports of pain 3 during morning cares. RN-D ed they were unaware of any morning cares with R73. RN-D d the nursing assistants to served pain to the nurse. RN-F usly assessed R73's pain, pain. RN-F further stated R73 h the current pain regimen but the circumstances of the pain as whether or not the resident d while receiving care. 1.2/12/16, at 8:30 a.m. RN-D ed a pain assessment on R73 care. She verified R73 d his face away even when wash R73's face, indicating liscomfort. RN-D stated she	2 830			
	had requested the medications to R73 morning cares from a.m. RN-D stated the pain medication, he during his morning expected the nursir report voiced or obstor the nurse to con resident's pain.	nurse administer pain B prior to completion of n now on. On 2/12/16, at 9:38 hat after R73 had received the e appeared more relaxed cares. RN-D stated she ng assistants to stop cares, served pain to the nurse, and nduct an assessment of the 'a.m. NA-C stated she				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE: 'MUST BE PRECEDED BY SC IDENTIFYING INFORM <i>A</i>	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 830	regularly works with moans and groans, when staff attempt extremity to wash h stated she believed and stated she believed and stated she didnobservations to the an every day thing R73 had received h prior to morning can he smiled and seen. During interview on facility's director of were expected to w pain for residents whether any signs of present, and for stain pain and report to said the nurses are for pain, medicate wappropriateness, and any required adjust DON further stated unnecessary pain of cares that could had An effort was made physician on 2/16/1 message was left for was received. The facility's policy COLLECTION AND 9/15, directed staff evaluate the pain m with pain. The polic to make a resident	a R73 and that he alvand sometimes yells to move his left upper im or get him dresse R73 was "probably it always report her nurse. NA-C stated with him." NA-C also is medications that res, "it went better for hed happy. 2/12/16, at 12:40 p.mursing (DON) stated atch for nonverbal curbo cannot talk, to obor symptoms of pain ff to stop care if the potter of the nurse. The DOI expected to assess with pain medication resident care plans and update their physiments of pain medication resident care plans and update their physiments of pain medication resident care plans and update their physiments of pain medication resident care plans and update their physiments of pain medication resident care plans and update their physiments of pain medication resident care plans and update their physiments of pain medication. R73 may have expense no 2/11/16, during his verbeen avoided.	s "ouch" er ed. NA-C in pain" , "it's like said after morning, r him" as m. the d the staff ues of serve are resident is N also residents as for cians for ation. The rienced morning y ugh a eturn call vised r and residents esistants rtable,	2 830			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00890		B. WING		02/1	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	8815 WES	DRESS, CITY, S T BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 830	The policy further d effectiveness of the weekly if high risk for	observed or reported pirected the RN to docu pain management pla or pain and at least mo he pain plan is effectiv	ment in onthly	2 830			
	On 2/9/16, at 3:46 p had side rails (inclu	o.m. when asked if resi des half or quarter rails ed resident had two gra	s) used				
	bed was observed of lying on her back in to the door was observed one to two in addition, the bolt po	o.m. during room obserwith two grab bars. R36 bed. The right grab baserved very loose and onches back and forth. Intion of the grab bar wound when the grab b	8 was ar close could be In as				
	remained loose. Wh	0 a.m. the right grab be nen asked if she used ated she did use it to t	the				
	used the grab bar for bed during cares, no "Yes." Surveyor and verified the grab bat if she had assisted to get ready, NA-A standard R38. When asked hof any concerns, NA nursing station and	2 p.m. when asked if report received assistant (NA)-A NA-A went to room any was very loose. Whe resident during morning stated therapy had asson maintenance was A-A brought surveyor to showed surveyor a en indicated was going	when in A stated and a sked ag cares aisted anotified to the				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING.			
	00890	B. WING		02/1	2/2016
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARITAN SOCIET	Υ - SPECIALLY CA	ST BROADW DALE, MN			
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 830 Continued From p	-	2 830			
resident used the during cares or whasked if she expeconcerns with the stated, "as a mattifilled a maintenan week." On 2/11/16, at 1:0 (OT) stated she hwith morning care independent with get herself dresses supine when getting the stated resident us side and OT state right grab bar was the asked how as loose grab bar, maintenance slip to be picked up. When asked if she 2/10/16, OT indicated the grab be from the left side if was chatting at the resident never sai bar. When asked if she have reported the imagine but I think the question was talking to surveyor and stated she too not noticed the local stated she too not noticed the	staff reported concerns such OT stated would fill a and left it at the reception desk e had assisted resident on ted she did however had not ar as she worked with resident by the window. OT further she is same time writing notes and did anything regarding the grab e would expect nursing staff to issue, OT stated "I would is she is up during day" thought hard to answer. As OT was to provide the conversation of had worked with her but had use grab bar because she also the left side, as this was				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPI A. BUILDING	LE CONSTRUCTION:		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	T ADDRESS, CITY, WEST BROADW BINSDALE, MN	/AY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 830	On 2/11/16, at 1:12 was conducted with (DOF), administrator grab bar was loose staff to put in a word DOF to check for a filled by RN-C. On 2/12/16, at appradministrator stated was no slip filled for On 2/12/16, at 11:1 expected the staff tresident care equip director of nursing (supposed to report immediately. When supposed to identify DON stated if a resindependent, she was to mention the grab R38's diagnoses in orthopedic aftercare amputation, unspect heart failure and ac above knee obtainer record dated Febru R38's care plan dat was at risk for falls amputation and decibalance instability. Educate/instruct resof assistive devices bend over to pick upencourage to use a significant of the supposed to use a significant or supposed to the	p.m. the environmental touth the director of facilities or and Intern. DOF verified is DOF stated would expect k order. Surveyor requested slip regarding the grab bar expected and the result of the grab bar last week. 4 a.m. when asked if she oreport, any concerns with ment such as grab bars; the DON) stated staff was it to maintenance asked if the care plan was by the grab bars for mobility, ident used them to be rould have expected care plan bars. cluded encounter for expected systolic (congestive) quired absence of right leg and from electronic medication ary 2016. ded 1/12/16, indicated residerelated to right leg above known as a conditioning as evidenced by condition	the d d ere e an on ent nee y se			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 27 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/1	2/2016
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN 🤄			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 830	Continued From pa	ge 27	2 830			
	The director of nurs	THOD OF CORRECTION: sing or designee could train all udits to ensure each resident riate nursing care and				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
2 890	MN Rule 4658.0529 Motion	5 Subp. 2 A Rehab - Range of	2 890			3/23/16
	that is directed town through positioning implemented and n comprehensive res of nursing services	motion. A supportive program ard prevention of deformities and range of motion must be naintained. Based on the ident assessment, the director must coordinate the ursing care plan which				
	without a limited rai experience reduction	ho enters the nursing home nge of motion does not on in range of motion unless al condition demonstrates range of motion is				
	by: Based on observation review, the facility for services including a motion (ROM) for reviewed for activitic contractures. As a	ent is not met as evidenced ion, interview and document ailed to provide care and assessment and range of 1 of 3 residents (R73) es of daily living (ADLs) and result of these failures, R73 narm, a decline in ROM of the		Corrected. No POC required.		

_	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION		E SURVEY PLETED
		00890	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815 WE	DRESS, CITY, S ST BROADWA SDALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	left upper extremity Findings include: R73 was admitted to experienced a cere affecting the left sid Admission Record. assessment and promaintain functional ROM. As a result restremity contracture wrist and fingers). During interview on registered nurse (Rontracture to his left (weakness of the ebody) due to a preversident did not use restorative ROM. On 2/9/16, at 4:49 prin a wheelchair in the across from his root observed to rest firm left hand against his approximately a 90 and three fingers of closed fist position. R73 was unable to There was no splint in R73's left hand. On 2/10/16, at 3:08 in bed. R73's left ar with the elbow bent on the left hand we	to the facility on 5/13/10, and bral vascular accident (stroke) le in October 2010, per the The facility failed to conduct ovide ROM services to R73 to ROM and prevent a decline in 173 developed left upper res (including shoulder, elbow, 2/9/16, at 7:25 p.m. N)-F stated R73 had a seft hand, left side hemiparesis ntire left or right side of the rious stroke, and that the eany splints or receive any one. R73's left arm was mly against his body with the schest, wrist bent at degree angle at the forearm, in the left hand held firmly in a When requested at that time, open his clenched left hand. It or rolled wash cloth in place one p.m. R73 was observed to be more rested against his chest at an angle, and three fingers re tightly clenched into a was no splint or rolled wash				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 29 of 62

Minnesota Department of Health

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		00890		B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F SC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 890	Continued From pa	age 29		2 890			
	2/11/16, at 7:03 a.n was observed to at away from his body resident's armpit. It unsuccessfully to p before stopping cal approximately 7:15 unsuccessfully atte while he remained grimaced, moaned approximately six to especially when stamove R73's left arm	o eight times during ca aff attempted to manip m. Neither NA-B or NA de any ROM services t	NA)-B t arm h the hpted on R73 n R73 ares oulate or				
	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.						
	ROM program, and provide gentle ROM extremities as toler bedtime cares. LPN were responsible to the nurses were recompletion of all care.	a.m. LPN-C stated R d the care plan directe M to upper and lower rated with morning and N-C further explained or the completion of R sponsible to ensuring ares. LPN-C acknowle ow long R73's contract	d staff to d the NAs OM, and overall dged				
	sitting in a wheelch table across from h	(11/16, R73 was obser pair in the common are nis room. A licensed processfully attempted	ea at a ractical				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 30 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:						3) DATE SURVEY COMPLETED	
		00890		B. WING		02/	12/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY F SC IDENTIFYING INFORMA"	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 890	extend the fingers of	on R73's left hand to		2 890			
	R73 moaned and you attempted to extend	the condition of R73's elled "ouch" when LP d his fingers. There w n cloth in place in the	N-C as no				
	at 12:05 p.m., NA-E any ROM services I	terview with NA-B on B stated R73 did not robecause ROM was no dex/NA assignment s	eceive ot				
	stated the nurses w R73 had a rolled wa his left hand. LPN-0 wash cloth placed in 2/10/16 or 2/11/16. treatment administr reviewed at that tim documented the rol R73's hand had bee	2/12/16, at 8:47 a.m. erer responsible for each cloth placed in the C verified R73 had non the palm of his hand However when R73's ation record (TAR) was, it indicated LPN-C led wash cloth to the en in place. LPN-C stor the discrepancy.	nsuring e palm of t had a d on s as had palm of				
	morning cares from a.m. R73 fidgeted a manipulated R73's him, or to get him d	to receive assistance NA-C on 2/12/16, at and moaned wheneve left upper extremity to ressed. NA-C did not to R73 during morning	9:05 er NA-C o wash provide				
	physical therapist (F completed a ROM a left extremity. The F contractures to the the joints in the sho fingers. The PT furt	2/12/16, at 11:00 a.m PT) stated she had ju assessment for R73's PT confirmed R73 had left upper extremity a ulder, elbow, wrist, had her stated provision of int devices and/or use	st s upper d ffecting and and of ROM				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 31 of 62

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815 WES	DRESS, CITY, S BT BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 890	rolled wash cloth to helped prevent furth helped prevent furth During interview on stated she had woryears. NA-C said Fithe left arm which right difficult, and stated special treatment for time, NA-C reviewes sheet. NA-C verificated to provide RO further stated she had services for R73. An interdisciplinary identified the first discontracture. The noweakness to his left contracted, and that and would bring in a sessment dated been discharged frow was totally dependently dependently in the left wrist becaus his stroke. The reconsessment related the left hand and with R73's care plan data resident had limited stroke with hemiple the body). The goal free of complication	the palm, would usually ner decline in contractures. 2/12/16, at 11:14 a.m. NA-C ked with R73 regularly for R73 was very contracted on nade cares and dressing R73 did not receive any or the contractures. At that d the Kardex/NA assignment at the Kardex did not direct M services for R73. NA-C had never provided ROM progress note dated 11/10/11, pocumentation related to R73's ate indicated R73 had thand which looked thospice had been notified a splint for R73 to use. Minimum Data Set (MDS) 1/18/11, indicated R73 had om hospice on 12/2/10, and ent on staff for personal athing, needed extensive polity, transfers and eating. The moted R73 utilized a splint to se it was weaker secondary to ord lacked evidence of any if to the noted contracture on	2 890			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 32 of 62

Minnesota Department of Health

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		00890	B. WING		02/1	02/12/2016	
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	<u> UZ/1</u>	2/2010	
GOODS	AMARITAN SOCIETY	- SPECIALTY CA 3815 WES	T BROADW	AY			
	I	ROBBINS	DALE, MN 5				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 890	Continued From pa	ge 32	2 890				
	range of motion as	aff were to "Provide gentle tolerated to (L) [left] upper and ith a.m, (morning) and hs					
	to 10/18/12, indicate limitation in ROM. Hand quarterly MDSs inconsistently identification in ROM or functional limitation dated 7/8/15, and quand 12/17/15, identification including hemipares affecting the left sidindicated R73 was with transfers and be impairment in ROM lower extremity. The (CAA) for the annual ROM did not trigger A medical progress Communication/Visidiscussion had occidents.	note dated 2/9/16, titled it with Physician, indicated a urred with the nurse					
	practitioner regarding on R73's left arm wand identified a goad However, review of including Geriatric Strogress Notes (the primary physician a 6/16/15, 8/10/15, 8/2/9/15 failed to identify or discussion about On 2/12/16, at 11:4 with RN-D and RN-	ng a decline to a contracture hich had gotten slightly worse, all to ensure comfort for R73. prior progress notes, Services of Minnesota e progress notes from R73's and nurse practitioner), dated 11/15, 8/12/15, 10/11/15 and tify any medical assessment R73's contractures. 3 a.m. during a joint interview F, they verified R73 had been lity in May 2010 and had					

Minnesota Department of Health

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 890 Continued From page 33 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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE : COMPI	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - SPECIALTY CA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 890 Continued From page 33 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				7 501251114.			
GOOD SAMARITAN SOCIETY - SPECIALTY CA (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 890 Continued From page 33 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		00890		B. WING		02/1	2/2016
(X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 890 Continued From page 33 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	NAME OF PROVIDER OR SUPPLIER		NAME OF PROVIDER OR SUPPLIE	, , ,			
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 2 890 Continued From page 33 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	GOOD SAMARITAN SOCIETY	- SPECIALTY CA	GOOD SAMARITAN SOCIET				
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	PREFIX (EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX (EACH DEFICIEN	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO	.D BE	COMPLETE
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	experienced a strok stated R73 had deve the stroke. Neither F state when the staff contractures. RN-D verified the ROM properties as care the NAs were acknowledged that to been receiving any locate plan and stated first been identified but that a "K" had not care intervention, the had not transfered to sheet as an interver RN-D and RN-F furtifunctional ROM assignarterly and annual then responsible to ensure the intervent Kardex. However, be not verified whether had been included in complete. RN-D ackfunctional ROM had in the facility. During interview on facility's director of refunctional ROM had in the facility staff thad contractures. The Deficition of the facility staff had contractures. The Deficition of the facility staff had contractures. The Deficition in functional	e in October 2010. They eloped the contractures after RN-D or RN-F were able to had first identified R73's reviewed the Kardex and ogram had not been included re to provide. RN-D was likely why R73 had not ROM. RN-D reviewed R73's d ROM services for R73 had on the care plan on 10/30/12, ot been checked next to the erefore the ROM services of the Kardex/NA assignment attion for the NAs to complete. There explained they completed essments at the time of all MDSs. They said they were update the care plan and ions were included on the oth acknowledged they had the ROM services for R73 in the Kardex for NAs to knowledged R73's decline in a occurred while he'd resided and control of the control of the entities were included on the entities were included on the entities were included on the entities were to make sure that is were included on the entities of the control o	experienced a str stated R73 had of the stroke. Neither state when the strocontractures. RN verified the ROM as care the NAS acknowledged the been receiving are care plan and staffirst been identified but that a "K" had care intervention, had not transfere sheet as an intermediate RN-D and RN-F functional ROM are quarterly and any then responsible ensure the interventional ROM and the proposition of the facility. During interview facility's director of were expected to and the nurse manual appropriate can kardex/NA assignstated the facility prevent further decontractures. The the facility staff here contractures. The decline in function				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 34 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) D CO			
		00890	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA 3815 V	T ADDRESS, CITY, WEST BROADW SINSDALE, MN	/AY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 890	provide care such a services. An effort was made physician on 2/16/1 message was left for was received. Assessments comprontractures and wistaff were requeste. The facility's RANG 9/12, indicated that comprehensive assensure that a reside a limited range of motion of motion is unavoid will ensure that a remotion receives appropriate to increase possible and to prevof motion." SUGGESTED MET The facility could we and therapy departing programming for remotion services or facility could develomotion services for QA Committee.	es rolled wash cloth and RO to call R73's primary 6, at 3:00 p.m. Although a or the physician, no return c	all ility d out ge / as ge			

6899

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 35	2 900			
2 900	MN Rule 4658.0529 Ulcers	5 Subp. 3 Rehab - Pressure	2 900			3/23/16
	comprehensive res of nursing services	sores. Based on the ident assessment, the director must coordinate the ursing care plan which				
	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.			Corrected. No POC required.		
	Findings include:					
	R97's morning care lying in bed on her brief was saturated bowel. Following innoted to have a recinch long fissure that	ion on 2/11/16, at 8:22 a.m. es were observed. R97 was right side. R97's incontinent with urine and soiled with continent cares, R97 was Idened coccyx area with a 1/2 at appeared to be open.				
	During a subseque	nt observation of cares on				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
NAME OF PROVIDER		- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
	CH DEFICIENCY	ATEMENT OF DEFICIENCI Y MUST BE PRECEDED B' SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION OF THE CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2/12/16 assess stage of eryther skin uld discold indurat on her as "a li A revie Care Of indicate "monite macers A Revi Care Of through refusion A Pres dated & impaire assista The Of but has [incont abnorm thrusts non-co include on how down. R97's of a self-of activitie	ded R97's skeppe pressured and intact special intact special in a coccyx. Sheppe process of a coccyx. Sheppe proce	m. registered nurse (in. RN-B stated R97 e ulcer (a non-blanch skin, the heralding lendividuals with darke skin, warmth, edemness may also be incedescribed the press " Samaritan Society Spredication Review R15, an order was recor worsening of	had a nable esion of er skin, na, dicators) sure ulcer decialty eport eeived to esion of for all nent of esion of er skin, na, dicators) sure ulcer decialty eport eived to esion of for all nent of esion of esio	2 900			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 37 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE 'MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 900	needed. The care pfor skin impairment prevent skin breakd skin was initiated af pressure ulcer on 2 R97's quarterly Min 11/12/15, indicated impaired and requir two staff for bed motoileting. A Progress Note daskin check indicated sacral area, but this 12/20/15, indicated Progress Note date on res [resident] but is healing." A quarte 1/11/16, indicated "buttockscreams a reposition but often dated 1/16/16, indicated R97 had sright side of the glut "pressure points." Vand progress notes skin issues dating be continual refusals owere no further care implemented to red breakdown.	olan did not address or identify intervent down. A care plan acter the surveyor ide /12/16. imum Data Set (MD she was severely content of the second of the was severely content of the was severely content of the was severely content of the was severely for the was a lightly of 12/26/15, indicated the was lightly of the was lightly as was lightly as li	ions to ddressing ntified the (S) dated ognitively ance of ssing and (ed R97's ned by d dated pink." A d "the skin naceration ted (c) on (ed 2/10/16, as at the ome essments ongoing (c) and tion, there ons	2 900			
	nursing assistant (N when R97 was last	NA)-D stated he did toileted or reposition one on the night shift. NA-D further state	not know ned. He t but did d he was				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 38 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00890	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA 3815 WES	DRESS, CITY, S ST BROADW SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETE DATE
2 900	During an interview stated staff had a h down. NA-E stated coccyx on and off a stated staff use cre check on her every stated when R97 si pressure goes on h reported R97's ope During an interview licensed practical n an ongoing treatmet that staff was apply stated, "All the time stated R97 had a si monitored and "nov During an interview RN-B stated, R97 of that she was aware even though R97's to "monitor buttocks maceration/skin bredid not look at R97' "The trained medica and report concerns." During an interview stated R97 has had she further stated R97 has had she further stated R97 ref continue to try. She pressure redistribut chair and on her be mattress and cushis stated R97 was toils stated R97 was toils stated R97 was toils.	on 2/11/16, at 8:41 a.m. NA-E ard time getting R97 to lay R97 had redness to her and it was "very ongoing." She am on R97's bottom and two hours. NA-E further ts in her chair, "all her er coccyx." NA-E stated she narea to the nurse that day. on 2/11/16, at 12:43 a.m. urse (LPN)-B stated R97 had ent for her reddened coccyx ing cream to it. He further the pressure is there." He mall area that was being vit is better." on 2/12/16, at 7:38 a.m. lid not have any skin concerns of. RN-B further explained treatment record directed staffs for worsening of eakdown" each shift, the nurse s bottom daily. She stated, ation aides (TMAs) look at it	2 900			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 39 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S T BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE LE APPROPRIATE	(X5) COMPLETE DATE
2 900	times. She stated no check at least week progress note, how lacked evidence of completed for R97. During an interview director of nursing (was R97's skin wour outine basis and winterventions should such as therapy and A facility policy labe 2002 indicated, resprovided necessary maintain the highest accordance with the The policy indicated individualized compinclude measurable toward achieving an optimal medical, nursessment instrumphysician's orders, concerns identified care will be modified required/provided for A facility policy titled Pressure Ulcers, dareviewed. The policy provide appropriate of pressure ulcers an ecessary. The policy receive appropriate promote and maintain the policy and maintain the policy appropriate promote and maintain the policy and maintain the policy appropriate promote and maintain the promote and promote appropriate promote and promote appropriate p	urses should be doingly and documenting ever, the medical recover, the medical recover doing the state of the state	a.m. the ectation red on a other for R97 ress. February d be attain or ng in essment. have an that will s directed sident's e resident e , and his plan of currently exercises was to evention when s would ervices to	2 900			

6899

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00890		B. WING		02/1	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S T BROADW DALE, MN &	= ==		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	policies and proced a comprehensive at developing pressur interventions could of Nursing or her de appropriate staff on related to pressure Nursing or her design monitoring system to assessed and received development of pressure	ure to ensure residents assessment of the risk re ulcers so that individe be implemented. The esignee could educate the polices and proceulcers. The Director of gnee could develop a to ensure residents are the present the present the polices.	for dualized Director all dures e e e vent the	2 900			
2 920	Subp. 6. Activities comprehensive resident who activities of daily living services to maintain and personal and of this MN Requirements.	is unable to carry out ing receives the neces a good nutrition, groom	on the ursing sary ning,	2 920	Corrected. No POC required.		3/23/16
	review, the facility fareceived grooming of 4 residents (R73 living (ADLs). Findings include: R73's nails were ob-	ailed to ensure a reside assistance for nail care) reviewed for activities served long and soiled and during subsequer	ent e for 1 s of daily d on		Soffected. No FOO fequiled.		

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00890	B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALLY CA	ST BROADW SDALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 920	Continued From pa	ge 41	2 920			
	hands were observe (approximately qua	o.m. R73's finger nails on both ed to be long and untrimmed rter [1/4] inch in length). p.m. R73 was observed in				
	bed awake, R73's le	eft arm rested against his n both hands were observed				
	2/11/16, at 7:03 a.m were observed to b 2/11/16, at 10:23 a. in a wheelchair in the across from his roo	during morning cares on h. finger nails on both hands e long and untrimmed. On m., R73 was observed sitting he common area at a table m. Licensed practical nurse '3's nails were long and dirty				
	12/17/15, identified assist of one staff whygiene needs. The Loss/Dementia date confusion, forgetful	imum Data Set dated R73 required total physical vith dressing and personal c CAA for Cognitive ed 7/14/15, identified R73 with ness and inability to make end stage dementia.				
	assistance with ADI cerebral vascular accurrent level of function eating, dressing, to hygiene" R73's Kassistant assignme	d 1/5/16, identified R73 needs L's due to dementia and ccident. Goal "will maintain tion in bed mobility, transfers, ilet use and personal ardex (the facility nursing nt sheet) directed R73 cance with personal hygiene				
	2/12/16, revealed d	der Summary Report dated iagnoses included cerebral stroke), hemiparesis				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA 3815 WE	DDRESS, CITY, S ST BROADW SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SECONDS) CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
2 920	(weakness of the elbody) and demential On 2/11/16, at 12:4 aide (TMA)-F stated approximately quare On 2/11/16, at 10:2 were responsible for days and nurses are completed. LPN-C assistant are to represident refuses nain the resident's recreviewed R73's meany documentation R73. LPN-C review verified R73 was so 2/3, 2/7 and 2/10/16 On 2/11/16, at 2:00 manager, registered expected staff to have once a week with side completed, the respected to let the stated she expected resident's medical requested but not possible to the stated she expected staff to have once a week with side completed. The nail care/ADLs requested but not possible to the stated she expected staff to have once a week with side completed. The nail care/ADLs requested but not possible to the stated she expected staff to have once a week with side completed.	ntire left or right side of the a. 9 p.m. the trained medication d R73's nails were ter (1/4) inch in length. 3 a.m. LPN-C stated NAs or nail care weekly on bath e responsible to ensure it was further stated nursing ort to the nurse any time a il care and nurses document for the refusals. LPN-C dical record and did not find of refusals of nail care by ed R73's medical record and sheduled for a bath on 1/31, a. p.m. the unit's nurse d nurse (RN)-D stated she are resident's nail care done hower/bath and if not able to nursing assistant was nurse know. RN-D further d nurses to document on record whenever nail care was provided. THOD OF CORRECTION: The could monitor for compliance staff in providing resident				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW SDALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 930	and feeding syringes. Based or assessment, a nurse B. a resident with gastrostomy tube or appropriate treatment aspiration pneumor dehydration, metab	ric tubes, gastrostom In the comprehensive	e resident are that: gastric or eives the revent g,	2 930			3/23/16
	by: Based on observati review the facility fa the gastrostomy tub administration of me (R77, R2). Findings Include R77's quarterly Min 12/23/15, identified by staff and his mer identified R77 was fa all activities of daily feeding tube and ha sclerosis (MS), aph R77's Care Area As 4/21/15, identified F	ent is not met as evion, interview and douiled for check placer be (G-tube) prior to edication for 2 of 4 residual and the folial place of the fol	cument ment of esidents S) dated assessed urther staff for ed a iple pression.		Corrected. No POC required.		

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	815 WES	DRESS, CITY, S T BROADW DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FUI SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
2 930	precautions were ta R77's care plan printed end-stage MS aplan further identified to meet nutrition and had no desire to ea R77 was to be free complications related. The Medication Restaff was to change plugged or leaking awere to be administ. On 2/11/16, at 7:29 was observed crush medications R77's amedication into its of medication cup. RN medication cup to the each medication will spoon. RN-A then regastric tube, inserted syringe without first added 30 ml water medication and prowater plus a protein course of the medication. RN-A stated she the be checked weekly she was not sure whad been checked, was checked in a subecause if it was not work. RN-A stated scheck tube placement.	ken to prevent aspiration ted 2/11/16, identified and history of stroke. The R77 required a tube of hydration needs and tor drink anything by more of side effects or end to tube feeding. View Report dated 2/11/2 the G-tube as needed and that all oral medical are by g-tube. a.m. registered nurse (hing R77's individual and emptied each crush	R77 he care feeding R77 houth. /16, if ations (RN-A) hed che tirred nite R77's and entered stated lent element ay not ly he	2 930			

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		00890	B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815 WE	DDRESS, CITY, SEST BROADW.	AY		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
2 930	the tube to confirm usually checks to sa a little bit of water to she felt it was work On 2/11/16, at 12:5 interview RN-A stat checking process is stethoscope to lister placement. She stanurse who started for check the placement before a could not remember check the placement medication administrated she expected placement first, and anything in the tube expect the nurses the stethoscope to make should be and aspit the contents and pure adding water and word acceptable for contents in the	placement. She stated she ee if it was working by adding to the syringe and if it drains ing. 9 p.m. during follow-up ed the tube placement s when you instill air and use a in for gurgling to confirm ted she thought the night R77's g-tube feeding should int. She stated it was possible point to check the tube diministering medications, but ir. She confirmed she did not int of R77's tube today before itration. p.m. unit manager (UM)-A d the nurses to check tube d every time before they put e. She stated she she would to blow air into tube and use a fee sure the tube was where it rate stomach contents, assess to the table was where it rate stomach contents was the table was where it rate stomach contents was the table was where it rate stomach contents was the table was where it rate stomach contents was the table was where it rate stomach contents was the ta	5			
	in persistent vegeta tolerate oral intake	red 2/12/16, identified R2 was ative state and unable to safely. The care plan further ed a tube feeding to meet				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 46 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		, ,	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
				A. BOILDING.			
		00890		B. WING		02/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 930	tolerate tube feeding to the connected R2's Jew nutritional formula fithe tube feeding matches the tube feeding matches the did not checked before connecting the tube feeding matches the did not checked before connecting the tube stated the facility's placement whenever residuals prior to acfeeding.	ion needs. R2 was a g and water flushes. administration observed in the gradient of the gradie	vation and 6, from cal nurse be with 10 irst ued to gh a s LPN-D and dense turned on mls/hour. edged nent. d have tion and LPN-D king hecking be	2 930			
	dated 11/2013, ider administer medicati a safe and appropri instructed staff to: "3. Check tube place	ntified the facility wou ions through a gastri- iate manner. The pol cement and patency change in external le	ld c tube in icy				
	the tube by determing placed at the tube. Remove caper -10 ml of air through Aspirate gastric conthe stomach.	ning whether the ma bes exit site has mo from feeding tube a	rk ved. nd inject 5 the tube. tube is in				

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 47 of 62

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			7. BOILDING.			
		00890	B. WING		02/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SDECINI I V CN	ST BROADW SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 930	refer to pH strip for SUGGESTED MET DON or designee of revise policies and residents with tube of the tube feeding medications are ad DON or designee of staff on the policies designee could dev ensure ongoing con	exact values." THOD OF CORRECTION: The could develop, review, and/or procedures to ensure feedings have the placement properly checked and liministered separately. The could educate all appropriate is and procedures. The DON or yelop monitoring systems to	2 930			
21565	Medications Self Ad Subp. 4. Self-adm self-administer med resident assessme care as required in 4658.0405 indicate is a written order from This MN Requirem by: Based on observat review, the facility fadministration of mensure safe administration and mensure safe administration and mensure safe administration self-adm Findings include:	5 Subp. 4 Administration of dmin ninistration. A resident may dications if the comprehensive nt and comprehensive plan of parts 4658.0400 and this practice is safe and there om the attending physician. ent is not met as evidenced ion, interview and document ailed to complete self-redication assessments and istration of nebulizer and is for 2 of 2 residents (R122, inistered medication. administration was observed a.m. registered nurse (RN)-A	21565	Corrected. No POC required.		3/23/16

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	1 3-7	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	ST BROADW DALE, MN 5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21565	entered R122's roo sounds and heart in Duo-neb vial into no system that adminitis inhaled into the linebulizer cup to face nebulizer mask to fam. RN-A returned The nebulizer was bed with the head on face. Nebulizer RN-A entered room turned off the nebul left in the cup. After RN-A checked R12 The Cognitive Caredated 9/15/15, was 9/3/15, annual MDS impaired cognition, rejection of cares a times during the as The CAA also indicand dementia with addressing cognition risks to R122. R122 quarterly Min 11/26/15, indicated impaired, requires a including eating. R122's care plan proceedings of the R122's care plan proceeding and respiratory fails. R122's Medication included DuoNeb s	m, assessed R122's lung ate. RN-A emptied the ebulizer (a medication delivery sters medication in a mist that lungs) cup. RN-A attached the ce mask and RN-A applied the R122 and left room. At 8:51 and look into R122's room. Still running. R122 was lying in of the bed elevated and mask was still running. At 8:59 a.m. a removed face mask and lizer. There was no medication washing the nebulizer cup, 22 lung sounds and heart rate. Area Assessment (CAA) triggered information on the Sindicated R122 had severely verbal and physical behaviors, and wandered one to three sessment reference period. Ated resident had Parkinson's the overall objective of on on the care plan to minimize imum Data Set (MDS) dated R122 was severely cognitively assistance with all ADL's 122's diagnoses on quarterly entia, Parkinson's, depression,	21565			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 49 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE / MUST BE PRECEDED BY SC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH) (EA	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21565	breathing), one vial for shortness of bre document the pulse post-administration nursing spent with r for self-administrati medication review r record did not inclurelated to R122's al medications. During interview on stated, "No, they [th there with him because off. That is what ou their own medication R122 did not have a medication assessment or get a Before getting the cassessment to make resident] to self-administreatments] the staff medication or get a Before getting the cassessment to make resident] to self-administre exident during. Procedure Resident Medications UDA (undetermine if the resident to be successive medications and to resident to be successive medication to be successive medication to be successive medication to be successive medications and to resident to be successive medications.	inhale orally three tigeth. The staff were to earth. The staff were to and lung sounds pure and record the total resident. There was on of medications were port. Review of the de evidence of an assolity to self-administ or 2/12/16, at 9:12 a.m. are nurses] should be ause he could pull it or procedure is. Nobelians up here." RN-J volument, care plan or or 2/12/16, at 10:52 a. the resident does no instration of nebs [new first should administer or order for self-administer they do need to be sure it is safe for the minister the neb."	to re- and time no order ras on the medical ssessment er n. RN-J staying in [the mask] ody gives erified of rder. m. ot have an b the neb inistration. o do an them [the ucted , stay with of ff: stration of ment) to ninister ist the s	21565			

Minnesota Department of Health

STATE FORM BZJW11 If continuation sheet 50 of 62

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN &			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21565	the resident can samedications must be record 7. A physician's ord the resident self-ad order must be speciself-administered 8. The care plan must be resident is self-akept, who will docur location of the administer of the resident is self-akept, who will docur location of the administer of	fely self-administer be documented in the endocumented in the er must be obtained ministering medication if ic to the medication ust indicate which meadministering, where ment the medication inistration, if applicated dministration was obtain. The trained medication a Proair 90 mcg (mixing the inhaler. TMAs to R74 and turned dedication Administrated one puff and gave did not breathe out from the inhaler or lads after taking a puffised 10/8/13, indicated cognitive functioned thought processes ton's Disease E/B [event to the end to the	prior to ons. The ons being edications they are and the ole" oserved on ation aide crogram) A-B did not back ation inhaler deeply hold f. ed "The old "Th	21565			

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	DRESS, CITY, S T BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21565	108 (90 Base) MCC morning for shortner was no order for se medications was or The review of the mevidence of an assa ability to self-admin. During interview on said we would asseresident to self-admincluding inhalers. "stretch, [R74] is her medication set up. I would be handed to resident I do not ne instructions." RN-I was lef-administration order or care plan. During interview on said, "Yes for the in self-administration of have an order I woo open mouth, use or verified turning back before resident use. During interview on pharmacist said, "T shaking inhalers be If a resident does not self-administration of administer the inhal inhaler. Before getting do need to do an as safe for the resident inhaler."	G one dose inhale orass of breath/wheeze If-administration of a the medication reviewed and record did not be sament related to R ister medications. 2/12/16, at 9:19 a.m. ass if it is appropriate a minister their own medications are because of his lacit would expect that the a resident. If I know cessarily repeat the verified R74 did not held for medication assess and the same puff or two puffs." It is to the medication did to the medi	ew report. t include 74's I. RN-I for a dications a real k of ne inhaler the have a sment, I. TMA-B re a nts] do not hat to do, TMA-B lrawer m. ild be ne inhaler. ild d the lity staff sure it is ne	21565			

6899

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890		B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER				STATE, ZIP CODE		
GOOD S	SAMARITAN SOCIETY	- SPECIALTY CA		ST BROADW DALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT	-	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21565	Inhalers revised 9/13. Have resident selevate head of bed 4. Listen to breath respiratory pattern. 5. Shake the conta 6. Remove the mocanister upright (notation 7. Spacers are offethere is Trouble cocanister with inhalatindicated. 8. Instruct resident exhale completely, mouthpiece in his contained in the selection of her lips around the 9. As you firmly put to inhale slowly and or her lungs feel fut 10. Ask the resident several seconds to into lungs. Ask resi possible through put SUGGESTED MET Director of Nursing appropriate assessensure the safe and The DON could enton the importance on the importance of the DON or design resident records to and documentation could random audit left with residents uniterdisciplinary teacould then be presented.	it up if condition permit d 30 to 45 degrees. sounds and observe ainer well. buthpiece cover and pozzle down). en used in the elderly vordinating the actuation tion; ass the spacer if to take a deep breath Have him or her place or her mouth and close mouthpiece. Ish the device ask the doto continue inhaling ull. In to try to hold breath felp medications reached to exhale out as sident to	sition when of the and the the the his or resident intil his or ch deep slowly as ON: The asure the to tions. ucated cess. dit itoring iN could in is not the udits QA&A	21565			

6899

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00890		B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- SPECIALTY CA	3815 WES	ST BROADW			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21565	Continued From pa	ge 53		21565			
21630	remaining in the nuit discharge of a resid prescribed, or any of discontinued permain manner recommend or the consultant physhamacist must furinstructions and forkept on file in the nuit be a light of the second discontinued permains according to part 6 be returned to the person destruction listing the medication, prescripperson destroying the witness to the destruction.	on of medications. It ions of controlled substance in the	ostances th or ere oyed in a Pharmacy d or the must be years. otion er the nom they royed or must o part ne of ure of the ure of the rded on	21630			3/23/16
	by: Based on observation review, facility failed medications were punits. In addition, the	ent is not met as evident, interview and dood to ensure expired roperly disposed off the facility failed to enserators was kept clea	cument for 3 of 6 sure 1 of		Corrected. No POC required.		

6899

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00890	B. WING		02/1	2/2016
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- SPECIALTY CA	T BROADW			
0/A) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	DALE, MN	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 54	21630			
	Findings include:					
	medication room or open multi dose via located in the medicated as havin licensed practical number dose flu vaccine via opened. LPN-C ver 10/7/15, and that it line addition the top sometime moted with pinkish-that the refrigerator sanitary. LPN-C fur shift were supposed refrigerator and free During interview on unit's nurse managistated she expected	of the Bluff Country in 2/11/2016, at 9:40 a.m. an all of influenza (flu) vaccine was cation refrigerator. The vial g been opened 10/7/15, the urse (LPN)-C stated multiflass are good for 30 days once iffied date vial was opened on was greater than 30 days. Shelve of the refrigerator was whitish stains. LPN-C verified was not kept clean and ther stated the nurses on night d to be cleaning the ezer once a week. 2/12/16, at 11:55 a.m. the er, registered nurse (RN)-D d medications to be properly expired and the refrigerator to				
	floor: During observation medication room or open bottle of milk	of the Boundary Waters of 2/12/16, at 6:56 a.m. an of magnesia (MOM-a stipation) was noted to have				
	2015. RN-E was ur	OM had expired in October of hable to say who had received most likely had been used				

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		00890		B. WING		02/1	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S T BROADW DALE, MN 5		·	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
21630	Arrowhead medicat During observation room on 2/12/16, at vial of influenza (flu medication refrigera having been openedose flu vaccine via opened. RN-E verif that it was greater to Lakes medication roughly During observation on 2/12/16, at 7:58 600+D was noted to bottle was dated "o medication aide (TN Calcium 600 +D was	tion room on the third of the Arrowhead me t 7:11 a.m. an open n) vaccine was located ator. The vial was dat d 10/23/15. RN-E sta als are good for 30 da ied date vial was ope	edication nulti dose d in the ed as ted multi ays once ned and oor: tion room ium The d ttle of iid "I do	21630			
	whenever you take the person doing so that time. I will leave nurse know." During interview on nurse manager, sai medication rooms f the TMA's check th pull them. When as vial of flu vaccine g believe." RN-J said of 2015. I am sure i vaccine after it expivial of influenza vac both Arrowhead and because the nurse RN-J said, "(RN-A)	lications in the med rea bottle or give a me or, checks the expirative it on the counter and 2/12/16, at 9:05 a.m. d the nurses check the expired medication e medication cards wheel how long was arood for RN-J replied, "I gave flu vaccine in one received the fred." RN-J verified the cine would have been decided boundary Waters under the word medication around around to going to get rid of it. I way."	dication, on date at d let the RN-J, he hs and then they hopen "30 days I h October lue same n used by nit nits. hexpired				

00890 B. WING 02/12	2/2016
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 3815 WEST BROADWAY ROBBINSDALE, MN 55422	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) SUMMARY STATEMENT OF DEFICIENCY PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21630 Continued From page 56 21630	
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 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 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	

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.			
		00890	B. WING		02/1	2/2016
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- SPECIALLY CA	ST BROADW SDALE, MN (
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21630	Continued From pa	ge 57	21630			
		of expired medications and dication for cleanliness.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21685	MN Rule 4658.1419 Housekeeping, Ope	5 Subp. 2 Plant eration, & Maintenance	21685			3/23/16
	including walls, floo systems, and equip continuous state of with regard to the h well-being of the re	plant. The physical plant, ors, ceilings, all furnishings, oment must be kept in a good repair and operation ealth, comfort, safety, and esidents according to a written e and repair program.				
	by: Based on observati review, the facility f	ent is not met as evidenced ion, interview, and document ailed to ensure 1 of 2 residents as maintained in good repair nmental concerns.		Corrected. No POC required.		
	Findings include:					
	observation, the Bruheelchair) handles peeling black electror porous foam type ovinyl covering on the back was observed cloth underneath no surface. When aske electrical tape that adhesive part, train	o.m. during resident room oda wheelchair (specialized s were observed wrapped with rical tape around the gray of material. In addition, the pink e wheelchair frame to the left of ripped exposing the meshot making it a cleanable ed about the porous foam and was peeling exposing the ed medication aide (TMA)-A need to protect the environment,				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		00890		B. WING		02/1	12/2016	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
GOOD SAMARITAN SOCIETY - SPECIALTY CA ROBBINSDALE, MN 55422								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETE DATE	
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.							
	was conducted with (DOF), administrate wheelchair out of the administration verifies was exposing the formula cleanable surface tore up vinyl on the checked the W/C's good repair, the administration verifies with the surface to the	p.m. the environmentant the director of facilities or and intern. DOF browner own both him and the ied the tape was peelin oam underneath makings. In addition, both verifications when asked who to make sure they were ministrator stated staff work order and the chairly.	s ught the he g and g it not ied the e in was					
	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.							
	had limited physical cerebrovascular ac supranucular palsy standing and sitting Care plan indicated	ted 10/6/14, indicated real mobility related to scident (CVA) with heming as manifested by altered balance and gait disturble resident used a Broda rear tip bars bilateral the	plegia, ed rbance. chair					
	revised 3/2013, dire walkers requiring re orders will be filled	Valker Cleaning Proced ected staff, "All chairs a epair will be identified a out and distributed for i	nd nd work repair."					
		THOD OF CORRECTIC sing (DON) or designee						

Minnesota Department of Health STATE FORM

BZJW11 If continuation sheet 59 of 62

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00890	B. WING		02/1	2/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA 3815 WE	DDRESS, CITY, S ST BROADW SDALE, MN			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
21685	develop a maintena damaged walls and maintain a safe, cle The DON or design appropriate staff or develop monitoring compliance.	age 59 ance program to ensure If wheelchairs are repaired to ean, homelike environment. Thee could educate all The program, and could The systems to ensure ongoing R CORRECTION: Twenty-one	21685			
21810	Residents of HC Fa Subd. 6. Appropriate Appropriate Appropriate Care designed to enhighest level of phy This right is limited	.651 Subd. 6 Patients & ac.Bill of Rights riate health care. Patients and e the right to appropriate nal care based on individual e care for residents means nable residents to achieve their risical and mental functioning. Where the service is not ablic or private resources.				3/23/16
	by: Based on observation review, facility failed (R252) call light was was capable of using Findings include: On 2/10/16, at 10:4 asked surveyor for 10:42 a.m. the licerentered R252's roo	ent is not met as evidenced ion, interview, and document d to ensure 1 of 1 resident's is in reach for a resident who ing the call light. If a.m. during interview R252 help locating the call light. At insed practical nurse (LPN)-A im, located the call light and int to R252. The call light was		Corrected. No POC required.		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		00890		B. WING		02/	12/2016
	PROVIDER OR SUPPLIER	- SPECIALTY CA	3815 WES	DRESS, CITY, S ST BROADW DALE, MN S			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21810	observed on the nigbehind R252 and not behind R252 and not on 2/10/16, at 10:4 was able to use cal within reach. LPN-A within reach for resusing call lights. On 2/10/16, at 10:4 (NA)-A stated R252 light. R252's fall care pla was at risk for falls right foot due to ost deconditioning and goal was noted to be through the review staff to remind residup dropped items. It to ask for assistance address call light addirected staff to endoministrator stated light was supposed who was capable of the facility's call light staff to ensure that calling for assistance place call light with	ght stand that was loo of within reach. 3 a.m. LPN-A verified I light and call light was a stated all call lights idents who were cap 4 a.m. nursing assist was capable of using and the description of the capable of the capable be "Resident will be find the "Resident will be find the "The care pland the "The care pland the capable of	d R252 ras not should be able of tant ng call atted R252 outation of ced by ns. The ree of falls directed to pick abber or not ngh it sistance. See (RN)-D, ne thin reach tour the if the call sidents directed thod of ed staff to				

6899

PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CD.	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
GOOD SAMARITAN SOCIETY - SPECIALTY CA 3815 WEST BROADWAY ROBBINSDALE, MN 55422 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 21810 Continued From page 61 director of nursing or designee could review and /			00890	B. WING	1	02/1	12/2016		
(X4) ID PREFIX TAG CONTINUED FROM PROPERTIES PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) 21810 Continued From page 61 director of nursing or designee could review and /	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE CONTINUED TO THE APPROPRIATE DEFICIENCY) 21810 Continued From page 61 director of nursing or designee could review and /	GOOD S	SAMARITAN SOCIETY	- SPECIALLY CA						
director of nursing or designee could review and /	PREFIX	X (EACH DEFICIENCY	Y MUST BE PRECEDED BY FUL	LL PREFI	(EACH CORRECTIVE A CROSS-REFERENCED TO	ACTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE		
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	director of nursing of or revise policies and appropriate table he Education could be quality assurance of system to monitor to TIME PERIOD OF	or designee could review of procedures for ensuring the provided to the staff. To committee could develop the effectiveness of the process.	w and / ring The o a plan.					