DEPARTMENT (	OF I	HEALTH A	ND HI	UMAN	SERVICES
--------------	------	----------	-------	------	----------

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					CION AND TRANSMITTAL     ID: C2JR       E STATE SURVEY AGENCY     Facility ID:		
MEDICARE/MEDICAID PROVIDER NO.     (L1) 245476     2.STATE VENDOR OR MEDICAID NO.     (L2) 017040200     5. EFFECTIVE DATE CHANGE OF OWNERSHI     (L9)		<ol> <li>NAME AND AE</li> <li>(L3) GOOD SAM</li> <li>(L4) 518 JEFFER</li> <li>(L5) PINE RIVEI</li> <li>PROVIDER/SU</li> <li>01 Hospital</li> </ol>	DDRESS OF FACIL ARITAN SOCI SON AVENUE R, MN	LITY ETY - PIN , PO BOX 2	E RIVER	Facility ID: 00058       4. TYPE OF ACTION:     7 (L8)       1. Initial     2. Recertification       3. Termination     4. CHOW       5. Validation     6. Complaint       7. On-Site Visit     9. Other       8. Full Survey After Complaint	
6. DATE OF SURVEY 08/21/2018	(L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	05 MIA 06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 09/30	
11. LTC PERIOD OF CERTIFICATION         From (a):         To (b):         12. Total Facility Beds         13. Total Certified Beds         14. LTC CERTIFIED BED BREAKDOWN         18 SNF         18/19 SNF         45         (L37)         16. STATE SURVEY AGENCY REMARKS (IF A	(L18) (L17) 19 SNF (L39)	Compliand 1. 4 B. Not in Cor Requirements ICF (L42)	nce With Requirements ce Based On: Acceptable POC mpliance with Prog and/or Applied Wai IID (L43)	ram ivers:	And/Or Approved Waivers Of Th        2. Technical Personnel        3. 24 Hour RN        4. 7-Day RN (Rural SNF        5. Life Safety Code         * Code: <b>A</b> 15. FACILITY MEETS         1861 (e) (1) or 1861 (j) (1):	<ul><li>6. Scope of Services Limit</li><li>7. Medical Director</li></ul>	
17. SURVEYOR SIGNATURE Rebecca Haberle. HFE - NE	: 11	Date :	08/24/2018		18. STATE SURVEY AGENCY A		
				(L19)	OFFICE OR SINGLE ST	(L20)	
19. DETERMINATION OF ELIGIBILITY         _X1. Facility is Eligible to Participate        2. Facility is not Eligible	(L21)	20. COM	APLIANCE WITH GHTS ACT:		21. 1. Statement of Finan	ncial Solvency (HCFA-2572) I Interest Disclosure Stmt (HCFA-1513)	
OF PARTICIPATION BI 05/01/1987 (L24) (L 25. LTC EXTENSION DATE: 27. AI A.	Suspensior	DATE VE SANCTIONS a of Admissions:	4. LTC AGREEM ENDING DAT (L25) (L44)		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimburseme         03-Risk of Involuntary Termination         04-Other Reason for Withdrawal	05-Fail to Meet Health/Safety ent 06-Fail to Meet Agreement	
28. TERMINATION DATE:		pension Date:	(L45)		30. REMARKS		
(L28		00140		(L31)			
31. RO RECEIPT OF CMS-1539 (L32		. DETERMINATION ( 08/08/2018	OF APPROVAL D.	ATE (L33)	DETERMINATION APPR	OVAL	



Protecting, Maintaining and Improvingthe Health of All Minnesotans

CMS Certification Number (CCN): 245476

August 24, 2018

Administrator Good Samaritan Society - Pine River 518 Jefferson Avenue, PO Box 29 Pine River, MN 56474

Dear Administrator:

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 August 3, 2018 the above facility is recommended for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered August 24, 2018

Administrator Good Samaritan Society - Pine River 518 Jefferson Avenue, PO Box 29 Pine River, MN 56474

RE: Project Number S5476030

Dear Administrator:

On July 13, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 28, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On August 21, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on August 13, 2018 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 June 28, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of August 3, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 28, 2018, effective August 3, 2018 and therefore remedies outlined in our letter to you dated July 13, 2018, 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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us



Protecting, Maintaining and Improvingthe Health of All Minnesotans

Electronically delivered

August 24, 2018

Administrator Good Samaritan Society - Pine River 518 Jefferson Avenue, PO Box 29 Pine River, MN 56474

Re: Reinspection Results - Project Number S5476030

Dear Administrator:

On August 21, 2018 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 August 21, 2018, with orders received by you on July 16, 2018. At this time these correction orders were found corrected.

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,

Joanne Simon, Enforcement Specialist Minnesota Department of Health Licensing and Certification Program Program Assurance Unit Health Regulation Division Telephone: 651-201-4161 Fax: 651-215-9697 Email: joanne.simon@state.mn.us

#### DEPARTMENT OF HEALTH AND HUMAN SERVICES

#### **CENTERS FOR MEDICARE & MEDICAID SERVICES**

					AND TRANSMITTAL TE SURVEY AGENCY	ID: C2JR Facility ID: 00058
I. MEDICARE/MEDICAID PROVIDER NO.           (L1)         245476           2.STATE VENDOR OR MEDICAID NO.           (L2)         017040200	Э.	<ul> <li>3. NAME AND AI</li> <li>(L3) GOOD SAM</li> <li>(L4) 518 JEFFER</li> <li>(L5) PINE RIVEI</li> </ul>	IARITAN SOC SON AVENUE	IETY - PIN		4. TYPE OF ACTION:       2 (L8)         1. Initial       2. Recertification         3. Termination       4. CHOW         5. Validation       6. Complaint
5. EFFECTIVE DATE CHANGE OF OWN (L9)	ERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO 05 HHA	ORY 09 ESRD	<u>02</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint
<ul> <li>6. DATE OF SURVEY 06/28/20</li> <li>8. ACCREDITATION STATUS:</li> <li>0 Unaccredited 1 TJC 2 AOA 3 Other</li> </ul>	18 (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 ENDING DATE: (L35) 09/30
11. LTC PERIOD OF CERTIFICATION From (a): To (b):		Complian	nce With Requirements ce Based On:	S:	And/Or Approved Waivers Of Th 2. Technical Personnel 3. 24 Hour RN	6. Scope of Services Limit     7. Medical Director
12.Total Facility Beds 13.Total Certified Beds	<ul><li>45 (L18)</li><li>45 (L17)</li></ul>	X B. Not in Co	Acceptable POC mpliance with Prog and/or Applied Wa	<i>.</i>	4. 7-Day RN (Rural SNF 5. Life Safety Code * Code: <b>B</b> *	<ul> <li>Patient Room Size</li> <li>9. Beds/Room</li> </ul>
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 45	19 SNF	ICF	IID		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)
(L37) (L38) 16. STATE SURVEY AGENCY REMARKS	(L39) S (IF APPLICABL	(L42) E SHOW LTC CANC	(L43) ELLATION DATE	3):		
17. SURVEYOR SIGNATURE		Date:			18. STATE SURVEY AGENCY A	
<u>Rebecca Haberle, HFE</u>	NE II		07/26/2018	(L19)	Douglas Larson, Enfo	orcement Specialist 08/06/2018 (L20)
PAI	RT II - TO BI	E COMPLETED	BY HCFA R	EGIONAI	OFFICE OR SINGLE ST.	ATE AGENCY
<ol> <li>DETERMINATION OF ELIGIBILITY</li> <li>1. Facility is Eligible to Partic</li> </ol>	cipate		APLIANCE WITH GHTS ACT:	CIVIL	<ol> <li>1. Statement of Finar</li> <li>2. Ownership/Contro</li> <li>3. Both of the Above</li> </ol>	l Interest Disclosure Stmt (HCFA-1513)
2. Facility is not Eligible	(L21)					
22. ORIGINAL DATE 22. ORIGINAL DATE 23. OF PARTICIPATION 05/01/1987 (L24)	23. LTC AGREEM BEGINNING (L41)		<ol> <li>LTC AGREEN ENDING DA (L25)</li> </ol>		26. TERMINATION ACTION:         VOLUNTARY       00         01-Merger, Closure         02-Dissatisfaction W/ Reimbursement	05-Fail to Meet Health/Safety
25. LTC EXTENSION DATE: 2 (L27)		VE SANCTIONS n of Admissions: spension Date:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active
			(L45)			
28. TERMINATION DATE:	29	0. INTERMEDIARY/	CARRIER NO.		30. REMARKS	
	(L28)	00140		(L31)		
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL D	DATE		
	(L32)			(L33)	DETERMINATION APPR	OVAL



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 13, 2018

Mr. Michael Deuth, Administrator Good Samaritan Society - Pine River 518 Jefferson Avenue, PO Box 29 Pine River, MN 56474

RE: Project Number S5476030

Dear Mr. Deuth:

On June 28, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

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

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

#### attached deficiencies.

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

### DEPARTMENT CONTACT

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

Ms. Lyla Burkman, Unit Supervisor Bemidji Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 705 5th Street Northwest, Suite A Bemidji, Minnesota 56601-2933 Email: lyla.burkman@state.mn.us Phone: (218) 308-2104 Fax: (218) 308-2122

## **OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES**

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by August 7, 2018, 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 August 7, 2018 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. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

### Original deficiencies not corrected

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

#### Original deficiencies not corrected and new deficiencies found during the revisit

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

### Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by September 28, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies

have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by December 28, 2018 (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: <u>http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc\_idr.cfm</u>

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us

## Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

		& MEDICAID SERVICES					APPROVED . 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL		ONSTRUCTION		E SURVEY
	F CORRECTION	DENTIFICATION NUMBER:					IPLETED
		245476	B. WING			00/	00/0010
NAME OF F	PROVIDER OR SUPPLIER	243470	5		EET ADDRESS, CITY, STATE, ZIP CODE	06/	28/2018
					JEFFERSON AVENUE, PO BOX 29		
GOODS	AMARITAN SOCIETY	- PINE RIVER		PINE	E RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepare conducted on June during a recertificat		FO	00			
	survey was comple Minnesota Departm your facility was in c of 42 CFR Part 483	h June 28, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements b, Subpart B, and ong Term Care Facilities.					
	allegation of compli enrolled in the elect (ePOC), a signatur	on will serve as your facility's ance. Since your facility is tronic Plan of Correction re is not required at the bottom the CMS-2567 form.					
F 578 SS=D	Upon receipt of an acceptable ePOC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v)			78			8/3/18
	discontinue treatme	ight to request, refuse, and/or ent, to participate in or refuse perimental research, and to ce directive.					
	construed as the rig the provision of me	ing in this paragraph should be ght of the resident to receive dical treatment or medical					
	r DIRECTOR'S OR PROVID	ER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE 07/23/2018

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.

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245476	B. WING			06/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER	L		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 578	inappropriate. §483.10(g)(12) The requirements speci subpart I (Advance (i) These requirements inform and provide residents concerning medical or surgical resident's option, for (ii) This includes and facility's policies to and applicable Statt (iii) Facilities are per- entities to furnish the legally responsible requirements of this (iv) If an adult indivi- time of admission and information or article has executed an addition may give advance of individual's residentian with State Law. (v) The facility is not provide this information or she is able to recor- Follow-up procedure the information to the appropriate time. This REQUIREMENT by: Based on interview facility failed to identian	e facility must comply with the fied in 42 CFR part 489, Directives). Ents include provisions to written information to all adult of the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives e law. ermitted to contract with other his information but are still for ensuring that the s section are met. idual is incapacitated at the and is unable to receive ulate whether or not he or she dvance directive, the facility directive information to the t representative in accordance of relieved of its obligation to ation to the individual once he ceive such information. res must be in place to provide he individual directly at the NT is not met as evidenced v and document review the htify the preference for Health 1 of 1 resident (R27) reviewed	F 5	578	Preparation and execution of this response and plan of correction do constitute an admission or agreem agreement by the provider of the tr	ent or	
	Findings include:				the facts alleged or conclusions se in the statement of deficiencies. Th		

Facility ID: 00058

If continuation sheet Page 2 of 46

CENTER STATEMENT		AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ON E CONSTRUCTION	FORM / / <u>IB NO.</u> (X3) DATE	08/09/2018 APPROVED 0938-0391 SURVEY PLETED
		245476	B. WING			06/2	28/2018
	PROVIDER OR SUPPLIER	- PINE RIVER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 578	<ul> <li>6/5/18, indicated R2</li> <li>R27's Diagnosis repindicated R27 had displaced intertroch femur, acute respire (deficiency in the artissues), and centri emphysema (irreveconsists of destruct R27's Admission Reindicated R27 was 5/29/18, and the Actindicated "resuscitation].</li> <li>R27's Order Summincluded the followi -Advance Directive 5/29/18.</li> <li>R27's Care Plan praddress R27's prefidirective.</li> <li>R27's Social Service indicated R27 was decisions.</li> <li>On 6/27/18, at 9:56 worker (LSW) indicadvance directives for Life Sustaining information was preadmission. LSW in</li> </ul>	inimum Data Set (MDS) dated 27 was cognitively intact. port provided 6/28/18, diagnoses which included nanteric fracture of the left atory failure with hypoxia mount of oxygen reaching the lobular and panlobular rrsible lung diseases which tion of alveolar walls) ecord provided 6/28/18, admitted to the facility on lvance Directive section tte (CPR)" [cardiopulmonary ary Report dated 6/27/18,	F 5	578	<ul> <li>of correction is prepared and/ or exersiolely because it is required by the provisions of federal and state law. If the purposes of any allegation that the center is not in substantial compliance with federal requirements of particip, this response and plan of correction constitutes the center's allegation of compliance in accordance with sectior 7305 of the State Operations Manuae F578 Request/ Refuse/ Discontinue Treatment/ Formulate Advance Directives and plan of facility.</li> <li>2. All residents have been reviewer ensure Code Status and preference Advance Directives has been docum appropriately.</li> <li>3. Director of Nursing or designee provide re-education on the Good Samaritan Society Policy and Proceet for Advance Care Planning and Adva Directives to all Licensed Nursing St ensure resident preferences for advance directives and code status are appropriately addressed and docum</li> <li>4. Licensed Social Worker or designed will conduct auditing process by chareview for every new admission for the months to ensure resident preference advance directive and code status and appropriately addressed and docum Audit results will be reviewed by the Committee for further recommendation and state the status and appropriately addressed and docum appropriately addressed</li></ul>	For he ce ation, ion al. ctives the d to for nented will dure ance taff to ance taff to ance	

Facility ID: 00058

If continuation sheet Page 3 of 46

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DNSTRUCTION		(X3) DAT	0938-039 E SURVEY
		245476	B. WING			06/	00/0010
NAME OF	PROVIDER OR SUPPLIER	243470		ET ADDRESS, CITY, STATE, ZIP	CODE	00/	28/2018
GOOD S	AMARITAN SOCIETY	- PINE RIVER		EFFERSON AVENUE, PO BO RIVER, MN 56474	X 29		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY)	N SHOULD E APPROPF	BE	(X5) COMPLETIO DATE
F 578	she had stated she home. At 10:11 a.m. R27 with the social work facility. R27 indicat living will 15 years a which she stated ha R27 stated her dau will and she had a c believed she had to stated she did not w the event of a healt Review of R27 mec evidence of R27's li At 12:21 p.m. LSV remember if R27 ha advance directive u indicated she interv admission process request a copy. LS best to get a copy a admission and state Spaces (the facility' they probably did no At 1:42 p.m. family R27 had a living wil with R27 at the time facility and indicated FM-A stated she wa R27's living will con not want to be kept	was planning to discharge to confirmed she had spoken er upon her admission to the ed she had established a ago and named two hospitals ad copies of the living will. ghter had a copy of her living copy herself, at home. R27 ld the facility about it. R27 vant to be put on life support in h emergency. lical record revealed no ving will/advance directive. V stated she did not ad indicated she had an pon admission, however, iewed for this during the and it was her practice to W indicated she would do her t the time of a resident's ed if it was not in Resident s document imaging system),	F 57	8/3/2018			

Facility ID: 00058

If continuation sheet Page 4 of 46

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	IPLE CONSTRUCTION	OMB NO	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		IG		IPLETED
		245476	B. WING _		06/	28/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 578	On 6/28/18, at 10:2 (DON) confirmed th a copy of R27's livir	6 a.m. the director of nursing ne facility should have obtained ng will to ensure her dentified and carried out in the	F 57	78		
F 583 SS=D	Personal Privacy/C CFR(s): 483.10(h)(	onfidentiality of Records 1)-(3)(i)(ii)	F 58	3		8/3/18
		and Confidentiality. right to personal privacy and s or her personal and medical				
	accommodations, r telephone commun and meetings of far	onal privacy includes nedical treatment, written and ications, personal care, visits, mily and resident groups, but e the facility to provide a ch resident.				
	residents right to per right to privacy in hi written, and electro the right to send an mail and other lette materials delivered	facility must respect the ersonal privacy, including the is or her oral (that is, spoken), nic communications, including id promptly receive unopened rs, packages and other to the facility for the resident, vered through a means other ce.				
	and confidential per (i) The resident has of personal and me provided at §483.70 federal or state law (ii) The facility must	resident has a right to secure rsonal and medical records. the right to refuse the release edical records except as D(i)(2) or other applicable s. t allow representatives of the Long-Term Care Ombudsman				

If continuation sheet Page 5 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245476	B. WING			06/28/2018	
	PROVIDER OR SUPPLIER	- PINE RIVER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 583	administrative recor law. This REQUIREMEN by: Based on observat review, the facility fi information was nor residents, staff and residents (R5, R2, I information posted Findings include: R5's care plan revis had impaired cogni dementia evidence known, behaviors, a mobility and activitie total assistance of t mechanical lift and R5's Care plan prin was dependent on of daily living (ADL) with a total lift and I On 6/25/18, at 6:41 was observed hang bed. Written on the which was visible to -total lift with large s R2's care plan revis impaired cognition Parkinson's disease for all mobility and a	A section of the sect	F 5	83	<ul> <li>F583 Personal Privacy/ Confidentia Records</li> <li>1. R5, R2 and R16□s private/ confidential information on white bot these resident rooms has been ren</li> <li>2. All residents□ rooms that have confidential information on white bot has been removed.</li> <li>3. Director of Nursing and Staff Development will provide re-educa Notice of Privacy Practices and en- confidential information is not view. with licensed nurses, nursing assis and activity department employees</li> <li>4. Director of Nursing or designed audit all white boards in resident roo ensure personal/ confidential inform is not posted weekly times one mon then one time for one month. Audit will be reviewed by the QAPI Common for further recommendations.</li> <li>5. 8/3/2018</li> </ul>	tion on suring able tants, able tants, able tants,	

If continuation sheet Page 6 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING _			06/;	28/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
	Continued From par medium sling for tra On 6/25/18, at 7:09 hung on the wall ab Written on the boar visible to all who en -med sling full lift. On 6/27/18, at 1:07 explained the white how to transfer, the to use. NA-A agree available to anyone NA-A stated a care the information rega R16's quarterly Min 5/2/18, indicated R <sup>2</sup> and had diagnoses and depression. Th required extensive of daily living. On 6/25/18, at 7:45 a.m. a white, dry er hanging next to the board revealed the	age 6 ansfers. 9 p.m. a white, dry erase board bove R2's head of the bed. rd was the following which was			CROSS-REFERENCED TO THE APPROP		
	abbreviations mean and toilet use. RN- was private informa cares and it was re- staff and visitors to	stered nurse (RN)-A stated the nt to assist of one for transfers A confirmed the information ation used to assist R16 with adily available to all residents,					

Facility ID: 00058

If continuation sheet Page 7 of 46

TATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI 1	( TIPLE CONSTRUCTION	(X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		NG		IPLETED
		245476	B. WING _		06/	28/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST 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) COMPLETIO DATE
F 583 F 655 SS=D	boards for the past indicated the facility boards called "hollis the facility changed DON confirmed the boards was persons specific resident in not need access to stated the facility co of sharing care info The Notice of Priva 9/2013, indicated th medical information secure. Baseline Care Plan CFR(s): 483.21(a)( §483.21 Comprehe Planning §483.21(a) Baseline §483.21(a) (1) The f implement a baselin that includes the ins effective and person that meet professio The baseline care p (i) Be developed wit admission. (ii) Include the minin necessary to prope including, but not lir	cility had been using the white three years or so. The DON had previous used slide sters", however at some point to the white boards. The information on the white al care information for the the room and all visitors did that information. The DON build find an alternative method rmation with the staff. cy Practices policy dated he facility was required to keep about residents private and 1)-(3) nsive Person-Centered Care e Care Plans facility must develop and he care plan for each resident structions needed to provide n-centered care of the resident nal standards of quality care. blan must- thin 48 hours of a resident's mum healthcare information rly care for a resident nited to- ed on admission orders. s.	F 5			8/3/18

Facility ID: 00058

If continuation sheet Page 8 of 46

CENTER	RS FOR MEDICARE	AND HUMAN SERVICES	[	0	RINTED: 08/09/2018 FORM APPROVED MB NO. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		245476	B. WING		06/28/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474	
(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 APPROPF DEFICIENCY)	BE COMPLÉTION
F 655	Continued From pa (F) PASARR recom	ge 8 Imendation, if applicable.	F 65	5	
	comprehensive car care plan if the com (i) Is developed wit admission. (ii) Meets the requir	facility may develop a e plan in place of the baseline nprehensive care plan- thin 48 hours of the resident's rements set forth in paragraph excepting paragraph (b)(2)(i) of			
	resident and their re of the baseline care limited to: (i) The initial goals (ii) A summary of the dietary instructions. (iii) Any services and administered by the on behalf of the fac (iv) Any updated into of the comprehension	he resident's medications and nd treatments to be facility and personnel acting			
	Based on observatives, the facility find the facility for the facility for the facility for the facility and the facility for the facilit	tion, interview and document ailed to ensure a baseline care d, implemented and a copy sident and/or representative admission which addressed the s for 1 of 1 resident (R28) o the facility. innimum Data Set (MDS) ated R28 was alert and agnoses including multiple rtebral fractures, sleep apnea		<ul> <li>F655 Baseline Care Plan</li> <li>1. On 7/18/19 the RN Unit Manag reviewed and provided a copy of the Plan to R28.</li> <li>2. On 7/19/2018, current resident records of those admitted after Nov 28, 2018 were reviewed to ensure t baseline care plan was given/ documented. If there is not docume in Point Click Care that a baseline of plan had been given to the resident representative, the medical records</li> </ul>	e Care ember hat a entation care

Facility ID: 00058

If continuation sheet Page 9 of 46

TATEMEN	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY PLETED	
		245476	B. WING			06/28/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIC DATE	
F 655	and a history of res assessment indicat upon staff for trans- assistance for bed and bathing and wa R28's admission or orders for the follow -Albuterol Sulfate N milliliters (ml) every -Baclofen 10 mg ta -Celexa 20 mg twice -Ice Bags as neede -Klonopin 1 mg thre -Lidoderm Patch 59 -Lopressor 50 mg t -Proventil inhaler or -Oxycodone 5 mg e pain -Tylenol 500 mg two needed for pain. R28's initial Care P R28 had been adm The initial care plar interventions for the - limited physical m - activity of daily livi - risk for falls - oxygen therapy - nutritional concerr - risk for skin integr - discharge plan On 6/25/18, at 5:40	piratory failure. The ted R28 was totally dependent fers, required extensive mobility, dressing grooming as unable to ambulate. ders dated 5/20/18, included ving medications: lebulizer 2.5 milligrams (mg)/3 of four hours as needed blets three times a day (TID) te a day ed for pain te times per day % to back once a day wice a day ne puff as needed once a day every four hours as needed for tablets every hour hours as lan dated 5/31/18, indicated itted to the facility on 5/30/18. n included a focus, goals and e following areas: obility. ng.	F 65	<ul> <li>reviewed to ensure that a care conference/ care plan review has occurred since admission.</li> <li>3. Director of Nursing and Staff Development will provide re-educ all nursing staff on developing a l care plan within 48 hours and documentation that the baseline was reviewed and a written copy resident and/or representative wa provided per Good Samaritan Sc Policy &amp; Procedure and Federal Regulation.</li> <li>4. Director of Nursing/ Designe audit medical records in Point Cli for documentation that baseline of was given to all new admissions months. Audit results will be revie the QAPI Committee for further recommendations.</li> <li>5. 8/3/2018.</li> </ul>	e will care plan for as ciety e will ck Care care plan for 3		

If continuation sheet Page 10 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/09/2018 APPROVED 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION		E SURVEY PLETED
		245476	B. WING _			06/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 655	copy to his fiance b On 6/27/18, at 12:4 (RN)-B stated upon the activity of daily I resident, however, s residents being give plan within 48 hours if a resident wanted they would have to form prior to obtain knowledge, R28 ha care plan. On 6/27/18, at 3:00 (DON) stated the fa process to ensure t of the initial care pla admission. The res release of informati the plan, however, the process. The D have received a cop required. The Comprehensive Conference policy of to develop a care p provide a summary resident or represent document in the me summary had been representative.	ge 10 the facility may have given a ut he could not recall. 0 p.m. registered nurse admission, the staff reviewed iving needs with each she was unaware of the en a copy of the initial care s of admission. RN-B added a copy of the initial care plan, fill out a release of information ng a copy. To RN-B's d not requested a copy of the p.m. the director of nurses cility was working on the he residents' received a copy an within 48 hours of sidents did not need to fill out a on form to receive a copy of the facility was still working on DON stated R28 would not by of the initial care plan, as e Care Plan and Care lated 2/2018, directed the staff lan within 24 hours and to of the care plan to the native. The staff were to edical record after the given to the resident or rest/Needs Each Resident	F 6				8/3/18
SS=D	CFR(s): 483.24(c)( §483.24(c) Activities	1)	ГО	19			0/3/10

If continuation sheet Page 11 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	08/09/2018 APPROVEE 0938-039
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING		06/2	28/2018
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2	•	
GOOD SA	MARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO	BOX 29	
				PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
	the comprehensive and the preferences program to support activities, both facili individual activities designed to meet the physical, mental, are each resident, enco- and interaction in the This REQUIREMEN by: Based on observate review, the facility fac- centered activity pre- individualized interve (R28) reviewed for Findings include: R28's admission Mid dated 6/6/18, indicated oriented and had di pelvic fractures, ver acetabulum fractures and socket" of the I indicated R28 was for transfers, require bed mobility, dressi and was unable to a indicated it was ver with family/friends a around animals. The Activities of Da Assessment (CAA) was unable to bear	acility must provide, based on assessment and care plan s of each resident, an ongoing residents in their choice of ty-sponsored group and and independent activities, ne interests of and support the nd psychosocial well-being of buraging both independence the community. NT is not met as evidenced ion, interview and document ailed to assess resident eferences and develop rentions for 1 of 2 residents	F		individualized ets his bserved to ensure ndividualized the Activity Data and Activity Data and Activity staff on the gresident activity bing basis and o meet those lopment and ducate activity of documentation al of individualized Designee will ervation audits on lents weekly times	

Facility ID: 00058

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE	E SURVEY PLETED	
		245476	B. WING			06/28/2018		
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI> TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 679	depressed following struggling to cope w The severe pain fro ability to participate R28's Activity Intere 6/1/18, indicated R2 fishing, watching te traveling. The asse able to make his ow transfer, ambulate Collection Tool did how the facility wou R28's Care Plan da multiple fractures d able to participate i visiting with friends, adjust to the facility ensure R28 express of activities and lev asked. The care pl watching television about hunting and f On 6/25/18, at 4:54 bored at the facility the facility for five w accident which had bored watching television done at home, yet fabout it. R28 state	ed 6/6/18, indicated R28 was g a severe accident and was with his lack of independence. om his injuries affected his in activities he enjoyed. Applied the enjoyed of the enjoyed of the activities he enjoyed of the enjoyed of the activities for R28 was of the enjoyed of the enjoyed of the activity goal was to and the enjoyed of the enjoyed of the activity involvement when an interventions included to using the phone and talking ishing. Applied the enjoyed of the activity and required time to the activity involvement when an interventions included the phone and talking ishing. Applied the phone and talking ishing. Applied the phone and talking ishing a significant and he spent the majority of the and he spent the majority of the and he spent the majority of the and his fiance visited him and he spent her visits made	F 6	79	Committee for further recommenda 5. 8/3/2018	tions.		

If continuation sheet Page 13 of 46

		I AND HUMAN SERVICES E & MEDICAID SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	``'		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING			06/:	28/2018
NAME OF I	PROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 679	<ul> <li>From 5:00 p.m. to to remain in his roo closed.</li> <li>On 6/26/18, at 12:4 watched more televent than he had in his e occasionally he was was tired of game as</li> <li>On 6/27/18, at 7:54 eating breakfast in and dog would be we was looking forward</li> <li>On 6/27/18, at 12:2 had left the facility be tomorrow and until stated the staff mer- him medications, as delivered his meals members visited wi When asked if he he things to do in his re- watched television, waited for the phon</li> <li>At 12:52 p.m. regi R28 was bedridden RN-B stated R28's watched television RN-B stated R28 po shades closed and He would talk to the but he did not partice Review of the Active 6/2018, indicated R</li> </ul>	<ul> <li>8:00 p.m. R28 was observed om, in bed, with the door</li> <li>9:00 p.m. R28 stated he had vision in the past five weeks entire life. R28 stated s able to find a movie, but he shows and the news.</li> <li>9:4 a.m. R28 was observed bed. R28 stated his fiance visiting the facility soon and he d to seeing them.</li> <li>27 p.m. R28 stated his fiance but she would be back then, he would be bored. R28 mbers visited, came in to give ssisted with cares, and s. However, none of the staff ith him for any period of time. had been offered alternative oom, R28 stated 'no" he just played on his computer or</li> </ul>	F 6	79			

Facility ID: 00058

If continuation sheet Page 14 of 46

		AND HUMAN SERVICES				FORM	: 08/09/2018 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION		E SURVEY IPLETED	
		245476	B. WING			06/28/2018		
NAME OF I	PROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE	
F 679	single note dated 6 was confined to be unable to read at th on the words. The unable to attend an On 6/28/18, at 8:20 stated R28 had be approximately five activity documental activities R28 partic visited and not whe activities for/with hi his fiance, watching computer. The AD one to one visits fro not requested the v was a younger pers family visits may be however, it was not The AD stated the a each day to drop of calendar/menu pap visit with him. The received an individu the staff were deper to provide activities had "gotten lost" in structured activity p established for R28 The One to One Ac dated 8/2015, direct	ity Progress Notes included a /1/18, which indicated R28 d, watched television, was his time due to inability to focus note indicated R28 was by type of group activities. a.m the activity director (AD) en at the facility for weeks. Upon review of the tion, the AD stated the 19 cipated in were when his fiance in the staff were providing m. R28 spent his days with g television or playing on the stated R28 had not received om the activity staff as he had risits. The AD confirmed R28 son and indicated 2-4 hours of e enough for an elderly person, activity staff were in his room if the morning activity ber, but they did not stay and AD confirmed R28 had not ualized activity program and indent upon his family/friends for him. The AD stated R28 our day to day activities and a program had not been 3.	F	579				
	focused on needs,	vity for individual resident that abilities , strength and taff to resident one to one						

Facility ID: 00058

If continuation sheet Page 15 of 46

		AND HUMAN SERVICES			FORM	: 08/09/2018 APPROVED . 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED	
		245476	B. WING _		06/28/2018		
	PROVIDER OR SUPPLIER	- PINE RIVER		STREET ADDRESS, CITY, STATE, ZIP CODI 518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC 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 679	one to one interven involved in a rehabi focused on going h	by directed staff to consider tions for a resident who was ilitation program and was ome.	F 6			8/3/18	
F 688 SS=E	CFR(s): 483.25(c)( §483.25(c) Mobility §483.25(c)(1) The f resident who enters range of motion dor range of motion unl condition demonstr of motion is unavoid §483.25(c)(2) A res motion receives ap services to increase prevent further dec §483.25(c)(3) A res receives appropriat assistance to maint the maximum pract reduction in mobility This REQUIREMEN	acility must ensure that a s the facility without limited es not experience reduction in less the resident's clinical ates that a reduction in range dable; and ident with limited range of propriate treatment and e range of motion and/or to rease in range of motion. ident with limited mobility e services, equipment, and tain or improve mobility with ticable independence unless a y is demonstrably unavoidable. NT is not met as evidenced			ase in	8/3/18	
	review, the facility f motion (ROM) serv and/or prevent furth 4 of 4 residents (R3 limitations in ROM	tion, interview and document ailed to provide range of ices in order to maintain her decline in ROM abilities for 3, R7, R16, R15) who had and had not received ROM to their individualized		<ul> <li>F688 Increase/ Prevent Decrease/ ROM/ Mobility</li> <li>1. R3, R7, R16, and R15 are range of motion services accound individualized assessed need assessments were reviewed for and necessary updates will be on assessment.</li> <li>2. All residents on ROM services account of the service of the serv</li></ul>	receiving ding to or accuracy, reflected		

Event ID:C2JR11

Facility ID: 00058

If continuation sheet Page 16 of 46

CENTE	RS FOR MEDICARE	AND HUMAN SERVICES				<u>MB NO.</u>	APPROVEI 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				· · /	E SURVEY PLETED	
		245476	B. WING _			06/2	28/2018	
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474			
(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) COMPLETIOI DATE	
F 688	3/23/18, indicated F cognitive impairment including diabetes r MDS indicated R3 r with activites of dail unable to ambulate limitations of ROM significant change I the same informatio 3/23/18. R3's Activity of daily (CAA) dated 9/28/1 with therapy but wa making progress w R3's Care plan date required restorative physical mobility. T participate in a funct (FMP) up to three to included: - NURSING REHAM motion] to bilateral up to 3 times per w past 90 degrees for - NURSING REHAM 5 repetitions up to t - NURSING REHAM red theraband and repetitions x 3 sets - NURSING REHAM raises, 15 reps up t - NURSING REHAM	num Data Set (MDS) dated R3 displayed moderate int and had diagnoses mellitus and dementia. The required extensive assistance ly living (ADLs) and was . R3 did have functional in the lower extremities. R3's MDS dated 9/25/17, identified on as the quarterly MDS dated / living Care Area Assessment 7, indicated R3 was working s not participating well or ith the therapy. ed 9/26/17, indicated R3 interventions due to limited the plan directed R3 to ctional maintenance program imes per week. The program imes per week. The program B #1: AAROM [active range of shoulder in all planes 10 reps eek. Do not range shoulder shoulder flex. B #2: Should blade squeezes, hree times per week B #3: Outward rotation with shoulders snuggled up, 10 up to three times per week. B #4: Bilateral straight leg o three items per week. B #5: Bilateral hip abductions, three times per week. B #5: Bilateral hip abductions, three times per week. B #6: Bridges, 15 repetitions	F 68	88	receiving range of motion services according to their individualized as needs. Restorative assessments we reviewed for accuracy, and any neu updates will be reflected on assess 3. Director of Nursing/ Staff Development will re-educate all Nur Assistants on how to provide range motion services to ensure that ROI be completed according to residen individualized assessed needs. 4. Director of Nursing/ Designeer observe/audit the medical record documentation of ROM services pr to 7 random residents weekly times months to ensure services are beir provided. Audit results will be reviet the QAPI Committee for further recommendations. 5. 8/3/2018.	vere cessary sment. rsing of M will ts will rovided s three ng		

If continuation sheet Page 17 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING			06/2	28/2018
NAME OF I	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	-NURSING REHAE stretches, 2 repetiti- hold up to three tim On 6/25/18, at 6:25 were stiff and he ha year or so. R3 state exercise program. During the survey of 1:00 p.m. to 8:00 p. to 4:30 p.m., on 6/2 p.m. and on 6/28/18 R3 was not observer restorative exercise -Review of R3's res documentation rever April 2018: -nursing rehab #1- exercises on 2 of 10 -nursing rehab #3- exercises on 3 of 11 -nursing rehab #3- exercises on 3 of 11 -nursing rehab #4- exercises on 3 of 11 -nursing rehab #5- exercises on 3 of 11 -nursing rehab #5- exercises on 3 of 11 -nursing rehab #7 exercises on 3 of 11 -nursing rehab #7	<ul> <li>#7: hamstring/heel cord ons each foot x 30 second es per week.</li> <li>p.m. R3 stated his shoulders ad not been able to walk in a ed that he did participate in an</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m.</li> <li>conducted on 6/25/18, from .m., on 6/26/18, fr</li></ul>	F	588			

Facility ID: 00058

If continuation sheet Page 18 of 46

		AND HUMAN SERVICES				FORM	: 08/09/2018 APPROVED : 0938-0391	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				E SURVEY IPLETED	
		245476	B. WING	i		06/28/2018		
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE	
F 688	exercises on 6 of 1 -nursing rehab #3- exercises on 6 of 1 -nursing rehab # 4- exercises on 6 of 1 -nursing rehab #5- exercises on 6 of 1 -nursing rehab #6- exercises on 6 of 1 -nursing rehab #7 - exercises on 6 of 1 On 6/26/18, at 12:5 (NA)-B stated she 4 programs for R3 ea stated she was to 4 week as the restora frequently pulled to instead of providing stated she attempto programs done, ho working the floor. I she would be provi- restorative program On 6/27/18, at 9:10 stated she provided program. RN-A st reassigned to provi	<ul> <li>6 opportunities.</li> <li>R3 participated in the</li> <li>6 opportunities.</li> <li>80 p.m. nursing assistant completed the restorative arlier in the morning. NA-B vork at the facility four days a ative NA, however, she was the floor to provide direct care grestorative services. NA-B ed to get all of the restorative wever, was unable to due NA-B stated the next two days, ding direct care and not</li> </ul>	F	588	3			
	she too would also medications. RN-A NA-B were providir programs were not was to participate in three times a week	be reassigned to pass A stated, when both she and ng direct care, the restorative completed. RN-A stated R3 n the restorative program up to , as directed by the care plan. restorative documentation,						

Facility ID: 00058

If continuation sheet Page 19 of 46

		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES					0. 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		LE CONSTRUCTION		TE SURVEY MPLETED
		245476	B. WING			06	100/0010
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	00	/28/2018
					518 JEFFERSON AVENUE, PO BOX 29		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			PINE RIVER, MN 56474		
(X4) ID			ID		PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	Х	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		COMPLETION DATE
					DEFICIENCY)		
E 000			·				
F 688	Continued From pa	-	F 6	88	<b>i</b>		
		B had not participated in the as directed by the care plan.					
	restorative program	as directed by the dare plan.					
		A cued R3 to lift his arms. R3					
		ave limitations in both evented him from lifting his					
		. R3 stated his shoulders had					
		ears and his ROM ability had					
		as observed to lift his legs and					
		nd forth. R3 stated he could					
		e was not able to stand on ned R3 had limitations in his					
		ot received ROM services as					
	directed by the care						
	R7's quartarly MDS	dated 4/9/18, indicated R7					
		ted and had diagnoses					
		and schizoaffective disorder.					
		R7 required extensive					
		d mobility and transfers and					
		e of one to ambulate in her The assessment did not					
		y type of limitation in ROM.					
	-						
		ed 4/19/18, directed the staff					
		front wheeled walker. It also ing restorative nursing					
	program:						
	-NURSING REHAB repetitions up to 3 t	8 #1, Bilateral should shrugs. 5					
		B #2: AAROM to bilateral					
		es of normal joint movement					
	10 repetitions each	up to three times per week.					
		3 #3: Pull back with one pound					
		ons x 2 sets. Up to three times					
	per week.	3: Ambulate with assist of one					
		walker and wheelchair to					

If continuation sheet Page 20 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	(X3) DATE	E SURVEY
AND PLAN O	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING _		COM	IPLETED
		245476	B. WING			06/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	as tolerates. On 6/25/18, at 2:40 received assistance R7 stated she was but she only receive the mornings Mond was also to do exer except the nursing a restorative, was usu direct care. R7 stat participate in the re- facility did not have -Review of R7's res documentation reve April 2018: -nursing rehab #1-1 exercises on 4 of 10 -nursing rehab #2- exercises on 4 of 10 -nursing rehab #3-1 exercises on 4 of 10 -nursing rehab #3-1 exercises on 4 of 10 -nursing rehab #3-1 exercises on 7 of 10 -nursing rehab #1- as opportunities in 11 May 2018: -nursing rehab #1- exercises on 7 of 10 -nursing rehab #3-1 exercises on 7 of 10 -nursing rehab #3-1	<ul> <li>twice a day. Goal 120 feet or</li> <li>p.m. R7 stated she had not</li> <li>with ambulation as directed.</li> <li>to walk twice a day every day,</li> <li>ed assistance to ambulate in</li> <li>ay - Friday. R7 stated she</li> <li>cises with her shoulders,</li> <li>assistant assigned to</li> <li>ually was pulled to provide</li> <li>ted she did not routinely</li> <li>storative program because the</li> <li>enough staff.</li> </ul> torative nursing flowsheet ealed the following: R7 participated in the 6 opportunities. R7 ambulated 27 times out of the evening. R7 participated in the 6 opportunities. R7 ambulated 18 times out of the morning and 3 times out of the morning and 3 times out of	F 6	88			
	exercises on 7 of 10 -nursing rehab #3- exercises on 7 of 10 -nursing rehab # 4-	6 opportunities. R7 participated in the 6 opportunities. R7 ambulated 18 times out of the morning and 3 times out of					

Facility ID: 00058

If continuation sheet Page 21 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES								APPROVED	
CENTERS FOR MEDICARE & MEDICAID SERVICES								0938-0391	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(	(X3) DATE SURVEY COMPLETED		
		245476	B. WING				06/28/2018		
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		00/2	-0/2010	
GOOD	SAMARITAN SOCIETY			5	18 JEFFERSON AVENUE, PO BOX 29				
GOOD	SAMANTAN SOCIETT			PINE RIVER, MN 56474					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD E	ЗE	(X5) COMPLETION DATE	
F 688	Continued From pa	ge 21	F6	688					
	June 2018: -nursing rehab #1- exercises on 7 of 10 -nursing rehab #2- exercises on 7 of 10 -nursing rehab #3- exercises on 7 of 10 -nursing rehab # 4- 26 opportunities in 12 27 opportunities in 12 On 6/27/18, at 7:30 think she would be program as NA-B w stated sometimes se exercises, but some - At 11:00 am. RN-A room with a front w observed to ambula -At 11:10 a.m. RN-A arm. R7 stated the ROM for several ye her left arm approxi- not observed to have confirmed R7 had li -At 11:51 a.m. RN-A receiving ROM and directed by the care R16's quarterly MD as being alert and co including atrial fibril The MDS indicated assistance of one for	R7 participated in the 6 opportunities. R7 participated in the 6 opportunities. R7 participated in the 6 opportunities. R7 ambulated 22 times out of the morning and 5 times out of the morning and 5 times out of the evening. a.m. R7 stated she did not participating in her restorative vas providing direct care. R7 she had time to help us with etimes she did not. A ambulated R7 out of her heeled walker. R7 was ate 200 feet without difficulty. A directed R7 to stretch her left should had limitations in ears. R7 was observed to lift imately half way up. R7 was ve full ROM in the arm. RN-A imitations in the left shoulder. A confirmed R7 had not been ambulation services as							

If continuation sheet Page 22 of 46

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			PLE CONSTRUCTION		X3) DATE SURVEY		
		A. BUILDIN	G	CON	COMPLETED		
		B. WING _		06/28/2018			
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474			
(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 SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE	
F 688	did not display func R16's Care Plan da was to participate in programs: -NURSING REHAE shoulders (has limit use caution), five re- week -NURSING REHAE pound weight, 10 re- week. -NURSING REHAE abduction/adduction sung up elbow and 10 repetitions x 2 se- week. -NURSING REHAE dowel and red thera up to three times pe- -NURSING REHAE straight leg raises 1 week -NURSING REHAE straight leg raises 1 week. -NURSING REHAE straight leg raises 1 week. -NURSING REHAE cord stretches 2 rep to three times per w -NURSING WALKI	<ul> <li>a. The MDS indicated R16 tional ROM limitations.</li> <li>a. ted 4/19/18, indicated R16 in the following nursing rehab</li> <li>b. #1: AAROM to bilateral ted range in the right shoulder, epetitions up to three times per</li> <li>b. #2: Bicep flexion with a two epetitions up to three times per</li> <li>b. #3; Horizontal in with a one pound weight push one pound across body, ets, up to three times per</li> <li>b. #4 Pull back with one pound aband 10 repetitions x 3 sets er week.</li> <li>b. #5 while in bed: bilateral 5 repetitions up to 3 times per</li> <li>b. #6: while in bed bridges. 15 ee times per week.</li> <li>b. #7" While in bed: bilateral hip etitions up to three times per</li> <li>b. #8: Bilateral hamstring/heel petitions with second hold up</li> </ul>					

If continuation sheet Page 23 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391		
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLI		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		245476	B. WING _			06/28/2018			
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD S	AMARITAN SOCIETY	- PINE RIVER			8 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474				
(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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	) BE	(X5) COMPLETION DATE		
F 688	however, the facility assist her with amb walked in three day walk, however, they stated she was to p program but she ha the program. R16 arm and stated her Review of R16's rea documentation reve April 2018: -nursing rehab #1- -ambulation: R16 h morning and seven had refused to part times. May 2018: -nursing rehab #1- exercises on 1 of 1 -ambulation: R16 h morning and 12 tim refused to participa June 2018: -nursing rehab #1- exercises on four o refused the program -ambulation: R16 h the morning and for had refused to part times. On 6/26/18, at 1:35 stated R16 was not FM-B stated R16 h	<ul> <li>y did not have enough staff to pulation, therefore, she had not vs. R16 stated she liked to y didn't have time. R16 also participate in an exercise ad not received assistance with lifted her right arm with the left right arm was weak.</li> <li>storative nursing flowsheet ealed the following:</li> <li>#7 no data was available ad ambulated four times in the evening. R16 icipate in the program 29</li> <li>#7, R16 participated in the 6 opportunities. ad ambulated 12 times in the evening. R16 had tte in the program 33 times.</li> <li>#7: R16 participated in the f16 opportunities and had</li> </ul>	F 6	38					

Facility ID: 00058

If continuation sheet Page 24 of 46

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION       (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:       (X2) MULTIPLE CONSTRUCTION A. BUILDING       (X3) DATE SURVEY COMPLETED         AMD PLAN OF CORRECTION       245476       B. WING       06/28/2018         NAME OF PROVIDER OR SUPPLIER       STREET ADDRESS, CITY, STATE, ZIP CODE 518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474       518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474       VING			AND HUMAN SERVICES			FORM	: 08/09/2018 APPROVED . 0938-0391	
NAME OF PROVIDER OR SUPPLIER     STREET ADDRESS, CITY, STATE, ZIP CODE       GOOD SAMARITAN SOCIETY - PINE RIVER     518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474       (%) ID PREPIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC DENTIFYING INFORMATION)     D PREPIX TAG     PROVIDER'S PLAN OF CORRECTION (EACH OBRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)     (%) (EACH OBRECTIVE ACTION SHOULD BE CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY)       F 688     Continued From page 24 received the assistance to participate in the program. FM-B stated she would like to make sure R16 continued to ambulate.     F 688       On 6/27/18, at 11:00 am. RN-A confirmed R16 had not been receiving assistance with ROM and ambulation as directed by the care plan. RN-A directed R16 to lift her arm. R16 was not observed to have limitations in the left arm, but had an approximately 50% ROM loss in the right should. R16 stated the right arm had been bad for years.       -At 11:25 a.m. RN-A and nursing assistant (NA)-B were observed to ambulate R16 75 feet with an EZ walker. R16 tolerated the ambulation as directed.       -At 11:47 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.       R15's quarterly MDS dated 5/7/18, indicated R15 was cognitively intact and had diagnoses which included multiple sclerosis (MS), pain and lymphedema (swelling caused by a build-up of lymph fluid under the skin). The MDS also indicated R15 was totally dependent upon two statf for transfers and totale use and required	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			IPLE CONSTRUCTION	(X3) DAT	(X3) DATE SURVEY		
GOOD SAMARITAN SOCIETY - PINE RIVER     518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474       (M) ID TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REQULATORY ON LSC IDENTIFYING INFORMATION)     PIE PRETIX TAG     PREVER, MN 56474     Commention (EACH CORRECTIVE ACTION SHOLLD BE CROSS-REFERENCE) TO THE APPROPRIATE DEFICIENCY)     COMMENTION (EACH DEFICIENCY)     C			245476	B. WING		06/	06/28/2018	
GOOD SAMARITAN SOCIETY - PINE RIVER     PINE RIVER, MN 56474       (x) ID PREFIX TAG     SUMMARY STATEMENT OF DEFICIENCIES (EACH EORICENCY WISTER PERCEDED DE PY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)     ID PREFIX FAG     PROVIDER'S PLAN OF CORRECTIVE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)     COMMENT DEFICIENCY       F 688     Continued From page 24 received the assistance to participate in the program. FM-B stated she would like to make sure R16 continued to ambulate.     F 688     F 688       On 6/27/18, at 11:00 am. RN-A confirmed R16 had not been receiving assistance with ROM and ambulation as directed by the care plan. RN-A directed R16 to lift her arm. R16 was not observed to have limitations in the left arm, but had an approximately 50% ROM loss in the right should. R16 stated the right arm had been bad for years.     -At 11:25 a.m. RN-A and nursing assistant (NA)-B were observed to ambulate R16 75 feet with an EZ walker. R16 tolerated f16 was not receiving assistance with ROM and ambulation as directed.     -At 11:47 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.       -At 11:25 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.     -At 11:47 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.       R15's quarterly MDS dated 577/18, indicated R15 was cognitively intact and had diagnoses which included multiple solerosis (MS), pain and lymphedema (swelling caused by a build-up of lymph fluid under the skin). The MDS also indicated R15 was statally dependent upon two statif for transfers and tolied use and required	NAME OF F	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 CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)       COMPLET DATE         F 688       Continued From page 24 received the assistance to participate in the program. FM-B stated she would like to make sure R16 continued to ambulate.       F 688       F 688         On 6/27/18, at 11:00 am. RN-A confirmed R16 had not been receiving assistance with ROM and ambulation as directed by the care plan. RN-A directed R16 to lift her arm. R16 was not observed to have limitations in the left arm, but had an approximately 50% ROM loss in the right should. R16 stated the right arm had been bad for years.       -At 11:25 a.m. RN-A and nursing assistant (NA)-B were observed to ambulate R16 75 feet with an EZ walker. R16 tolerated the ambulation well.         -At 11:47 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.       R15's quarterly MDS dated 5/7/18, indicated R15 was cognitively intact and had diagnoses which included multiple sclerosis (MS), pain and lymphedema (swelling caused by a build-up of lymph fluid under the skin). The MDS also indicated R15 was totally dependent upon two staff for transfers and tole use and required	GOOD SA	AMARITAN SOCIETY	- PINE RIVER					
<ul> <li>received the assistance to participate in the program. FM-B stated she would like to make sure R16 continued to ambulate.</li> <li>On 6/27/18, at 11:00 am. RN-A confirmed R16 had not been receiving assistance with ROM and ambulation as directed by the care plan. RN-A directed R16 to lift her arm. R16 was not observed to have limitations in the left arm, but had an approximately 50% ROM loss in the right should. R16 stated the right arm had been bad for years.</li> <li>-At 11:25 a.m. RN-A and nursing assistant (NA)-B were observed to ambulate R16 75 feet with an EZ walker. R16 tolerated the ambulation well.</li> <li>-At 11:47 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.</li> <li>R15's quarterly MDS dated 5/7/18, indicated R15 was cognitively intact and had diagnoses which included multiple sclerosis (MS), pain and lymphedema (swelling caused by a build-up of lymph fluid under the skin). The MDS also indicated R15 was totally dependent upon two staff for transfers and toilet use and required</li> </ul>	PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE	COMPLETION	
dressing, and personal hygiene. The MDS further indicated R15 had functional limitations in range of motion with impairment to both lower extremities. R15's ADL [activities of daily living]/Rehabilitation Care Area Assessment (CAA) dated 11/10/17, indicated R15 had severely impaired mobility and impaired muscle strength and coordination due to multiple sclerosis, was no longer able to stand or bear her own weight and was dependent on staff	F 688	received the assista program. FM-B sta sure R16 continued On 6/27/18, at 11:0 had not been receive ambulation as direct directed R16 to lift I observed to have lift had an approximate should. R16 stated for years. -At 11:25 a.m. RN-/ were observed to a EZ walker. R16 tol -At 11:47 a.m. RN-/ receiving assistance as directed. R15's quarterly MD was cognitively intal included multiple so lymphedema (swell lymph fluid under the indicated R15 was staff for transfers an extensive assist of dressing, and perso further indicated R17 range of motion wit extremities. R15's ADL [activitie Care Area Assessmi indicated R15 had si impaired muscle sta multiple sclerosis, w	ance to participate in the ated she would like to make d to ambulate. 0 am. RN-A confirmed R16 ving assistance with ROM and cted by the care plan. RN-A her arm. R16 was not mitations in the left arm, but ely 50% ROM loss in the right d the right arm had been bad A and nursing assistant (NA)-B mbulate R16 75 feet with an erated the ambulation well. A confirmed R16 was not e with ROM and ambulation VS dated 5/7/18, indicated R15 tot and had diagnoses which clerosis (MS), pain and ling caused by a build-up of ne skin). The MDS also totally dependent upon two nd toilet use and required two staff for bed mobility, onal hygiene. The MDS 15 had functional limitations in th impairment to both lower	F 68				

If continuation sheet Page 25 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING			06/;	28/2018
NAME OF	PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 688	for all mobility and <i>A</i> for transfers, was n the total lift to sit up R15 was at risk for weakness, skin bre depression due to c R15's Care Plan pre had a need for reste limited physical mol sclerosis and chron variable muscle we mobility. The care p occasionally refuse maintenance progra the following restora -NURSING REHAB shoulders in all plan reps [repetitions] up -NURSING REHAB with left hand, 10 reps -NURSING REHAB right hand, 10 reps -NURSING REHAB green TheraBand (I to 3 times per week -NURSING REHAB theraBand, 10 reps week -NURSING REHAB with resistance, 10- times per week -NURSING REHAB resident holding X s tolerates) up to 3 tir rehab aide sitting in resident's thigh up a	ADLs. She required a total lift on-ambulatory, and needed in bed. The CAA indicated contractures, increasing akdown, and feelings of decreased independence. ovided 6/28/18, indicated R15 orative intervention due to bility related to multiple ic back pain as evidenced by akness and decreased plan indicated R15 d her FMP [functional am]. The care plan directed ative interventions: #1: AAROM to bilateral nes of normal joint motion, 5 o to 3 times per week. #2: Squeeze yellow sponge eps up to 3 times per week #3: Squeeze red sponge with up to 3 times per week #4: Left shoulder flex with resistance band), 10 reps up 4 #5: Chest pulls with green at 2 sets up to 3 times per #7: Hip abduction/adduction 20 reps (as tolerates) up to 3 #8: Knee extensions with 5 seconds, 10-20 reps (as nes per week. Complete with a chair and supporting	F	5888			

Facility ID: 00058

If continuation sheet Page 26 of 46

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUI		CONSTRUCTION		0938-039 E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:				· /	PLETED
		245476	B. WING			06/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			8 JEFFERSON AVENUE, PO BOX 29 NE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 688	Continued From pa	ge 26	F 6	88			
	(with knee bent), 10 times per week. Co chair and supportin angle. -NURSING REHAE to 30 second hold, week. Complete wit (Do not combine wi -NURSING REHAE extension with leg I reps up to 3 times p aide sitting in a cha cord stretch) On 6/25/18, at 5:48 a joke. R15 stated with ROM three tim received the service stated two weeks p services on Monda previous week only Tuesday. R15 stated was often called to have enough help, of therapy and the f done. R15 was ablu unable to reach mo left arm. She state move and she was of her left hand a lit multiple sclerosis a	2-20 reps (as tolerates) up to 3 implete with rehab sitting in a g resident's thigh up at a slight 8 #10: Heel cord stretch X up 1-2 reps up to 3 times per th rehab aide sitting in a chair. The hamstring stretch (knee ift) X up to 30 second hold, 1-2 ber week. Complete with rehab ir. (Do not combine with heel 5 p.m. R15 stated therapy was she was supposed to work es a week, however, had not es on a regular basis. R15 rior she had received ROM y and Tuesday and the received services on ed the aid assigned to do it the floor because they didn't therefore nobody got any type basic therapy was no longer to lift her right arm but was ore than a few inches with her d her left arm was unable to only able to move her fingers the bit. R15 stated she had nd was unable to walk. R15 ave wraps to both of her lower					
	April 2018, May 20 <sup>-</sup>	on Survey Report v2 dated 18, and June 2018, revealed by was provided as follows:					

If continuation sheet Page 27 of 46

		AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			(X3) DATE	E SURVEY
		245476	B. WING			06/	28/2018
NAME OF	PROVIDER OR SUPPLIER		<u>i</u> [	S	TREET ADDRESS, CITY, STATE, ZIP CODE	00/2	20/2010
600D S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29		
				Р	INE RIVER, MN 56474		
(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 SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 688	available x 1, Blank -May 2018: Reside Blank x 28 -April 2018: Reside 1, Blank x 27 On 6/28/18, at 9:01 was reviewed with F restorative participal stated the restorative assist with resident had not been provid issue the facility new At 10:11 a.m. R15 received ROM serv she had only receive stated she did not for decline but was abor R15 stated she had related to her MS. At 10:34 a.m. RN- ROM services for F would not be able to now as R15 was in exercises were do b chair. R15 was obe squeezes, left shou green band, chest p and then hip adducc presses. R15 tolera pain. The Range of Motio 10/2017, directed th	a.m. R15's medical record RN-A who verified the above ation documentation and ve aid was pulled to the floor to cares therefore the service ded. RN-A stated it was an	Fé	588			

Facility ID: 00058

If continuation sheet Page 28 of 46

		AND HUMAN SERVICES			FOF	D: 08/09/2018 MAPPROVED O. 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				ATE SURVEY OMPLETED
		245476	B. WING	à		6/28/2018
NAME OF F	PROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From pa	ge 28	F	695		
F 695 SS=D	Respiratory/Trache CFR(s): 483.25(i)	ostomy Care and Suctioning	F	695		8/3/18
	The facility must en needs respiratory c care and tracheal s care, consistent wit practice, the compr care plan, the resid and 483.65 of this s This REQUIREMEN by: Based on observat review, the facility fi positive airway pres maintained in good directed for 1 of 1 r utilize a CPAP mac Findings include: R28's admission M dated 6/6/18, indica	and tracheal suctioning. Isure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences, subpart. NT is not met as evidenced tion, interview and document ailed to ensure a continuous sure (CPAP) machine was repair and cleaned as esident (R28) who was to			<ul> <li>F695 Respiratory/ Tracheostomy Care and Suctioning</li> <li>1. R28 S CPAP is being maintained ar cleaned as directed. CPAP Machine was inspected by Maintenance Dept. on Tuesday, July 17th No functional or safety concerns noted. Resident will be supplied a new CPAP machine upon being approved for Medicaid.</li> <li>2. There are no other residents in the</li> </ul>	
	pelvic fractures, vertebral fractures, sleep apnea and a history of respiratory failure. The assessment indicated R28 was totally dependent upon staff for transfers, required extensive assistance for bed mobility, dressing grooming and bathing and was unable to ambulate. The				<ol> <li>facility that require the use of a CPAP.</li> <li>Director of Nursing will re-educate th Licensed Nurses and HIM on the Non-Invasive Respiratory Support Policy and Procedure. CPAP care directives with the odded to P28 a Nursing Orders.</li> </ol>	,
	machine daily. R28's Physican Orc 6/22/18, included a be utilized per hom	der Summary Report dated n order for a CPAP machine to e setting. The machine was to dtime and taken off in the			<ul> <li>be added to R28 s Nursing Orders.</li> <li>4. Director of Nursing/ Designee will audit the Nursing Order documentation that water reservoir was filled nightly, weekly for 2 months. Director of Nursing Designee will audit that the CPAP has</li> </ul>	g/

Facility ID: 00058

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		IDENTIFICATION NONIDER.	A. BUILDING	3	001		
		245476	B. WING			28/2018	
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474	9		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE	
F 695	CPAP machine. R28's Care Plan da required the use of of respiratory failure to apply oxygen as plan did not addres On 6/25/18, at 5:13 observed on the be R28 stated he had several year and hi facility. R28 stated had washed the ma CPAP in any manne Upon inspection of reservoir was noted residue on the inne CPAP mask was no and mouth, however repaired with a 2-3 both sides. The co and the initial tubing electrical tape and initial tubing and the also held securely velcro headgear us also had three area stated he had put the and tubing to ensurd during the night. T added because the and was not fitting		F 695	5 been cleaned 3 times per week weeks, then weekly for 4 week results will be reviewed by the 0 Committee for further recommends 5. 8/3/2018.	s. Audit QAPI		

If continuation sheet Page 30 of 46

	-	AND HUMAN SERVICES			FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245476	B. WING		<b>06</b> //	28/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		18 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(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 695	nobody had cleaned On 6/26/18, at 1:50 stated R28 was abl and off as he wishe assist R28 with the On 6/27/18, at 7:40 stated R28 wore the wished and sometir other times he did r requested assistand -At 12:35 p.m. regis R28's CPAP machin home and she did r even in the building electronic treatmen had been taken off to her knowledge, t inspected for prope cleaning it and were he required. RN-B observed the mach working order. -At 1:05 p.m. RN-B machine. RN-B stat in need of replacem	however, while at the facility, d the machine. p.m. nursing assistant (NA)-E e to put the CPAP machine on ed. NA-E stated she did not CPAP machine. a.m. the night shift NA-C e CPAP machine when he mes would wear it all night and not. NA-C stated R28 had not ce with the CPAP machine. Stered nurse (RN)-B stated ne had been brought in from not know the machine was until she had to sign the t record (ETAR) indicating it in the morning. RN-B stated he machine had never been er function, the staff were not e only assisting R28 with is as confirmed she had not ine to ensure it was in good	F 695			
	in need of cleaning be replaced. R28 s distilled water adde however, he did not water. RN-B stated each night per his p A copy of the manu	and the headgear needed to stated he preferred to have d to the reservoir each night, t have access to the distilled d the reservoir could be filled				

If continuation sheet Page 31 of 46

		AND HUMAN SERVICES			FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING		06/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		18 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(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 695	Continued From pa none was provided.	-	F 695			
	(DON) stated the m should have inspec it being brought into electrical functions properly. In addition inspecting the mask the machine and fill DON reviewed R28	p.m. the director of nurses naintenance department ted the CPAP machine prior to of the facility to ensure the of the machine were working n, the nursing staff should be k daily and assisting to wash ling the humidifier daily. The t's clinical record and had inspected the CPAP ed its functionality.				
	not assisted him with	5 a.m. R28 stated the staff had th adding water the the nachine had not yet been				
F 725 SS=E	5/2016, indicated re home CPAP device checked prior to us and connections wa machines were to b two weeks. Sufficient Nursing S		F 725			8/3/18
	the appropriate com provide nursing and resident safety and practicable physical well-being of each r resident assessment	nt Staff. twe sufficient nursing staff with npetencies and skills sets to d related services to assure attain or maintain the highest I, mental, and psychosocial resident, as determined by nts and individual plans of care e number, acuity and				

Facility ID: 00058

If continuation sheet Page 32 of 46

CENTE	RS FOR MEDICARE	I AND HUMAN SERVICES E & MEDICAID SERVICES				RM APPROVED IO. 0938-0391
STATEMEN	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTIO	N (X3) [	DATE SURVEY
		245476	B. WING			06/28/2018
NAME OF	PROVIDER OR SUPPLIER	1		STREET ADDRESS	, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON PINE RIVER, MI	AVENUE, PO BOX 29 N 56474	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CO	DER'S PLAN OF CORRECTION DRRECTIVE ACTION SHOULD BE FERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 725	diagnoses of the fa accordance with th at §483.35(a)(1) The by sufficient number types of personnel nursing care to all or resident care plans (i) Except when wat this section, license (ii) Other nursing p limited to nurse aid §483.35(a)(2) Exce paragraph (e) of th designate a license nurse on each tour This REQUIREME by: Based on observa review, the facility f staffing was available restorative nursing residents assessed potential to affect a receive restorative Findings include: See F688: The fac motion (ROM) serva and/or prevent furt 4 of 4 residents (Ra limitations in ROM	facility's resident population in e facility assessment required facility must provide services ers of each of the following on a 24-hour basis to provide residents in accordance with s: lived under paragraph (e) of ed nurses; and ersonnel, including but not les. ept when waived under is section, the facility must ed nurse to serve as a charge of duty. NT is not met as evidenced tion, interview and document failed to ensure sufficient ble in order to implement programs in accordance to the d need. This practice had the all 23 residents who were to	F 7	F725 Suffic 1. We are that R3, R7, restorative n their assess 2. We are that all resid nursing prog assessed ne 3. We are nursing staff provide ROM Care Plan	ient Nursing Staffing sufficiently staffed to ensure R16, and R15 are receiving nursing programs according ed needs. sufficiently staffed to ensure ents are receiving restorativ grams according to their	y to ?e

If continuation sheet Page 33 of 46

# PRINTED: 08/09/2018

## DEPARTMENT OF HEALTH AND HUMAN SERVICES

Facility ID: 00058

TATEMENT		KMEDICAID SERVICES     (X1) PROVIDER/SUPPLIER/CLIA     IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED
	F CORRECTION	IDENTIFICATION NOMBER.	A. BUILDIN	NG	COM	IFLETED
		245476	B. WING _			28/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, 2		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO PINE RIVER, MN 56474	BOX 29	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 725	Continued From pa	ige 33	F 72	25 of ROM services will be	monitored on on	
	orientated resident	) p.m. R7, an alert and , stated she had not received bulation as directed. R7		Designee to ensure com services per Care Plan.	or of Nursing/	
	she only received a mornings Monday- also to do exercise the nursing assista usually was pulled stated she did not r	valk twice a day every day, but assistance to ambulate in the Friday. R7 stated she was s with her shoulders, except nt assigned to restorative, to provide direct care. R7 routinely participate in the n because the facility did not		4. Director of Nursing/ observe/audit the medic documentation of ROM to 7 random residents w months to ensure servic provided. Audit results w the QAPI Committee for recommendations.	al record services provided reekly times three res are being vill be reviewed by	
	resident, stated the she was supposed a week, however, h on a regular basis. she had received F Tuesday and the pr services on that Tu assigned to provide to the floor because help, therefore nob services. R15 state longer done. R15 v but was unable to r with her left arm. S unable to move and her fingers of her le she had multiple so walk. R15 was obs	an alert and orientated brapy was a joke. R15 stated to work with ROM three times had not received the services R15 stated two weeks prior ROM services on Monday and revious week only received esday. R15 stated the aid the services was often called the services was often called the the services was often called the basic therapy was no was able to lift her right arm each more than a few inches She stated her left arm was d she was only able to move eff hand a little bit. R15 stated clerosis and was unable to served to have wraps to both of stated they were for edema.		5. 8/3/2018		
	stated his shoulder been able to walk in	n alert and orientated resident, s were stiff and he had not n a year or so. R3 stated that n an exercise program.				

If continuation sheet Page 34 of 46

DEPARTMENT OF HEALTH AND HUMAN SERVICES							FORM	APPROVED
		& MEDICAID SERVICES	<del></del>			1		0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(		E SURVEY PLETED
		245476	B. WING				00%	00/0010
	PROVIDER OR SUPPLIER	243470	D. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	06/2	28/2018
					518 JEFFERSON AVENUE, PO BOX 29			
GOOD SA	AMARITAN SOCIETY	- PINE RIVER			PINE RIVER, MN 56474			
(X4) ID		TEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECT			(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO			COMPLETION DATE
TAG			IAG		DEFICIENCY)	51 10		
F 725	Continued From pa	lge 34	F7	725	i l			
	-At 7:45 pm B16 ;	an alert and orientated						
		e was to receive assistance						
		ce a day, however, the facility						
		h staff to assist her with						
		ore, she had not walked in ated she liked to walk,						
		did not have the time. R16						
		s to participate in an exercise						
	program but she ha the program.	ad not received assistance with						
	Family Concerns:							
	stated R16 was not FM-B stated R16 has was not enough sta received the assista waking program. F	5 p.m. family member (FM)-B t assisted to walk enough. ad the ability to walk but there aff at the facility to ensure she ance to participate in the FM-B stated she would like to ntinued to ambulate.						
	Staff concerns:							
	stated the facility has scheduled to work & RN-A stated if the re- from restorative to p restorative aide can assist with the restor she provided oversit	a.m. registered nurse (RN)-A ad a restorative aide 8 hours Monday - Thursday. restorative aide was pulled provide direct care, then the me to the facility on Friday to prative programs. RN-A stated ite for the restorative program providing the restorative ras able.						
	(NA)-B stated she of programs for the re	50 p.m. nursing assistant completed the restorative esidents. NA-B stated she was ty four days a week as the						

If continuation sheet Page 35 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING			06/;	28/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	х	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETION DATE
F 725	restorative NA, how pulled to the floor to stated the next two providing direct care restorative program -At 1:48 p.m. NA-E enough staff to com however, they did n ensure the restorati the residents. NA-E were pulled from re provide personal ca On 6/27/18, at 9:10 provided oversite of stated when NA-B w direct care, she was exercises. However be reassigned to pa therefore would not restorative serves. and NA-B were pro- restorative program -At 12:04 p.m. the r coordinator stated t restorative aide sch that aide was allowed she had not comple programs during tha receptionist also sta three nursing assist during the day along restorative aide. Ho	vever, she was frequently o provide direct care. NA-B scheduled days, she would be e and not completing the is. stated the facility usually had inplete the basic cares, ot have enough staff to ive programs were provided to E stated the restorative staff storative services in order to ares several times per week. a.m. RN-A confirmed she f the restorative program and was reassigned to provide is to assist to provide the ROM r, RN-A stated she too would ass resident medication be able to provide the RN-A stated, when both she viding direct care, the is were not completed. eceptionist/staffing he facility was to have a neduled four days a week and ed to pick an additional day if at four day time frame. The ated the facility was to have tants to provide direct cares g with a bath aide and a owever, the facility had been des multiple times per week, ative aide was pulled to	F 7	25			

Facility ID: 00058

If continuation sheet Page 36 of 46

	-	AND HUMAN SERVICES & MEDICAID SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245476	B. WING			06/	28/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
000000				5	18 JEFFERSON AVENUE, PO BOX 29		
GOOD S	AMARITAN SOCIETY			P	PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 725	Review of the week revealed the freque having been pulled -Week of 4/20/18: N day. -Week of 5/7/18: N was reassigned on -Week of 5/14/18: N days, had a meeting illness another day. -Week of 5/21/18: N part of a shift all fou- -week of 5/28/18: N and was off for holid -Week of 6/4/18: N direct care for two f -Week of 6/4/18: N direct care for two f -Week of 6/11/18: N and was ill one day -Week of 6/18/18: N On 6/27/18, at 3:05 (DON) stated the re changed to direct th services to read up some weeks the sta complete the ROM week. The DON st was for the restorat three times a week short staffed. The I residents were not programs as directed care always came f restorative aide was provide direct care restorative exercise	Ity restorative worksheet incy of the restorative aide from providing the services: NA-B was reassigned on one A-B was ill for two days and one day. NA-B was reassigned two g one day and left early due to NA-B was reassigned all or ir days. IA-B was reassigned two days day one day. A-B was reassigned to provide nours. NA-B was reassigned to provide nours.	F	725			

If continuation sheet Page 37 of 46

		AND HUMAN SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245476	B. WING _		06/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(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 725	Continued From pa	ge 37	F 72	25		
F 761 SS=D	directed the facility to provide nursing a or maintain the high spiritual, mental and each resident, as de assessment and ind Label/Store Drugs a	and Biologicals	F 76	61		8/3/18
	Drugs and biological labeled in accordan professional princip appropriate access	g of Drugs and Biologicals als used in the facility must be ace with currently accepted ales, and include the ory and cautionary e expiration date when				
	§483.45(h) Storage	of Drugs and Biologicals				
	Federal laws, the fa biologicals in locked	cordance with State and acility must store all drugs and d compartments under proper ls, and permit only authorized access to the keys.				
	locked, permanently storage of controlle the Comprehensive Control Act of 1976 abuse, except when package drug distril quantity stored is m be readily detected.	facility must provide separately y affixed compartments for d drugs listed in Schedule II of e Drug Abuse Prevention and and other drugs subject to in the facility uses single unit bution systems in which the inimal and a missing dose can NT is not met as evidenced				

If continuation sheet Page 38 of 46

		& MEDICAID SERVICES					0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (		SURVEY
		245476	B. WING			06/2	8/2018
NAME OF	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 761	Continued From pa	ge 38	F 7	61			
	Based on observat review, the facility fa were secured at all carts used. This has residents whose ma medication cart B. Findings include: During an observat medication cart B w unattended with R4 Systane solution ey medication cart B, u licensed practical n medication cart B fr end of the hall station unlocked, I had to a On 6/25/18, at 7:31 about the mess, lea medication on top." needed to answer a should have put the medication cart and cart. LPN-A confirm the hall could have cart and its content On 6/28/18, at 10:1 (DON) stated the m been locked and th been left unattende The facility provided Dispensing and Sto	tion, interview and document ailed to ensure medications times in 1 of 2 medication ad the potential to affect 19 edications were stored in ion on 6/25/18, at 7:25 p.m. vas observed unlocked and 's vial of Lantus insulin and re drops laying on top of unsecured. At 7:29 p.m. urse (LPN)-A arrived at rom a resident's room at the ng, "Oh, I left the cart answer a call light." p.m. LPN-A, stated "I'm sorry aving the cart unlocked and the LPN - A went on to say she a call light, and confirmed she e mediations back in the d locked it prior to leaving the ned anyone walking though had access to the mediation s. 9 a.m. the director of nursing hedication cart should have e medications should not have			<ol> <li>F761 Label/ Store Drugs and Biolog</li> <li>All medications are secure in medication cart B at all times per Go Samaritan Society Policy and Procee Acquisition, Receiving, Dispensing a Storage of Medication.</li> <li>All resident medications are sec all medication carts at all times per G Samaritan Society Policy and Procee Acquisition, Receiving, Dispensing a Storage of Medication.</li> <li>Director of Nursing provided education to the nurse on duty at the All Licensed Nurses will be re-educa on Good Samaritan Society Policy a Procedure Acquisition, Receiving, Dispensing and Storage of Medication</li> <li>Director of Nursing/ Designee w randomly audit through observation medication carts ensuring that the ca are always secured per policy twice times two weeks, then weekly times weeks, and one time per month time month. Audit results will be reviewed the QAPI Committee for further recommendations.</li> <li>8/3/2018.</li> </ol>	ood dure and cure in Good dure and e time. ated and on. vill all arts daily six es one	

If continuation sheet Page 39 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY IPLETED
		245476	B. WING			06/:	28/2018
NAME OF	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 838 SS=C			F 8	38			8/3/18
	facility-wide assess resources are nece competently during and emergencies. T update that assess least annually. The update this assess facility plans for, an substantial modifica assessment. The fa address or include: §483.70(e)(1) The f including, but not lir (i) Both the number resident capacity; (ii) The care require considering the type physical and cognit and other pertinent that population; (iii) The staff compe provide the level an resident population (iv) The physical en services, and other that are necessary (v) Any ethnic, cultu may potentially affe facility, including, bu food and nutrition s §483.70(e)(2) The f but not limited to,	anduct and document a ment to determine what essary to care for its residents both day-to-day operations The facility must review and ment, as necessary, and at facility must also review and ment whenever there is, or the y change that would require a ation to any part of this acility assessment must facility's resident population, mited to, of residents and the facility's ed by the resident population es of diseases, conditions, ive disabilities, overall acuity, facts that are present within etencies that are necessary to nd types of care needed for the ; wironment, equipment, physical plant considerations to care for this population; and ural, or religious factors that bot the care provided by the ut not limited to, activities and					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATI	E SURVEY PLETED
		245476	B. WING _		06/3	28/2018
NAME OF F	PROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	C PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 838	and vehicles; (ii) Equipment (meo (iii) Services provide pharmacy, and spec (iv) All personnel, in employees and those contract), and volur education and/or tra- related to resident of (v) Contracts, mem- or other agreements services or equipmer normal operations a (vi) Health information such as systems for patient records and information with othen §483.70(e)(3) A face community-based re- all-hazards approace This REQUIREMENT by: Based on interviewer facility failed to comma assessment of the face effective plan was in practicable care for facility. Findings include: Upon entrance to the p.m. the facility provides During the course of conducted on 6/25/	lical and non- medical); ed, such as physical therapy, cific rehabilitation therapies; nocluding managers, staff (both se who provide services under theers, as well as their aining and any competencies care; orandums of understanding, s with third parties to provide ent to the facility during both and emergencies; and fon technology resources, r electronically managing electronically sharing er organizations. ility-based and isk assessment, utilizing an ch. NT is not met as evidenced r and document review, the plete a comprehensive facility needs to ensure an n place to maintain the highest all 31 residents residing at the the facility on 6/25/18, at 1:00 vided a copy of the facility	F 8	<ul> <li>F838 Facility Assessment</li> <li>The Facility Assessment inclunumber of restorative staff membrare required to provide ROM serveducational training, and how were sufficient resources to provide car residents.</li> <li>The Facility Assessment inclunumber of restorative staff membrare required to provide ROM serveducational training, and how were sufficient resources to provide car residents.</li> <li>The Facility Assessment inclunumber of restorative staff membrare required to provide ROM serveducational training, and how were sufficient resources to provide car residents.</li> </ul>	ers that ces, the will have e to the des the ers that ces, the will have	

Facility ID: 00058

If continuation sheet Page 41 of 46

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DATE	0938-039
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	G	COM	PLETED
		245476	B. WING		06/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 838	Continued From pa	ae 41	F 83	3		
	nursing care which	was not being provided due (See F688 and F735) .		3. Administrator will re-educate al leaders on Good Samaritan Society Facility Assessment Policy & Proce	y	
	revealed the facilty the assessment that provide residents re- restorative nursing time in the assessment number of restorati required to provide the educational trais members or how the sufficient resources residents. The ass facility resources co Link and Tels" On 6/28/19, at 12:2	ity Assessment dated 4/6/18, had identified multiple times in at they had the ability to esiding at the facility with programs. However, at no nent, did the facility identify the ve staff members that were the aforementioned services, ning for restorative staff ley were to ensure they had a to provide the care to the sessment indicated that the build be obtained from "Career 3 p.m. the administrator in per Link and Tels was not part		<ol> <li>Administrator/ Designee will reithe Facility Assessment to ensure the Facility Assessment to ensure the requirements are met per Good Samaritan Society Facility Assessment of the Policy &amp; Procedure. Facility Assess will then be reviewed biannually an monitored through the QAPI Comm 5. 8/3/18</li> </ol>	view hat all nent ment d	
	of the facility asses facility assessment staff required to pro	eer Link and Tels was not part sment and confirmed the did not identify the number of ovide restorative care or how uld be obtained for the				
F 880 SS=D	A policy related to t requested and non- Infection Prevention CFR(s): 483.80(a)(	n & Control	F 88	D		8/3/18
	infection prevention designed to provide comfortable enviror	tablish and maintain an and control program a safe, sanitary and ment and to help prevent the ansmission of communicable				

Facility ID: 00058

If continuation sheet Page 42 of 46

	-	AND HUMAN SERVICES				FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245476	B. WING _			06/2	28/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD BE COMPL			
F 880	Continued From pa	ge 42	F 88	80			
	program. The facility must es	n prevention and control stablish an infection prevention n (IPCP) that must include, at owing elements:					
	reporting, investigat and communicable staff, volunteers, vis providing services u arrangement based	d upon the facility assessment ng to §483.70(e) and following					
	procedures for the p but are not limited to (i) A system of surve possible communica- infections before the persons in the facilir (ii) When and to wh communicable dise reported; (iii) Standard and tra- to be followed to pre- (iv)When and how i resident; including to (A) The type and du depending upon the involved, and (B) A requirement th least restrictive pos- circumstances. (v) The circumstance	reillance designed to identify sable diseases or ey can spread to other ity; nom possible incidents of ease or infections should be ransmission-based precautions event spread of infections; isolation should be used for a					

If continuation sheet Page 43 of 46

		AND HUMAN SERVICES & MEDICAID SERVICES	_		F	ORM /	08/09/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION (X3		SURVEY PLETED
		245476	B. WING			06/2	28/2018
NAME OF I	PROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		(X5) COMPLETION DATE
F 880	contact with resider contact will transmi (vi)The hand hygier by staff involved in §483.80(a)(4) A sys- identified under the corrective actions ta §483.80(e) Linens. Personnel must han transport linens so infection. §483.80(f) Annual r The facility will cond IPCP and update th This REQUIREMEN by: Based on observat review the facility fa handwashing after for 2 of 2 residents technique preparing for 2 of 2 residents Findings include: On 6/25/18, at 7:29 (LPN)-A was observe which included Lan Without wiping the pad, LPN-A obtaine needle into the rubb withdrew the insulin LPN-A donned glov into R4's right delto	skin lesions from direct the or their food, if direct t the disease; and he procedures to be followed direct resident contact. stem for recording incidents facility's IPCP and the aken by the facility. hdle, store, process, and as to prevent the spread of eview. duct an annual review of its heir program, as necessary. NT is not met as evidenced ion, interview and document illed to ensure proper glove usage was performed (R4, R1), and aseptic g and administration of insulin	F	380	<ul> <li>F880 Infection Prevention and Control</li> <li>R1 and R4 are receiving proper infection control techniques when receiving insulin. Licensed Nurses are using proper infection control technique when preparing and administering insu</li> <li>All residents receiving insulin have been observed to ensure nurses are u proper infection control techniques when preparing and administering their insu</li> <li>Director of Nursing will provide re-education/ reminders to all licensed nurses on using proper infection control techniques when preparing and administering insulin.</li> </ul>	e ules ulin. e using ien lin.	

Facility ID: 00058

If continuation sheet Page 44 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245476	B. WING			06/2	28/2018
NAME OF I	PROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 INE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	removed her gloves hands proceeded to touching the door k to the medication cat the medication cat. On 6/25/18, at 7:45 set up R1's medicat insulin 8 units at be- Lantus injecting the without wiping off th LPN-A proceeded to gloves and injected of his abdomen with alcohol prior. Follow removed the gloves hands she touched medicaiton cart as w as well as the mous On 6/25/18, at 7:55 not to wash her har would break down. employees hands s removal. When ask stopper with alcoho did and thought usin was preferred. On 6/28/18 at 10:19 (DON) confirmed th hands after glove re rubber stopper on ti been swabbed with needle and drawing DON stated the res	s, and without washing her o walk out of the room while nob of R4's room and the keys art along with the drawers on p.m. LPN-A was observed to tions which included Lantus dtime. LPN-A drew up the e needle into the insulin vial he stopper with alcohol. o was to R1's room, donned the Lantus into R1's left side hout cleansing the skin with ving the injection, LPN-A s, and without washing her the door knob, the keys to the well as the drawers to the cart se to the computer. 5 p.m. LPN-A stated she tried hods so much because her skin However, LPN-A confirmed should be washed after glove ad about wiping the rubber of, she stated sometimes she ng the alcohol wipe on the skin P a.m. the director of nursing he staff should wash their emoval, and also verified the he insulin vials should have alcohol prior to inserting the g up mediation. In addition, the ident;s skin was also to be cohol pad prior the the	F 8	80	<ol> <li>Director of Nursing/ Designee to observation will audit insulin administration and aseptic technique. R4 and R1 and up to three other redaily times one week, twice per weat three weeks, than monthly times two months. Audit results will be review the QAPI Committee for further recommendations.</li> <li>8/3/2018</li> </ol>	ie on sidents ek for vo	

Facility ID: 00058

If continuation sheet Page 45 of 46

		AND HUMAN SERVICES				FORM	08/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		245476	B. WING			06/	28/2018
NAME OF I	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- PINE RIVER			18 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ITEMENT 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 APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 880	10/17, directed staf an antiseptic swab from center outwar Policy Injections da would be administe techniques and pro Procedure Hand Hy revised 1/18, indica	ction-Subcutaneous revised f to cleanse the skin site with using circular motion, moving d about two inches. ted 9/12, indicated injections red to residents using sterile	F	380			

Facility ID: 00058

If continuation sheet Page 46 of 46

### DEPARTMENT OF HEALTH AND HUMAN SERVICES

### F5476029

PRINTED: 07/24/2018 FORM APPROVED OMB NO. 0938-0391

CENTER	S FOR MEDICARE	& MEDICAID SERVICES		F94 16001	OMB NO. 0938-	039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION IG 01 - 1985 BUILDING AND ADDITIONS	(X3) DATE SURVE COMPLETED	
		245476	B WING		06/28/201	8
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474	1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPL	(5) LETIC ATE
K 000	INITIAL COMMEN	TS	K 00	00		
	FIRE SAFETY					
	ALLEGATION OF DEPARTMENT'S A SIGNATURE AT T	POC WILL SERVE AS YOUR COMPLIANCE UPON THE ACCEPTANCE. YOUR HE BOTTOM OF THE FIRST IS-2567 WILL BE USED AS F COMPLIANCE.				
	ONSITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS H	OF AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT OMPLIANCE WITH THE AS BEEN ATTAINED IN /ITH YOUR VERIFICATION.				
	Minnesota Departr Marshal Division. Good Samaritan S not in compliance participation in Me Subpart 483.70(a) 2012 edition of Na Association (NFPA	e Survey was conducted by the ment of Public Safety, Fire At the time of this survey, Society Pine River was found with the requirements for dicare/Medicaid at 42 CFR, , Life Safety from Fire, and the tional Fire Protection A) Standard 101, Life Safety oter 19 Existing Health Care,				
		SE AN EPOC, A PAPER COPY CORRECTION IS NOT		EPOC		
	PLEASE RETURN CORRECTION FO	N THE PLAN OF DR THE FIRE SAFETY				
	Y DIRECTOR'S OR PROV	IDER/SUPPLIER REPRESENTATIVE'S SIG	BNATURE	TITLE	(X6) DA 07/23	

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.

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF			E SURVEY
	OF CORRECTION		A. BUILDING	G 01 - 1985 BUILDING AND ADDITIONS	CON	MPLETED
		245476	B. WING		06	/28/2018
ME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(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 CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIC DATE
K 000	Continued From pa	-	K 00	ο		
	STATE FIRE MAR	STREET, SUITE 145				
	By e-mail to both: Marian.Whitney@s and Angela.Kappenma					
		ORRECTION FOR EACH ST INCLUDE ALL OF THE ORMATION:				
	1. A description of to correct the defic	what has been, or will be, done iency.				
	2. The actual, or p	roposed, completion date.				
	responsible for col	or title of the person rrection and monitoring to ence of the deficiency				
	building with two b constructed at five nursing home was of Type II(111) cor In 1968 an additio of the original build of Type II(111) cor In 1985 an additio	building: Bociety of Pine River is a 1-story asements. The building was a different times. In 1961 the a built and was determined to be astruction without a basement. In was constructed to the north ding, that was determined to be astruction and has a basement. In was constructed to the 961 building that was				

Facility ID: 00058

If continuation sheet Page 2 of 6

		& MEDICAID SERVICES		<i>V</i>		0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G 01 - 1985 BUILDING AND ADDITIONS	(X3) DAT CON	E SURVEY IPLETED
		245476	B. WING		06/	28/2018
AME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
BOOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BË	(X5) COMPLETION DATE
K 321	constructed to the was determined to In 1996 the last ad the 1993 addition to Type II (111) constri- into 7 smoke zone barriers. The facilit barriers form an ou- building. The facility is fully a fire alarm system corridors and space monitored for auto notification. The facility has a co- census of 31 at the The requirement an NOT MET. Hazardous Areas Hazardous Areas Hazardous Areas having 1-hour fire fire rated doors) of system in accorda When the approve system option is u separated from ot partitions and doo Doors shall be sel	nent. In 1993 an addition was west of the 1985 addition that be of Type II(111) construction. dition was added to the west of hat was determined to be of uction. The building is divided s by one and two hour fire y is separated by 2-hour fire utpatient physical therapy fire sprinkler protected and has n with smoke detection in the tes open to the corridors, that is matic fire department capacity of 50 beds and had a time of the survey. t 42 CFR, Subpart 483.70(a) is - Enclosure	K 00			8/3/18

20

Facility ID: 00058

If continuation sheet Page 3 of 6

		& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA			OMB NO.	SURVEY	
			· · /	PLE CONSTRUCTION G 01 - 1985 BUILDING AND ADDITIONS		PLETED	
		245476	B. WING		06/2	28/2018	
AME OF I	AME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - PINE RIVER				518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX T <b>A</b> G	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE	
K 321	hazardous areas th 19.3.2.1, 19.3.5.9 Area Separation N// a. Boiler and Fuel-f b. Laundries (large c. Repair, Maintena d. Soiled Linen Roo e. Trash Collection (exceeding 64 gallo f. Combustible Stor (over 50 square fee g. Laboratories (if of Hazard - see K322 This REQUIREME by: Based on observa revealed that the fa proper protection for areas located throu accordance with N Code" 2012 edition deficient conditions allow smoke and fil effected corridors a untenable, which co	the door. and zone locations of hat are deficient in REMARKS. Automatic Sprinkler A Fired Heater Rooms r than 100 square feet) ance, and Paint Shops oms (exceeding 64 gallons) Rooms ons) rage Rooms/Spaces et) classified as Severe	K 32	1. Door to the soiled utility roo located in the Birch Wing acros Resident Room 209 has been a fully close and latch into the fra regulation. All other necessary been observed when closing an if needed. Maintenance technic been re-educated on the requir regarding doors fully latching. T that the correction is sustained maintenance technician or des conduct audits on all necessary ensure that they latch appropria will be done bi-weekly times tw then monthly times two months	s from adjusted to me per doors have ad adjusted tian has ement to ensure our gnee will y doors to ately. This o months, s. Audit		
	On facility tour beto on 06/28/2018, ob the soiled utility roo	ween 10:00 a.m. to 2:00 p.m. servations revealed the door to om that is located in the Birch esident room 209 has a door		<ul><li>committee for further recommittee</li><li>2. 8/3/18</li></ul>	QAPI		

Facility ID: 00058

If continuation sheet Page 4 of 6

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUCTION 01 - 1985 BUILDING AND ADDITIONS		E SURVEY PLETED
245476		B. WING	06/28/2018			
AME OF F	ROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE		
			5	518 JEFFERSON AVENUE, PO BOX 29		
SOOD S/	AMARITAN SOCIETY	- PINE RIVER	F	PINE RIVER, MN 56474		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5) COMPLETIO
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO		DATE
IAG	REGOLATORTORE			DEFICIENCY)		
K 321	Continued From pa		K 321			
N JZ I		•	K 52 I	3. Tonya Ehlers Administrator ir	Training	
	the time of the insp	ose and latch into the frame at		3. Tonya Emers Administrator in	r training	
1	the time of the map					
	This deficient cond	ition was confirmed by a				
	Maintenance Staff	Member.				
		ylinder and Container Storag	K 923	8		8/3/18
SS=F	CFR(s): NFPA 101					
	Gas Equipment - C	Cylinder and Container Storage				
		ual to 3,000 cubic feet				
		are designed, constructed, and				
		dance with 5.1.3.3.2 and				1
	5.1.3.3.3.					
	>300 but <3,000 ct	are outdoors in an enclosure or				
		interior space of non- or				
		le construction, with door (or				
		at can be secured. Oxidizing				
		ed with flammables, and are				
		mbustibles by 20 feet (5 feet if				
		closed in a cabinet of				
	1/2 hr. fire protection	onstruction having a minimum				
	Less than or equal					
		compartment, individual				
		for immediate use in patient				
		aggregate volume of less than				
		bic feet are not required to be				
		sure. Cylinders must be autions as specified in 11.6.2.				
		autions as specified in 11.0.2.				
		of a cylinder storage room,				
	where the sign inc	ludes the wording as a				
	minimum "CAUTIC	ON: OXIDIZING GAS(ES)				
	STORED WITHIN					
	Storage is planned	so cylinders are used in order				

Event ID: C2JR21

Facility ID: 00058

If continuation sheet Page 5 of 6

PRINTED: 07/24/2018

			A, BUILDING 01 - 1985 BUILDING AND ADDITIONS		00	
		245476	B, WING		06/2	28/2018
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- PINE RIVER		518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474		
(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) COMPLETIO DATE
K 923	cylinders. When fa integral pressure ga considered empty is are marked to avoid in the open are pro 11.3.1, 11.3.2, 11.3 This REQUIREMEN by: Based on observat the oxygen storage accordance with NI Care Facilities 2012 create an oxygen e contribute to rapid to negatively affect 20 undetermined num facility. Findings include: On facility tour betw on 06/28/2018, obso oxygen storage roo not separated by fu inspection.	e segregated from full cility employs cylinders with auge, a threshold pressure s established. Empty cylinders d confusion. Cylinders stored tected from weather. .3, 11.3.4, 11.6.5 (NFPA 99) NT is not met as evidenced tions and staff interview, that room was not maintained in FPA 99 Standards for Health 2. This deficient practice could mriched atmosphere that could fire growth. This could 0 of 50 residents as well as an ber of staff, and visitors to the ween 10:00 a.m. to 2:00 p.m. servations revealed that in the om the oxygen cylinders were all and empty at the time of the ition was confirmed by a	K 92	<ol> <li>Signs have been placed in ox storage room to clearly separate empty oxygen cylinders. Second storage room in building was obs and corrected with signs to ensur separation of full and empty oxyg cylinders. All staff whom have act oxygen storage rooms will be edu the regulation regarding oxygen storage rooms will be edu the regulation regarding oxygen s and the importance of placing cyl the appropriate side of the room. ensure that the correction is sust our maintenance technician or de will conduct audits on both oxyge storage rooms to ensure that sign specifying full and empty are still and oxygen cylinders are being p appropriate sides of the room. Th audits will be done weekly times months, then monthly times two Audit results will be reviewed by Committee for further recomment 2. 8/3/18</li> <li>Tonya Ehlers Administrator in</li> </ol>	full and oxygen erved e proper en cess to ucated on storage inders on To ained, esignee n sin place laced on nese two months. the QAPI dations.	

Event ID: C2JR21

Facility ID: 00058

If continuation sheet Page 6 of 6



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered July 13, 2018

Mr. Michael Deuth, Administrator Good Samaritan Society - Pine River 518 Jefferson Avenue, PO Box 29 Pine River, MN 56474

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5476030

Dear Mr. Deuth:

The above facility was surveyed on June 25, 2018 through June 28, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. 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 or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute 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 order within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <u>http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm</u>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered 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 or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

Good Samaritan Society - Pine River July 13, 2018 Page 2

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

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

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

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.

alison Helm

Alison Helm, Enforcement Specialist Licensing and Certification Minnesota Department of Health P.O. Box 64970 Saint Paul, Minnesota 55164-0970 Phone: 651-201-4206 Email: alison.helm@state.mn.us

cc: Licensing and Certification File

Minneso	ota Department of He	alth				
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE COMP	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPI	LETED
		00058	B. WING		06/2	8/2018
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74		
(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) COMPLETE DATE
2 000	Initial Comments		2 000			
	*****ATTE	NTION*****				
	NH LICENSING	CORRECTION ORDER				
	144A.10, this corre- pursuant to a surver found that the defice herein are not corre- not corrected shall with a schedule of f the Minnesota Depa Determination of wi corrected requires of requirements of the number and MN Ru When a rule contai comply with any of lack of compliance. re-inspection with a result in the assess	hether a violation has been				
	that may result from orders provided that the Department wit	hearing on any assessments n non-compliance with these at a written request is made to hin 15 days of receipt of a ent for non-compliance.				
Minnesota D	receipt of State lice the Minnesota Dep Informational Bullet http://www.health.s	participate in the electronic nsure orders consistent with artment of Health tin 14-01, available at tate.mn.us/divs/fpc/profinfo/inf e licensing orders are		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal so Tag numbers have been assigned Minnesota state statutes/rules for N Homes.	ftware. to	
		DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE		(X6) DATE

Electronically Signed

07/23/18

If continuation sheet 1 of 39

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:         00058		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00058	B. WING		06/2	8/2018
	PROVIDER OR SUPPLIER	- PINE RIVER 518 JEF		STATE, ZIP CODE ENUE, PO BOX 29 74		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE
2 000	Department of Hea you electronically. is necessary for Sta enter the word "cor text. You must then State licensure pro- completion date, th corrected prior to e Minnesota Department On June 25 - June Department's staff the following correct Please indicate in y correction that you	Ith orders being submitted to Although no plan of correction ate Statutes/Rules, please rected" in the box available for i indicate in the electronic cess, under the heading e date your orders will be lectronically submitting to the		The assigned tag number a far left column entitled "ID The state statute/rule out of listed in the "Summary Stat Deficiencies" column and re Comply" portion of the correc This column also includes t which are in violation of the after the statement, "This R as evidence by." Following findings are the Suggested Correction and Time period PLEASE DISREGARD THE THE FOURTH COLUMN W STATES, "PROVIDER'S PL CORRECTION." THIS APP FEDERAL DEFICIENCIES WILL APPEAR ON EACH F THERE IS NO REQUIREM SUBMIT A PLAN OF CORF VIOLATIONS OF MINNESO	Prefix Tag." f compliance is ement of eplaces the "To ection order. the findings state statute cule is not met the surveyors Method of for Correction. E HEADING OF /HICH _AN OF PLIES TO ONLY. THIS PAGE. ENT TO RECTION FOR	
2 800	Staffing requirement Subpart 1. Staffing home must have on number of qualified registered nurses, I nursing assistants to residents at all nurs in all buildings if more	requirements. A nursing n duty at all times a sufficient I nursing personnel, including licensed practical nurses, and to meet the needs of the ses' stations, on all floors, and ore than one building is udes relief duty, weekends,	2 800			8/3/18

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED 06/28/2018	
		00058	B. WING			
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S	STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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) COMPLET DATE
2 800	Continued From pa	ge 2	2 800			
	by: Based on observati review, the facility f staffing was availab restorative nursing residents assessed	ent is not met as evidenced ion, interview and document ailed to ensure sufficient ble in order to implement programs in accordance to the I need. This practice had the II 23 residents who were to nursing services.		Licensing orders corrected.		
	Findings include:					
	motion (ROM) serv and/or prevent furth 4 of 4 residents (R3 limitations in ROM	ility failed to provide range of ices in order to maintain her decline in ROM abilities for 3, R7, R16, R15) who had and had not received ROM to their individualized				
	Resident concerns:	:				
	orientated resident, assistance with am stated she was to w she only received a mornings Monday- also to do exercises the nursing assistant usually was pulled to stated she did not r	p.m. R7, an alert and stated she had not received bulation as directed. R7 valk twice a day every day, but issistance to ambulate in the Friday. R7 stated she was s with her shoulders, except int assigned to restorative, to provide direct care. R7 outinely participate in the n because the facility did not				
	resident, stated the she was supposed a week, however, h	an alert and orientated rapy was a joke. R15 stated to work with ROM three times ad not received the services R15 stated two weeks prior				

TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	00058	B. WING	B. WING		28/2018
AME OF PROVIDER OR SUPPLI	ER STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
OOD SAMARITAN SOCIE	IY - PINE RIVER	FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
REFIX (EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800 Continued From	page 3	2 800			
Tuesday and the services on that assigned to provi to the floor beca help, therefore r services. R15 s longer done. R <sup>2</sup> but was unable to with her left arm unable to move her fingers of he she had multiple walk. R15 was of her lower legs a -At 6:25 p.m. R3 stated his should been able to wa he did participat -At 7:45 p.m. R1 resident, stated with ambulation did not have end ambulation, ther three days. R16 however, the sta also stated she program but she the program. Family Concerns	d ROM services on Monday and e previous week only received Tuesday. R15 stated the aid ride the services was often called use they did not have enough obody received any type of tated the basic therapy was no 5 was able to lift her right arm o reach more than a few inches . She stated her left arm was and she was only able to move r left hand a little bit. R15 stated observed to have wraps to both o hd stated they were for edema. A, an alert and orientated resident ders were stiff and he had not k in a year or so. R3 stated that e in an exercise program. 6, an alert and orientated she was to receive assistance twice a day, however, the facility ough staff to assist her with efore, she had not walked in a stated she liked to walk, iff did not have the time. R16 was to participate in an exercise had not received assistance with a stated she liked to walk, off did not have the time. R16 was to participate in an exercise had not received assistance with a stated she liked to walk, and not received assistance with a stated she liked to walk, and not received assistance with a stated she liked to walk hut there bad not received assistance with a stated she liked to walk enough. a bad the ability to walk but there	n			

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
00058		00058	B. WING		06/:	28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC <sup>\</sup>	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	age 4	2 800			
	make sure R16 continued to ambulate.					
	Staff concerns:	Staff concerns:				
	stated the facility h scheduled to work RN-A stated if the r from restorative to restorative aide car assist with the rest she provided overs	3 a.m. registered nurse (RN)-A ad a restorative aide 8 hours Monday - Thursday. restorative aide was pulled provide direct care, then the me to the facility on Friday to orative programs. RN-A stated site for the restorative program providing the restorative vas able.				
	(NA)-B stated she programs for the re to work at the facili restorative NA, how pulled to the floor to stated the next two	50 p.m. nursing assistant completed the restorative esidents. NA-B stated she was ty four days a week as the wever, she was frequently o provide direct care. NA-B o scheduled days, she would be re and not completing the ns.				
	enough staff to cor however, they did r ensure the restorat the residents. NA- were pulled from re	E stated the facility usually had nplete the basic cares, not have enough staff to tive programs were provided to E stated the restorative staff estorative services in order to ares several times per week.				
	provided oversite of stated when NA-B direct care, she wa exercises. However be reassigned to p	a.m. RN-A confirmed she of the restorative program and was reassigned to provide as to assist to provide the ROM er, RN-A stated she too would ass resident medication t be able to provide the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	00058		B. WING		06/	28/2018
NAME OF I	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- PINE RIVER	ERSON AVEN ER, MN 56474	IUE, PO BOX 29 4		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ge 5	2 800			
	and NA-B were pro	RN-A stated, when both she viding direct care, the s were not completed.				
	restorative aide sch that aide was allow she had not comple programs during the receptionist also sta three nursing assist during the day alon restorative aide. He short direct care aid	he facility was to have a reduled four days a week and ed to pick an additional day if sted all of the restorative at four day time frame. The fact the facility was to have tants to provide direct cares g with a bath aide and a bowever, the facility had been des multiple times per week, ative aide was pulled to				
	revealed the freque	ly restorative worksheet ncy of the restorative aide from providing the services:				
	day. -Week of 5/7/18: N. was reassigned on -Week of 5/14/18: N days, had a meeting illness another day. -Week of 5/21/18: N part of a shift all fou- week of 5/28/18: N and was off for holid -Week of 6/4/18: N direct care for two h -Week of 6/11/18: N and was ill one day	NA-B was reassigned two g one day and left early due to NA-B was reassigned all or Ir days. IA-B was reassigned two days day one day. A-B was reassigned to provide nours. IA-B was reassigned two days				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		00058	B. WING		06/28	/2018
AME OF F	ROVIDER OR SUPPLIER		DDRESS, CITY, ST	TATE, ZIP CODE		
	AMARITAN SOCIETY	518 JEE		IUE, PO BOX 29		
JOOD 3/	AWARITAN SOCIETT	PINE RIVER PINE RIV	/ER, MN 56474	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 800	Continued From pa	ige 6	2 800			
	changed to direct th services to read up some weeks the st complete the ROM week. The DON st was for the restorat three times a week short staffed. The residents were not programs as direct care always came to restorative aide wa provide direct care restorative exercise	esident care plans had been ne provision of restorative to three times a week, in case aff did not have the time to services at least three times a ated the facility expectation tive care to be done at least , but sometimes they were DON stated she was aware receiving the restorative ed, however, basic resident first. The DON confirmed the s reassigned to the floor to therefore sometimes the es were not provided. The the facility was short of				
	directed the facility to provide nursing a or maintain the high spiritual, mental an each resident, as d	es Staff policy dated 12/2015, to have sufficient nursing staff and related services to attain nest practicable physical, d psychosocial well-being of etermined by the resident dividual care plans.				
	The director of nurs develop, review, an procedures to ensu available to comple residents who requ The DON or design systems to ensure	THODS OF CORRECTION: sing (DON) or designee could d /or revise policies and are sufficient nurse staffing was the restorative programs for ired restorative programs. nee could develop monitoring ongoing compliance and to the quality assurance	5			
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	•			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED
		00058	B. WING		06/28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74	
(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 B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
2 830	Proper Nursing Car	0 Subp. 1 Adequate and re; General general. A resident must	2 830		8/3/18
	receive nursing car custodial care, and individual needs an the comprehensive plan of care as des 4658.0405. A nursi of bed as much as written order from t	e and treatment, personal and supervision based on d preferences as identified in resident assessment and scribed in parts 4658.0400 and ing home resident must be out possible unless there is a he attending physician that the in in bed or the resident			
	by: Based on observati review, the facility f positive airway pres maintained in good	ent is not met as evidenced ion, interview and document ailed to ensure a continuous ssure (CPAP) machine was repair and cleaned as esident (R28) who was to hine.		Licensing orders corrected.	
	Findings include:				
	dated 6/6/18, indica oriented and had di pelvic fractures, ver and a history of res assessment indicat upon staff for transf assistance for bed and bathing and wa	innimum Data Set (MDS) ated R28 was alert and agnosis including multiple rtebral fractures, sleep apnea piratory failure. The ted R28 was totally dependent fers, required extensive mobility, dressing grooming as unable to ambulate. The brequired the use of a CPAP			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION		E SURVEY PLETED			
		00058	B. WING	B. WING		06/28/2018			
AME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, S	TATE, ZIP CODE					
GOOD SAMARITAN SOCIETY - PINE RIVER 518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLE DATE			
2 830	Continued From pa	age 8	2 830						
	6/22/18, included a be utilized per hom	der Summary Report dated In order for a CPAP machine to Ie setting. The machine was to dtime and taken off in the							
	Review of R28's clinical record lacked documentation related to the use or care of the CPAP machine.								
	required the use of of respiratory failure to apply oxygen as	ated 5/31/18, indicated R28 oxygen at time due to hisoty e. The plan directed the staff needed, however, the care as the use of a CPAP machine.							
	observed on the be R28 stated he had several year and hi facility. R28 stated had washed the ma CPAP in any mann Upon inspection of reservoir was noted residue on the inner	B p.m. a CPAP machine was edside stand next to R28's bed been using the CPAP for is fiance had brought it into the none of the staff members achine or assisted with the er since coming to the facility. the machine, the water d to have dried brown tinged er aspect of the reservoir. The							
	and mouth, however repaired with a 2-3 both sides. The co and the initial tubing electrical tape and initial tubing and the also held securely	oted to cover both the nose er the edges of the mask were inch piece of electrical tape or onnection between the mask g was secured with black the connection between the e main tube of the CPAP was with black electrical tape. The sed to hold the mask into place							
	also had three area stated he had put the and tubing to ensure	as of black electrical tape. R28 he electrical tape on the mask re they did not come apart he tape on the head gear was							

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/	28/2018
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 56474	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
2 830	added because the and was not fitting been using the sam for years. While at machine regularly, nobody had cleane On 6/26/18, at 1:50 stated R28 was ab and off as he wishe assist R28 with the On 6/27/18, at 7:40 stated R28 wore th wished and someti other times he did requested assistan -At 12:35 p.m. regis R28's CPAP machi home and she did even in the building electronic treatmer had been taken off to her knowledge, to inspected for proper cleaning it and wer he required. RN-B observed the mach working order. -At 1:05 p.m. RN-B machine. RN-B stati in need of replacer in need of cleaning be replaced. R28 stati distilled water adde	e headgear had stretched out correctly. R28 stated he had ne mask, headgear and tubing home, R28 washed the CPAP however, while at the facility, d the machine. ) p.m. nursing assistant (NA)-E le to put the CPAP machine on ed. NA-E stated she did not				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/28/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 830	Continued From pa	ge 10	2 830			
		facture instructions for the CPAP was requested and				
	On 6/27/18, at 3:00 p.m. the director of nurses (DON) stated the maintenance department should have inspected the CPAP machine prior to it being brought into the facility to ensure the electrical functions of the machine were working properly. In addition, the nursing staff should be inspecting the mask daily and assisting to wash the machine and filling the humidifier daily. The DON reviewed R28's clinical record and confirmed nobody had inspected the CPAP machine or evaluated its functionality.					
	not assisted him wi	5 a.m. R28 stated the staff had th adding water the the machine had not yet been				
	5/2016, indicated re home CPAP device checked prior to us and connections wa	Respirator Support policy dated esidents were able to utilize es. The systems were to be e. Inspection of the tubing as to be completed. The be cleaned at least once every				
	The director of nurs develop, review, an procedures to conti pressure (CPAP) m education to the sta could develop mon	THODS OF CORRECTION: sing (DON) or designee could id /or revise policies and nuous positive airway nachines and provide aff. The DON or designee itoring systems to ensure e and report those results to ce committee.				

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X:	3) DATE SURVEY COMPLETED	
		00058	B. WING		06/28/2018	
AME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, 3	STATE, ZIP CODE		
SOOD SA	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74		
(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 BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
2 830	Continued From pa	ge 11	2 830			
	TIME PERIOD FOF (21) days.	R CORRECTION: Twenty-one				
2 895	MN Rule 4658.0528 Motion	5 Subp. 2.B Rehab - Range of	2 895		8/3/18	
	that is directed towa through positioning implemented and m comprehensive res of nursing services development of a n provides that: B. a resident wit receives appropriat	motion. A supportive program and prevention of deformities and range of motion must be haintained. Based on the ident assessment, the director must coordinate the ursing care plan which h a limited range of motion e treatment and services to notion and to prevent further of motion.				
	by: Based on observati review, the facility fa motion (ROM) serv and/or prevent furth 4 of 4 residents (R3 limitations in ROM	ent is not met as evidenced on, interview and document ailed to provide range of ices in order to maintain her decline in ROM abilities for 8, R7, R16, R15) who had and had not received ROM to their individualized		Licensing orders corrected.		
	R3's quarterly Minir 3/23/18, indicated F cognitive impairment including diabetes r	num Data Set (MDS) dated R3 displayed moderate nt and had diagnoses mellitus and dementia. The required extensive assistance				

TATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV COMPLETE	
			A. BOILDING.			
		00058	B. WING		06/28/2018	
IAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD SA	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	MPLET DATE
2 895	Continued From pa	age 12	2 895			
	unable to ambulate limitations of ROM significant change	ly living (ADLs) and was e. R3 did have functional in the lower extremities. R3's MDS dated 9/25/17, identified on as the quarterly MDS dated				
	(CAA) dated 9/28/1	y living Care Area Assessment I7, indicated R3 was working as not participating well or vith the therapy.				
	required restorative physical mobility. T participate in a fund	ed 9/26/17, indicated R3 e interventions due to limited The plan directed R3 to ctional maintenance program times per week. The program				
	motion] to bilateral up to 3 times per w past 90 degrees for - NURSING REHA 5 repetitions up to 1 - NURSING REHA red theraband and repetitions x 3 sets - NURSING REHA raises, 15 reps up to - NURSING REHA 15 repetitions up to	B #2: Should blade squeezes three times per week B #3: Outward rotation with shoulders snuggled up, 10 up to three times per week. B #4: Bilateral straight leg to three items per week. B #5: Bilateral hip abductions, o three times per week. B #6: Bridges, 15 repetitions				
	-NURSING REHAE	3 #7: hamstring/heel cord ions each foot x 30 second				
		5 p.m. R3 stated his shoulders ad not been able to walk in a				

STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/28/2018	
	PROVIDER OR SUPPLIER				06/.	20/2010
		518 JEF	DDRESS, CITY, ST	IUE, PO BOX 29		
GOOD S	AMARITAN SOCIETY		'ER, MN 56474			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 13	2 895			
	year or so. R3 stat exercise program.	ed that he did participate in an				
	1:00 p.m. to 8:00 p to 4:30 p.m., on 6/2 p.m. and on 6/28/1	conducted on 6/25/18, from .m., on 6/26/18, from 8:00 a.m 27/18, from 7:00 a.m. to 3:30 8, from 8:00 a.m. to 1:30 p.m. ed to participate in a e program.				
	-Review of R3's res documentation reve	storative nursing flowsheet ealed the following:				
	exercises on 2 of 1 -nursing rehab #2- exercises on 3 of 1 -nursing rehab #3- exercises on 2 of 1 -nursing rehab # 4- exercises on 3 of 1 -nursing rehab #5- exercises on 3 of 1 -nursing rehab #6- exercises on 1 of 1 -nursing rehab #7 - exercises on 3 of 1	R3 participated in the 6 opportunities. R3 participated in the 6 opportunities.				
	May 2018: no data	was recorded.				
	exercises on 6 of 1 -nursing rehab #2- exercises on 6 of 1 -nursing rehab #3- exercises on 6 of 1	R3 participated in the 6 opportunities. R3 participated in the 6 opportunities. R3 participated in the				

Minnesota Department of Health STATE FORM

6899

C2JR11

If continuation sheet 14 of 39

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY IPLETED			
		00058	B. WING		06/28/2018				
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE					
GOOD SAMARITAN SOCIETY - PINE RIVER 518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE			
2 895	Continued From pa	age 14	2 895						
	exercises on 6 of 1 -nursing rehab #6- exercises on 6 of 1 -nursing rehab #7 - exercises on 6 of 1 On 6/26/18, at 12:5 (NA)-B stated she 6 programs for R3 ea stated she was to v week as the restora frequently pulled to instead of providing stated she attempte programs done, ho working the floor.	R3 participated in the 6 opportunities. R3 participated in the 6 opportunities 50 p.m. nursing assistant completed the restorative arlier in the morning. NA-B work at the facility four days a ative NA, however, she was the floor to provide direct care g restorative services. NA-B ed to get all of the restorative wever, was unable to due NA-B stated the next two days ding direct care and not							
	stated she provided program. RN-A sta reassigned to provi assist to provide the she too would also medications. RN-A NA-B were providin programs were not was to participate in three times a week Upon review of the RN-A confirmed R3 restorative program - At 11:27 a.m. RN- was observed to ha	a.m. registered nurse (RN)-A d oversite of the restorative ated when NA-B was de direct care, she was to e ROM exercises, however, be reassigned to pass A stated, when both she and ng direct care, the restorative completed. RN-A stated R3 in the restorative program up to a sdirected by the care plan. restorative documentation, a had not participated in the n as directed by the care plan.							
	arms over his head	evented him from lifting his I. R3 stated his shoulders had ears and his ROM ability had							

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	- (X3) DATE SURVEY COMPLETED				
		00058	B. WING		06/	28/2018			
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE					
GOOD SAMARITAN SOCIETY - PINE RIVER 518 JEFFERSON AVENUE, PO BOX 29 PINE RIVER, MN 56474									
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLET DATE			
2 895	not changed. R3 w move them back ar move his legs but h them. RN-A confirr shoulder and had n directed by the care R7's quarterly MDS was alert and orien including diabetes a The MDS indicated assistance with bed required assistance room and hallway. indicate R7 had any R7's Care Plan date to ambulate with a t identified the follow program: -NURSING REHAE repetitions up to 3 t -NURSING REHAE shoulder in all plane 10 repetitions each -NURSING REHAE dowel. Ten repetition per week. -NURSING REHAE with front wheeled y follow close behind as tolerates.	as observed to lift his legs and ad forth. R3 stated he could e was not able to stand on ned R3 had limitations in his ot received ROM services as e plan. dated 4/9/18, indicated R7 ted and had diagnoses and schizoaffective disorder. R7 required extensive mobility and transfers and e of one to ambulate in her The assessment did not y type of limitation in ROM. ed 4/19/18, directed the staff front wheeled walker. It also ing restorative nursing #1, Bilateral should shrugs. 5 imes per week. #2: AAROM to bilateral es of normal joint movement up to three times per week. #3: Pull back with one pound ns x 2 sets. Up to three times at Ambulate with assist of one walker and wheelchair to twice a day. Goal 120 feet or	2 895						
	received assistance R7 stated she was but she only receive the mornings Mond	p.m. R7 stated she had not with ambulation as directed. to walk twice a day every day, ed assistance to ambulate in ay - Friday. R7 stated she cises with her shoulders,							

STATE FORM

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/28/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 16	2 895			
	restorative, was use direct care. R7 star participate in the re facility did not have -Review of R7's res documentation reve April 2018: -nursing rehab #1- exercises on 4 of 1 -nursing rehab #2- exercises on 4 of 1 -nursing rehab #3- exercises on 4 of 1 -nursing rehab #3-	storative nursing flowsheet ealed the following: R7 participated in the 6 opportunities. R7 participated in the 6 opportunities. R7 participated in the 6 opportunities. R7 ambulated 27 times out of the morning and 2 times out o				
	exercises on 7 of 1 -nursing rehab #2- exercises on 7 of 1 -nursing rehab #3- exercises on 7 of 1 -nursing rehab # 4-	R7 participated in the 6 opportunities. R7 participated in the 6 opportunities. R7 ambulated 18 times out of the morning and 3 times out o				
	-nursing rehab #1- exercises on 7 of 1 -nursing rehab #2- exercises on 7 of 1 -nursing rehab #3- exercises on 7 of 1 -nursing rehab # 4-	R7 participated in the 6 opportunities. R7 participated in the				

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/28/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETI DATE
2 895	Continued From pa	age 17	2 895			
	27 opportunities in	the evening.				
	think she would be program as NA-B v stated sometimes s exercises, but som - At 11:00 am. RN- room with a front w observed to ambula -At 11:10 a.m. RN- arm. R7 stated the ROM for several ye her left arm approx not observed to har confirmed R7 had I -At 11:51 a.m. RN- receiving ROM and	<ul> <li>a.m. R7 stated she did not participating in her restorative was providing direct care. R7 she had time to help us with etimes she did not.</li> <li>A ambulated R7 out of her wheeled walker. R7 was ate 200 feet without difficulty.</li> <li>A directed R7 to stretch her e left should had limitations in ears. R7 was observed to lift timately half way up. R7 was ve full ROM in the arm. RN-A limitations in the left shoulder.</li> <li>A confirmed R7 had not been a mbulation services as</li> </ul>				
	as being alert and o including atrial fibril The MDS indicated assistance of one f was able to ambula extensive assistanc did not display func R16's Care Plan da was to participate in programs:	2S dated 5/2/18, identified R16 oriented with diagnoses llation and diabetes mellitus. I R16 required extensive for activities of daily living and ate in the hallway with ce. The MDS indicated R16 ctional ROM limitations. ated 4/19/18, indicated R16 in the following nursing rehab				
	shoulders (has limi	3 #1: AAROM to bilateral ted range in the right shoulder epetitions up to three times per				

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/28/2018	
		00058	B. WING			
IAME OF	PROVIDER OR SUPPLIER		DDRESS, CITY, S			
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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)	I SHOULD BE	(X5) COMPLET DATE
2 895	Continued From pa	ge 18	2 895			
	-NURSING REHAE pound weight, 10 reveek. -NURSING REHAE abduction/adduction sung up elbow and 10 repetitions x 2 so week. -NURSING REHAE dowel and red thera up to three times per- NURSING REHAE straight leg raises 1 week -NURSING REHAE repetitions up to thr -NURSING REHAE abductions. 15 reper- week. -NURSING REHAE cord stretches 2 rep to three times per v -NURSING REHAE cord stretches 2 rep to three times per v -NURSING WALKII two with EZ walker a day. Goal of 20 - On 6/25/18, at 7:45 receive assistance however, the facility assist her with amb walked in three day walk, however, they stated she was to p program but she has the program. R16 fa	<ul> <li>B #2: Bicep flexion with a two epetitions up to three times per</li> <li>B #3; Horizontal n with a one pound weight push one pound across body, ets, up to three times per</li> <li>B #4 Pull back with one pound aband 10 repetitions x 3 sets er week.</li> <li>B #5 while in bed: bilateral 5 repetitions up to 3 times per</li> <li>B #6: while in bed bridges. 15 ree times per week.</li> <li>B #7" While in bed: bilateral hip etitions up to three times per</li> <li>B #8: Bilateral hamstring/heel betitions with second hold up veek.</li> <li>NG: Ambulate with assist of and wheelchair to follow twice 70 feet or as tolerates.</li> <li>p.m. R16 stated she was to with ambulation twice a day, / did not have enough staff to ulation, therefore, she had not received assistance with ifted her right arm with the left right arm was weak.</li> </ul>				

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED 06/28/2018	
		00058	B. WING			
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
good s	AMARITAN SOCIETY	- PINE RIVER	ERSON AVEN ER, MN 56474	UE, PO BOX 29 4		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLET DATE
2 895	April 2018: -nursing rehab #1-; -ambulation: R16 his morning and seven had refused to partit times. May 2018: -nursing rehab #1-; exercises on 1 of 10 -ambulation: R16 his morning and 12 tim refused to participa June 2018: -nursing rehab #1-; exercises on four of refused the program -ambulation: R16 his the morning and four had refused to partition times. On 6/26/18, at 1:35 stated R16 was not FM-B stated R16 his was not enough star received the assistar program. FM-B star sure R16 continued On 6/27/18, at 11:00 had not been received ambulation as direct directed R16 to lift H observed to have lift had an approximate	<ul> <li>#7 no data was available ad ambulated four times in the times in the evening. R16 icipate in the program 29</li> <li>#7, R16 participated in the 6 opportunities. ad ambulated 12 times in the evening. R16 had te in the program 33 times.</li> <li>#7: R16 participated in the f 16 opportunities and had n x 3. ad ambulated eight times in ur times in the evening. R16 icipate in the program 40</li> <li>p.m. family member (FM)-B assisted to walk enough. ad the ability to walk but there iff at the facility to ensure she ance to participate in the times times in the times times in the times times the times in the times times the times times in the times times</li></ul>	2 895			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/28/2018	
IAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		ERSON AVEN ER, MN 56474	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	age 20	2 895			
	-At 11:25 a.m. RN-A and nursing assistant (NA)-B were observed to ambulate R16 75 feet with an EZ walker. R16 tolerated the ambulation well.		;			
	-At 11:47 a.m. RN-A confirmed R16 was not receiving assistance with ROM and ambulation as directed.					
	was cognitively inta included multiple so lymphedema (swell lymph fluid under th indicated R15 was staff for transfers a extensive assist of dressing, and perso further indicated R2	S dated 5/7/18, indicated R15 act and had diagnoses which clerosis (MS), pain and ling caused by a build-up of ne skin). The MDS also totally dependent upon two nd toilet use and required two staff for bed mobility, onal hygiene. The MDS 15 had functional limitations in th impairment to both lower				
	Care Area Assessm indicated R15 had a impaired muscle st multiple sclerosis, w bear her own weigh for all mobility and a for transfers, was m the total lift to sit up R15 was at risk for weakness, skin bre	es of daily living]/Rehabilitation nent (CAA) dated 11/10/17, severely impaired mobility and rength and coordination due to was no longer able to stand or nt and was dependent on staff ADLs. She required a total lift non-ambulatory, and needed o in bed. The CAA indicated contractures, increasing eakdown, and feelings of decreased independence.				
	had a need for rest limited physical mo sclerosis and chror	ovided 6/28/18, indicated R15 orative intervention due to bility related to multiple nic back pain as evidenced by eakness and decreased				

STATE FORM

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00058	B. WING	B. WING		28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY		ERSON AVEN ER, MN 5647	IUE, PO BOX 29 4		
(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 DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
2 895	Continued From pa	ge 21	2 895			
	maintenance progra	occasionally refused her FMP [functional maintenance program]. The care plan directed the following restorative interventions:				
	shoulders in all plar reps [repetitions] up -NURSING REHAB with left hand, 10 re -NURSING REHAB right hand, 10 reps -NURSING REHAB green TheraBand (ft to 3 times per week -NURSING REHAB TheraBand, 10 reps week -NURSING REHAB with resistance, 10- times per week -NURSING REHAB resident holding X & tolerates) up to 3 tir rehab aide sitting in resident's thigh up a	<ul> <li>#5: Chest pulls with green</li> <li>x 2 sets up to 3 times per</li> <li>#7: Hip abduction/adduction</li> <li>20 reps (as tolerates) up to 3</li> <li>#8: Knee extensions with</li> <li>5 seconds, 10-20 reps (as</li> <li>mes per week. Complete with</li> <li>a chair and supporting</li> <li>at a slight angle.</li> </ul>				
	(with knee bent), 10 times per week. Co chair and supportin angle. -NURSING REHAB to 30 second hold,	#9: Resistive leg presses 0-20 reps (as tolerates) up to 3 mplete with rehab sitting in a g resident's thigh up at a slight #10: Heel cord stretch X up 1-2 reps up to 3 times per th rehab aide sitting in a chair.				
	(Do not combine wi -NURSING REHAB extension with leg li reps up to 3 times p	th hamstring stretch) 8 #11: Hamstring stretch (knee ift) X up to 30 second hold, 1-2 per week. Complete with rehat ir. (Do not combine with heel	2			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		- 06/28/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, ST	ATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY		ERSON AVEN ER, MN 56474	UE, PO BOX 29 4		
(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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	ON SHOULD BE	(X5) COMPLETI DATE
2 895	a joke. R15 stated with ROM three tim received the service stated two weeks p	p.m. R15 stated therapy was she was supposed to work les a week, however, had not es on a regular basis. R15 prior she had received ROM y and Tuesday and the	2 895			
	previous week only Tuesday. R15 state was often called to have enough help, of therapy and the l done. R15 was abl unable to reach mo left arm. She state move and she was of her left hand a lit multiple sclerosis a	received services on ed the aid assigned to do it the floor because they didn't therefore nobody got any type basic therapy was no longer le to lift her right arm but was ore than a few inches with her d her left arm was unable to only able to move her fingers ttle bit. R15 stated she had ind was unable to walk. R15 ave wraps to both of her lower				
	April 2018, May 20	on Survey Report v2 dated 18, and June 2018, revealed by was provided as follows:				
	available x 1, Blank -May 2018: Reside Blank x 28	eted x 3, Resident not x x 22 ent refused x 1, Completed x 2, ent refused x 2, Completed x				
	was reviewed with restorative participa stated the restorativ assist with resident	a.m. R15's medical record RN-A who verified the above ation documentation and ve aid was pulled to the floor to cares therefore the service ded. RN-A stated it was an eded to fix.				
	At 10:11 a.m. R15	5 confirmed she had not				

STATE FORM

Minneso	ta Department of He	alth				ATTROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00058	B. WING		06/2	8/2018
NAME OF F	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- PINE RIVER	ERSON AVE ER, MN 564	NUE, PO BOX 29 74		
(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 APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 895	Continued From pa	ge 23	2 895			
	she had only receiv stated she did not f decline but was abo	ices as directed and indicated red ROM once this week. R15 eel like she had experienced a put the same in her abilities. I good days and bad days				
	ROM services for F would not be able to now as R15 was in exercises were do I chair. R15 was obs squeezes, left shou green band, chest p and then hip adduc	A was observed to provide R15. RN-A indicated she o do all of her exercises right bed and some of the be done while R15 sat up in a served to do sponge Ider flexion exercises with a bulls, AAROM to her shoulders tion/abduction and leg ated the ROM well and denied				
	10/2017, directed th	on and Ambulation policy dated ne staff to provide ROM and sted by the care plan and				
	The director of nurs develop, review, an procedures for rang education to the sta could develop mon	HODS OF CORRECTION: sing (DON) or designee could d /or revise policies and ge of motion and provide aff. The DON or designee itoring systems to ensure e and report those results to ce committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one				
21375	MN Rule 4658.0800 Program	) Subp. 1 Infection Control;	21375			8/3/18
Minnesota De STATE FORM	epartment of Health ⁄I		6899	C2JR11	If continuatio	n sheet 24 of 39

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION (X	3) DATE SURVEY COMPLETED
		00058	B. WING		06/28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74	
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	E COMPLET
21375	Continued From pa	ge 24	21375		
	Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment.				
	This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure proper handwashing after glove usage was performed for 2 of 2 residents (R4, R1), and aseptic technique preparing and administration of insulin for 2 of 2 residents (R4) and (R1).			Licensing orders corrected.	
	Findings include:				
	(LPN)-A was observed which included Land Without wiping the pad, LPN-A obtained needle into the rubble withdrew the insuling LPN-A donned glow into R4's right delto with alcohol prior to removed her glowes hands proceeded to touching the door k	p.m. licensed practical nurse ved to set up R4's medication tus insulin 40 units at bedtime. insulin vial with an alcohol ed a syringe and inserted the per stopper of the vial, and proceeded to R4's room. res and injected the Lantus id, without cleansing the skin the injection. LPN-A s, and without washing her b walk out of the room while nob of R4's room and the keys art along with the drawers on			
	set up R1's medica insulin 8 units at be Lantus injecting the without wiping off th	p.m. LPN-A was observed to tions which included Lantus dtime. LPN-A drew up the needle into the insulin vial ne stopper with alcohol. o was to R1's room, donned			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/28/2018	
NAME OF I	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 56474	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACT) CROSS-REFERENCED TO T DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21375	Continued From pa	ge 25	21375			
	of his abdomen wit alcohol prior. Follow removed the gloves hands she touched medicaiton cart as as well as the mous On 6/25/18, at 7:55 not to wash her har would break down. employees hands s removal. When ask stopper with alcoho did and thought usi was preferred.	I the Lantus into R1's left side hout cleansing the skin with wing the injection, LPN-A s, and without washing her the door knob, the keys to the well as the drawers to the cart se to the computer. 5 p.m. LPN-A stated she tried nds so much because her skin However, LPN-A confirmed should be washed after glove ked about wiping the rubber ol, she stated sometimes she ng the alcohol wipe on the skin 9 a.m. the director of nursing				
	(DON) confirmed th hands after glove re rubber stopper on t been swabbed with needle and drawing DON stated the res	ne staff should wash their emoval, and also verified the he insulin vials should have alcohol prior to inserting the g up mediation. In addition, the ident;s skin was also to be cohol pad prior the the				
	10/17, directed stat an antiseptic swab	ction-Subcutaneous revised f to cleanse the skin site with using circular motion, moving d about two inches.				
		ted 9/12, indicated injections ared to residents using sterile per equipment.				
	revised 1/18, indica	ygiene and Handwashing Ited glove use required I donned and doffed.				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00058	B. WING		06/28/2018	
AME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
OOD S	AMARITAN SOCIETY		FERSON AVE	NUE, PO BOX 29 74		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE DATI	
21375	Continued From pa	ige 26	21375			
	The director of nurs develop, review, an procedures for infe- provide education t designee could dev ensure ongoing cor	THODS OF CORRECTION: sing (DON) or designee could id /or revise policies and ction control practices and o the staff. The DON or relop monitoring systems to mpliance and report those y assurance committee.				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	9			
21435	MN Rule 4658.090 Recreation Program	0 Subp. 1 Activity and n; General	21435		8/3/18	
	home must provide recreation program based on each indi strengths, and need meet the physical, i well-being of each i comprehensive res comprehensive pla 4658.0400 and 469 provided opportunit	al requirements. A nursing an organized activity and . The program must be vidual resident's interests, ds, and must be designed to mental, and psychological resident, as determined by the ident assessment and n of care required in parts 58.0405. Residents must be ties to participate in the opment of the activity and				
	by: Based on observati review, the facility f centered activity pr	ent is not met as evidenced ion, interview and document ailed to assess resident eferences and develop ventions for 1 of 2 residents activities.		Licensing orders corrected	l.	

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00058	B. WING		06/28/2018	
AME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, SI	TATE, ZIP CODE		
	AMARITAN SOCIETY	- PINE RIVER 518 JEF	FERSON AVEN	IUE, PO BOX 29		
		PINE RIV	/ER, MN 5647	4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
21435	Continued From pa	ige 27	21435			
	Findings include:					
	dated 6/6/18, indica oriented and had d pelvic fractures, ve acetabulum fractur and socket" of the indicated R28 was for transfers, requir bed mobility, dress and was unable to indicated it was ver	innimum Data Set (MDS) ated R28 was alert and iagnoses including multiple rtebral fracture and a left e (socket portion of the "ball left hip). The assessment totally dependent upon staff red extensive assistance for ing, grooming, and bathing, ambulate. The assessment ry important for R28 to interact and it was very important to be				
	Assessment (CAA) was unable to bear	aily Living Care Area dated 6/6/18, indicated R28 weight on his legs due to actures and pain. R28 was				
	depressed following struggling to cope v The severe pain fro	ed 6/6/18, indicated R28 was g a severe accident and was with his lack of independence. om his injuries affected his in activities he enjoyed.				
	6/1/18, indicated R fishing, watching te traveling. The asse able to make his ov transfer, ambulate Collection Tool did	est Data Collection Tool dated 28 enjoyed hunting and elevision, Bingo, animals, and essment indicated R28 was wn decision and was unable to or use a wheelchair. The Data not include an assessment of ild provide activities for R28.	a			
	multiple fractures d	ated 6/1/18, indicated R28 had lue to an accident. He was n one to one conversations,				

AND PLAN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING		06/	28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE	1	
GOOD S	AMARITAN SOCIETY	- PINE RIVER	FERSON AVEN /ER, MN 56474	IUE, PO BOX 29		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		SUMMARY STATEMENT OF DEFICIENCIES     ID     PROVIDER'S PLAN OF CO       (EACH DEFICIENCY MUST BE PRECEDED BY FULL     PREFIX     (EACH CORRECTIVE ACTION)		FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
21435	Continued From pa	ige 28	21435			
	visiting with friends/family and required time to adjust to the facility. The activity goal was to ensure R28 expressed satisfaction with the type of activities and level of activity involvement when asked. The care plan interventions included watching television, using the phone and talking about hunting and fishing.		1			
	On 6/25/18, at 4:54 p.m. R28 stated he was very bored at the facility. R28 stated he had been at the facility for five weeks following a significant accident which had left him bedridden. R28 was bored watching television, he could not find his reading glasses, and he spent the majority of the day thinking of all of the things that needed to be done at home, yet he was unable to do anything about it. R28 stated his fiance visited him regularly, but the time in between her visits made for a very long day.					
		8:00 p.m. R28 was observed m, in bed, with the door				
	watched more televithan he had in his e occasionally he was	1 p.m. R28 stated he had vision in the past five weeks entire life. R28 stated s able to find a movie, but he shows and the news.				
	eating breakfast in	a.m. R28 was observed bed. R28 stated his fiance visiting the facility soon and he d to seeing them.				
	had left the facility l tomorrow and until	7 p.m. R28 stated his fiance but she would be back then, he would be bored. R28 mbers visited, came in to give	3			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY PLETED
		00058	B. WING		06/28/2018	
	PROVIDER OR SUPPLIER		DDRESS, CITY, S			20/2010
	NOVIDER OR OUT FIER			IUE, PO BOX 29		
SOOD S/	AMARITAN SOCIETY		ER, MN 5647			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO		(X5) COMPLET
TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO TH DEFICIENCY)	E APPROPRIATE	DATE
21435	Continued From pa	age 29	21435			
	members visited w When asked if he h things to do in his r	s. However, none of the staff ith him for any period of time. nad been offered alternative room, R28 stated 'no" he just				
	waited for the phor	, played on his computer or ne to ring. istered nurse (RN)-B stated				
	R28 was bedridder RN-B stated R28's watched television	n and could not go to activities. fiance visited him daily, he and played on his computer.				
	shades closed and He would talk to the	referred to keep the window the door closed at all times. e staff when they assisted him, cipate in other activities.				
	6/2018, indicated F activities, however,	vity Documentation report dated R28 had participated in 19 , the type of activity could not n the documention.	1			
	single note dated 6 was confined to be unable to read at th	vity Progress Notes included a 5/1/18, which indicated R28 d, watched television, was his time due to inability to focus note indicated R28 was				
		ny type of group activities. ) a.m the activity director (AD)				
	stated R28 had be approximately five					
	activities R28 parties visited and not whe activities for/with his	cipated in were when his fiance on the staff were providing im. R28 spent his days with				
	computer. The AD one to one visits from	g television or playing on the stated R28 had not received om the activity staff as he had <i>isits.</i> The AD confirmed R28				
acata D		son and indicated 2-4 hours of				

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00058	B. WING		06/	06/28/2018	
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	ATE, ZIP CODE	• • •		
OOD S	AMARITAN SOCIETY		FERSON AVEN VER, MN 56474	UE, PO BOX 29 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLE DATE	
21435	Continued From pa	ge 30	21435				
	however, it was not The AD stated the a each day to drop of calendar/menu pap visit with him. The received an individu the staff were depet to provide activities had "gotten lost" in structured activity p established for R28 The One to One Ac dated 8/2015, direc one structured activi focused on needs, interests during a s situation. The polic one to one interven involved in a rehab focused on going h	tivity Interventions policy ted staff to provide a one to vity for individual resident that abilities , strength and taff to resident one to one by directed staff to consider tions for a resident who was ilitation program and was ome.					
	The activity director review, and /or revi individualized activit the staff. The activit develop monitoring	HODS OF CORRECTION: r or designee could develop, se policies and procedures for ties and provide education to ity director or designee could systems to ensure ongoing port those results to the quality ee.					
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21610	MN Rule 4658.134 and Preparation Ar	0 Subp. 1 Medicine Cabinet ea;Storage	21610			8/3/18	
	Subpart 1. Storage	of drugs. A nursing home					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00058	B. WING		06/28/2018	
NAME OF F	PROVIDER OR SUPPLIER		DDRESS. CITY.	STATE, ZIP CODE	00/20/2010	
	AMARITAN SOCIETY	- PINE RIVER 518 JEF	FERSON AVE	NUE, PO BOX 29		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLET	
21610	Continued From pa	age 31	21610			
	under proper tempe	s in locked compartments erature controls, and permit sing personnel to have				
	by: Based on observat review, the facility f were secured at all carts used. This ha	ent is not met as evidenced ion, interview and document ailed to ensure medications times in 1 of 2 medication ad the potential to affect 19 edications were stored in		Licensing orders corrected.		
	Findings include:					
	medication cart B v unattended with R4 Systane solution ey medication cart B, v licensed practical n medication cart B f	ion on 6/25/18, at 7:25 p.m. vas observed unlocked and l's vial of Lantus insulin and ve drops laying on top of unsecured. At 7:29 p.m. iurse (LPN)-A arrived at rom a resident's room at the ng, "Oh, I left the cart answer a call light."				
	about the mess, lea medication on top." needed to answer a should have put the medication cart and cart. LPN-A confirm	p.m. LPN-A, stated "I'm sorry aving the cart unlocked and the ' LPN - A went on to say she a call light, and confirmed she e mediations back in the d locked it prior to leaving the med anyone walking though had access to the mediation s.				
	(DON) stated the m	9 a.m. the director of nursing nedication cart should have e medications should not have ed.	3			

	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		00058	B. WING	NG		28/2018
NAME OF I	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 56474	IUE, PO BOX 29 4		
(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 C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
21610	Continued From pa	ige 32	21610			
	Dispensing and Sto Procedure revised	d Acquisition, Receiving, orage of Medications 9/16, indicated medications a locked medication cart, 1.				
	The DON or design /or revise policies a storage and provide DON or designee of systems to ensure	THODS OF CORRECTION: nee could develop, review, and and procedures for medication e education to the staff. The could develop monitoring ongoing compliance and a to the quality assurance				
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one	•			
21840	MN St. Statute 144 Residents of HC Fa	.651 Subd. 12 Patients & ac.Bill of Rights	21840			8/3/18
	residents shall have based on the inform 9. Residents who r or dietary restriction likely medical or ma the refusal, with do medical record. In of incapable of unders has not been adjud legal requirements treatment, the cond	o refuse care. Competent e the right to refuse treatment nation required in subdivision refuse treatment, medication, ns shall be informed of the ajor psychological results of cumentation in the individual cases where a resident is standing the circumstances bu licated incompetent, or when limit the right to refuse ditions and circumstances shal d by the attending physician in cal record.	I			

STATEMEN	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00058	B. WING		06/28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74	
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETI
21840	Continued From pa	age 33	21840		
	by: Based on interview facility failed to ider	ent is not met as evidenced and document review the ntify the preference for Health 1 of 1 resident (R27) reviewed tives.		Licensing orders corrected.	
	Findings include:				
		inimum Data Set (MDS) dated 27 was cognitively intact.			
	indicated R27 had displaced intertroch femur, acute respir (deficiency in the a tissues), and centri emphysema (irreve	port provided 6/28/18, diagnoses which included nanteric fracture of the left atory failure with hypoxia mount of oxygen reaching the lobular and panlobular ersible lung diseases which tion of alveolar walls)			
	indicated R27 was 5/29/18, and the Ac	ecord provided 6/28/18, admitted to the facility on dvance Directive section ate (CPR)" [cardiopulmonary			
	included the followi	aary Report dated 6/27/18, ng order: : Resuscitate (CPR) dated			
		ovided 6/28/18, did not erences related to advance			
		e Assessment dated 6/26/18, able to make her own			

STATE FORM

STATEMENT OF DEFICIENCIES       (X1) PROVIDER/SUPPLIER/CLIA         AND PLAN OF CORRECTION       IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPL		
		00058	B. WING		06/28/2018		
	PROVIDER OR SUPPLIER		DDRESS, CITY, S		00/20/2010		
		518 JEE		IUE, PO BOX 29			
300D S	AMARITAN SOCIETY		/ER, MN 5647				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE	
21840	Continued From pa	age 34	21840				
	worker (LSW) indic advance directives for Life Sustaining information was pro admission. LSW in completing a POLS	a.m. the licensed social cated the facility policy for as well as the Physician Orde Treatment (POLST) ovided to residents upon ndicated R27 declined ST at the time of admission as a was planning to discharge to	r				
	with the social work facility. R27 indicat living will 15 years a which she stated ha R27 stated her dau will and she had a believed she had to	7 confirmed she had spoken ker upon her admission to the ted she had established a ago and named two hospitals ad copies of the living will. Ighter had a copy of her living copy herself, at home. R27 old the facility about it. R27 want to be put on life support in th emergency.	1				
		dical record revealed no living will/advance directive.					
	remember if R27 h advance directive u indicated she interv admission process request a copy. LS best to get a copy a admission and stat Spaces (the facility	W stated she did not ad indicated she had an upon admission, however, viewed for this during the and it was her practice to SW indicated she would do her at the time of a resident's red if it was not in Resident 's document imaging system), ot have a copy of it.					
	R27 had a living wi with R27 at the time	ly member (FA)-A confirmed II. FA-A stated she had been e of her admission to the d no representative of the					

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED	
		00058	B. WING		06/	28/2018	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 56474	IUE, PO BOX 29 4			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE	
21840	Continued From pa	age 35	21840				
	FM-A stated she ware R27's living will correct or want to be kept of recovery or if she the event of an em On 6/28/18, at 10:2 (DON) confirmed the a copy of R27's livit	26 a.m. the director of nursing he facility should have obtained ng will to ensure her dentified and carried out in the					
	The DON or design /or revise policies a directives and prov DON or designee of systems to ensure	THODS OF CORRECTION: nee could develop, review, and and procedures for advanced ide education to the staff. The could develop monitoring ongoing compliance and s to the quality assurance					
	TIME PERIOD FOI (21) days.	R CORRECTION: Twenty-one	9				
21860	MN St. Statute 144 Residents of HC Fa	.651 Subd. 16 Patients & ac.Bill of Rights	21860			8/3/18	
	and residents shall treatment of their p and may approve of individual outside the notified when person any individual outs someone to accomp	entiality of records. Patients I be assured confidential personal and medical records, or refuse their release to any the facility. Residents shall be onal records are requested by side the facility and may select npany them when the records the subject of a personal					

	ta Department of He IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		00058	B. WING		06/28/2018
NAME OF F	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY,	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY		ERSON AVE ER, MN 564	NUE, PO BOX 29 74	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLET
21860	Continued From pa	ige 36	21860		
	information from th available in accord section 144.335. T complaint investiga Department of Hea	of records and written e records shall be made lance with this subdivision and 'his right does not apply to tions and inspections by the lth, where required by third tracts, or where otherwise			
	by: Based on observat review, the facility f information was no residents, staff and	ent is not met as evidenced ion, interview and document ailed to ensure confidential t readily available for all visitors to view for 3 of 6 R16) observed to have private in their rooms.		Licensing orders corrected.	
	Findings include:				
	had impaired cogni dementia evidence known, behaviors, mobility and activiti	sed on 6/8/18, indicated R5 tive function related to d by inability to make needs and was dependent on staff for es of daily living. R5 required two staff for transfers with a large lift sling.	r		
	was dependent on	ted on 6/27/18, indicated R5 staff for mobility and activities ). R5 required assist of two arge lift sling.			
	was observed hang bed. Written on the	p.m. a white dry erase board ging above R5's head of the e board was the following o all who entered the room:			

	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING.			
		00058	B. WING		06/	28/2018
AME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, ST	TATE, ZIP CODE		
OOD S	AMARITAN SOCIETY	- PINE RIVER	FERSON AVEN /ER, MN 56474	IUE, PO BOX 29 4		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF		(X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLET DATE
21860	Continued From pa	nge 37	21860			
	-total lift with large sling.					
	impaired cognition Parkinson's diseas for all mobility and	sed 3/19/18, indicated R2 had related to dementia and e. R2 was dependent on staff activity of daily living needs. of two with a total lift with a ansfers.				
	hung on the wall at	p.m. a white, dry erase board bove R2's head of the bed. rd was the following which was ntered the room:				
	-med sling full lift.					
	explained the white how to transfer, the to use. NA-A agree available to anyone NA-A stated a care	p.m. nursing assistant (NA)-A boards informed the staff of resident and what size sling ed this information was who entered the rooms. sheet was not used to provide arding resident care needs.				
	5/2/18, indicated R and had diagnoses and depression. The	imum Data Set (MDS) dated 16 was alert and orientated including dementia, anxiety he MDS indicated R16 assist of one staff for activites				
	a.m. a white, dry er hanging next to the board revealed the	p.m. and on 6/27/18, at 11:16 ase board was observed bed in R16's room. The following information which no entered the room:				
	-AO1 for transfer/to	bilet				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
	00058		B. WING	B. WING		28/2018
AME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, ST			
SOOD S	AMARITAN SOCIETY		FERSON AVEN /ER, MN 5647	IUE, PO BOX 29 4		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE	(X5) COMPLET DATE
21860	Continued From pa	age 38	21860			
	<ul> <li>At 11:17 a.m. reginable viations means and toilet use. RN-was private informations are staff and visitors to On 6/27/18, at 3:16 (DON) stated the facility boards for the past indicated the facility boards called "hollit the facility changed DON confirmed the boards was person specific resident in not need access to stated the facility co of sharing care information secure.</li> <li>SUGGESTED MET The director of nurs develop, review, ar procedures for person secure for person secure for personal secure for personal secure for personal secure.</li> </ul>	istered nurse (RN)-A stated the nt to assist of one for transfers -A confirmed the information ation used to assist R16 with adily available to all residents,				
	the quality assuran TIME PERIOD FOI (21) days.	ce committee. R CORRECTION: Twenty-one				