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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C2JR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00058

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245476**

2.STATE VENDOR OR MEDICAID NO.
(L2) **017040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - PINE RIVER**
(L4) **518 JEFFERSON AVENUE, PO BOX 29**
(L5) **PINE RIVER, MN** (L6) **56474**

4. TYPE OF ACTION: **7** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **08/21/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Rebecca Haberle, HFE - NE II 08/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 08/24/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/08/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the 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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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: 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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: C2JR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00058

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(L1) **245476**

2.STATE VENDOR OR MEDICAID NO.
(L2) **017040200**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - PINE RIVER**
(L4) **518 JEFFERSON AVENUE, PO BOX 29**
(L5) **PINE RIVER, MN** (L6) **56474**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/28/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

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Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date:
Rebecca Haberle, HFE NE II 07/26/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas Larson, Enforcement Specialist 08/06/2018 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
05/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
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05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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:

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

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

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

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

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

attached deficiencies.

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

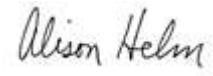
Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. 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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on June 25 through June 28, 2018 during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On June 25 through June 28, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The plan of correction will serve as your facility's allegation of compliance. Since your facility is enrolled in the electronic Plan of Correction (ePOC), a signature is not required at the bottom of the first page of the CMS-2567 form. 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.	F 000		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;FormIte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical	F 578		8/3/18

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

Electronically Signed | 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 1 services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to identify the preference for Health Care Directives for 1 of 1 resident (R27) reviewed for advanced directives. Findings include:	F 578	Preparation and execution of this response and plan of correction does not constitute an admission or agreement or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 2 R27's admission Minimum Data Set (MDS) dated 6/5/18, indicated R27 was cognitively intact. R27's Diagnosis report provided 6/28/18, indicated R27 had diagnoses which included displaced intertrochanteric fracture of the left femur, acute respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues), and centrilobular and panlobular emphysema (irreversible lung diseases which consists of destruction of alveolar walls) R27's Admission Record provided 6/28/18, indicated R27 was admitted to the facility on 5/29/18, and the Advance Directive section indicated "resuscitate (CPR)" [cardiopulmonary resuscitation]. R27's Order Summary Report dated 6/27/18, included the following order: -Advance Directive: Resuscitate (CPR) dated 5/29/18. R27's Care Plan provided 6/28/18, did not address R27's preferences related to advance directive. R27's Social Service Assessment dated 6/26/18, indicated R27 was able to make her own decisions. On 6/27/18, at 9:56 a.m. the licensed social worker (LSW) indicated the facility policy for advance directives as well as the Physician Order for Life Sustaining Treatment (POLST) information was provided to residents upon admission. LSW indicated R27 declined completing a POLST at the time of admission as	F 578	of correction is prepared and/ or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F578 Request/ Refuse/ Discontinue Treatment/ Formulate Advance Directives 1. R27 has been discharged from the facility. 2. All residents have been reviewed to ensure Code Status and preference for Advance Directives has been documented appropriately. 3. Director of Nursing or designee will provide re-education on the Good Samaritan Society Policy and Procedure for Advance Care Planning and Advance Directives to all Licensed Nursing Staff to ensure resident preferences for advance directives and code status are appropriately addressed and documented. 4. Licensed Social Worker or designee will conduct auditing process by chart review for every new admission for three months to ensure resident preferences for advance directive and code status are appropriately addressed and documented. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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	245476	A. BUILDING _____ B. WING _____	06/28/2018

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F 578	Continued From page 3 she had stated she was planning to discharge to home. --At 10:11 a.m. R27 confirmed she had spoken with the social worker upon her admission to the facility. R27 indicated she had established a living will 15 years ago and named two hospitals which she stated had copies of the living will. R27 stated her daughter had a copy of her living will and she had a copy herself, at home. R27 believed she had told the facility about it. R27 stated she did not want to be put on life support in the event of a health emergency. Review of R27 medical record revealed no evidence of R27's living will/advance directive. --At 12:21 p.m. LSW stated she did not remember if R27 had indicated she had an advance directive upon admission, however, indicated she interviewed for this during the admission process and it was her practice to request a copy. LSW indicated she would do her best to get a copy at the time of a resident's admission and stated if it was not in Resident Spaces (the facility's document imaging system), they probably did not have a copy of it. --At 1:42 p.m. family member (FA)-A confirmed R27 had a living will. FA-A stated she had been with R27 at the time of her admission to the facility and indicated no representative of the facility had requested a copy of R27's living will. FM-A stated she was not certain exactly what R27's living will contained, but did know R27 did not want to be kept alive if there was no chance of recovery or if she would be hugely disabled in the event of an emergency.	F 578	5. 8/3/2018	

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F 578	Continued From page 4 On 6/28/18, at 10:26 a.m. the director of nursing (DON) confirmed the facility should have obtained a copy of R27's living will to ensure her preferences were identified and carried out in the event of an emergency.	F 578		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii) §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman	F 583		8/3/18

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F 583	Continued From page 5 to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff and visitors to view for 3 of 6 residents (R5, R2, R16) observed to have private information posted in their rooms. Findings include: R5's care plan revised on 6/8/18, indicated R5 had impaired cognitive function related to dementia evidenced by inability to make needs known, behaviors, and was dependent on staff for mobility and activities of daily living. R5 required total assistance of two staff for transfers with a mechanical lift and large lift sling. R5's Care plan printed on 6/27/18, indicated R5 was dependent on staff for mobility and activities of daily living (ADL). R5 required assist of two with a total lift and large lift sling. On 6/25/18, at 6:41 p.m. a white dry erase board was observed hanging above R5's head of the bed. Written on the board was the following which was visible to all who entered the room: -total lift with large sling. R2's care plan revised 3/19/18, indicated R2 had impaired cognition related to dementia and Parkinson's disease. R2 was dependent on staff for all mobility and activity of daily living needs. R2 required assist of two with a total lift with a	F 583	F583 Personal Privacy/ Confidentiality of Records 1. R5, R2 and R16□s private/ confidential information on white boards in these resident rooms has been removed. 2. All residents□ rooms that have confidential information on white boards has been removed. 3. Director of Nursing and Staff Development will provide re-education on Notice of Privacy Practices and ensuring confidential information is not viewable with licensed nurses, nursing assistants, and activity department employees. 4. Director of Nursing or designee will audit all white boards in resident rooms to ensure personal/ confidential information is not posted weekly times one month, then every other week for one month, then one time for one month. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018	

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F 583	Continued From page 6	F 583		

medium sling for transfers.

On 6/25/18, at 7:09 p.m. a white, dry erase board hung on the wall above R2's head of the bed. Written on the board was the following which was visible to all who entered the room:

-med sling full lift.

On 6/27/18, at 1:07 p.m. nursing assistant (NA)-A explained the white boards informed the staff of how to transfer, the resident and what size sling to use. NA-A agreed this information was available to anyone who entered the rooms. NA-A stated a care sheet was not used to provide the information regarding resident care needs. R16's quarterly Minimum Data Set (MDS) dated 5/2/18, indicated R16 was alert and orientated and had diagnoses including dementia, anxiety and depression. The MDS indicated R16 required extensive assist of one staff for activites of daily living.

On 6/25/18, at 7:45 p.m. and on 6/27/18, at 11:16 a.m. a white, dry erase board was observed hanging next to the bed in R16's room. The board revealed the following information which was visible to all who entered the room:

-AO1 for transfer/toilet

- At 11:17 a.m. registered nurse (RN)-A stated the abbreviations meant to assist of one for transfers and toilet use. RN-A confirmed the information was private information used to assist R16 with cares and it was readily available to all residents, staff and visitors to R16's room.

On 6/27/18, at 3:16 p.m. the director of nursing

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F 583	Continued From page 7 (DON) stated the facility had been using the white boards for the past three years or so. The DON indicated the facility had previous used slide boards called "hollisters", however at some point the facility changed to the white boards. The DON confirmed the information on the white boards was personal care information for the specific resident in the room and all visitors did not need access to that information. The DON stated the facility could find an alternative method of sharing care information with the staff. The Notice of Privacy Practices policy dated 9/2013, indicated the facility was required to keep medical information about residents private and secure.	F 583		
F 655 SS=D	Baseline Care Plan CFR(s): 483.21(a)(1)-(3) §483.21 Comprehensive Person-Centered Care Planning §483.21(a) Baseline Care Plans §483.21(a)(1) The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must- (i) Be developed within 48 hours of a resident's admission. (ii) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to- (A) Initial goals based on admission orders. (B) Physician orders. (C) Dietary orders. (D) Therapy services. (E) Social services.	F 655		8/3/18

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F 655	Continued From page 8 (F) PASARR recommendation, if applicable. §483.21(a)(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan- (i) Is developed within 48 hours of the resident's admission. (ii) Meets the requirements set forth in paragraph (b) of this section (excepting paragraph (b)(2)(i) of this section). §483.21(a)(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to: (i) The initial goals of the resident. (ii) A summary of the resident's medications and dietary instructions. (iii) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility. (iv) Any updated information based on the details of the comprehensive care plan, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a baseline care plan was developed, implemented and a copy was given to the resident and/or representative within 48 hours of admission which addressed the individualized needs for 1 of 1 resident (R28) recently admitted to the facility. Findings include: R28's admission Minnimum Data Set (MDS) dated 6/6/18, indicated R28 was alert and oriented and had diagnoses including multiple pelvic fractures, vertebral fractures, sleep apnea	F 655	F655 Baseline Care Plan 1. On 7/18/19 the RN Unit Manager reviewed and provided a copy of the Care Plan to R28. 2. On 7/19/2018, current resident records of those admitted after November 28, 2018 were reviewed to ensure that a baseline care plan was given/ documented. If there is not documentation in Point Click Care that a baseline care plan had been given to the resident/ representative, the medical records were	

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F 655	Continued From page 9 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. R28's admission orders dated 5/20/18, included orders for the following medications: -Albuterol Sulfate Nebulizer 2.5 milligrams (mg)/3 milliliters (ml) every four hours as needed -Baclofen 10 mg tablets three times a day (TID) -Celexa 20 mg twice a day -Ice Bags as needed for pain -Klonopin 1 mg three times per day -Lidoderm Patch 5% to back once a day -Lopressor 50 mg twice a day -Proventil inhaler one puff as needed once a day -Oxycodone 5 mg every four hours as needed for pain -Tylenol 500 mg two tablets every hour hours as needed for pain. R28's initial Care Plan dated 5/31/18, indicated R28 had been admitted to the facility on 5/30/18. The initial care plan included a focus, goals and interventions for the following areas: - limited physical mobility. - activity of daily living. - risk for falls - oxygen therapy - nutritional concerns - risk for skin integrity concerns - discharge plan On 6/25/18, at 5:40 p.m. R28 stated he could not recall ever receiving a copy of his care plan. R28 stated when he was first admitted to the facility,	F 655	reviewed to ensure that a care conference/ care plan review has occurred since admission. 3. Director of Nursing and Staff Development will provide re-education for all nursing staff on developing a baseline care plan within 48 hours and documentation that the baseline care plan was reviewed and a written copy for resident and/or representative was provided per Good Samaritan Society Policy & Procedure and Federal Regulation. 4. Director of Nursing/ Designee will audit medical records in Point Click Care for documentation that baseline care plan was given to all new admissions for 3 months. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018.	

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F 655	Continued From page 10 he was very ill and the facility may have given a copy to his fiance but he could not recall. On 6/27/18, at 12:40 p.m. registered nurse (RN)-B stated upon admission, the staff reviewed the activity of daily living needs with each resident, however, she was unaware of the residents being given a copy of the initial care plan within 48 hours of admission. RN-B added if a resident wanted a copy of the initial care plan, they would have to fill out a release of information form prior to obtaining a copy. To RN-B's knowledge, R28 had not requested a copy of the care plan. On 6/27/18, at 3:00 p.m. the director of nurses (DON) stated the facility was working on the process to ensure the residents' received a copy of the initial care plan within 48 hours of admission. The residents did not need to fill out a release of information form to receive a copy of the plan, however, the facility was still working on the process. The DON stated R28 would not have received a copy of the initial care plan, as required. The Comprehensive Care Plan and Care Conference policy dated 2/2018, directed the staff to develop a care plan within 24 hours and to provide a summary of the care plan to the resident or representative. The staff were to document in the medical record after the summary had been given to the resident or representative.	F 655		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities.	F 679		8/3/18

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F 679	Continued From page 11 §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess resident centered activity preferences and develop individualized interventions for 1 of 2 residents (R28) reviewed for activities. Findings include: R28's admission Minnimum Data Set (MDS) dated 6/6/18, indicated R28 was alert and oriented and had diagnoses including multiple pelvic fractures, vertebral fracture and a left acetabulum fracture (socket portion of the "ball and socket" of the left hip). 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 assessment indicated it was very important for R28 to interact with family/friends and it was very important to be around animals. The Activities of Daily Living Care Area Assessment (CAA) dated 6/6/18, indicated R28 was unable to bear weight on his legs due to extensive pelvic fractures and pain. R28 was bedridden.	F 679	F679: 1. R28 is receiving an individualized activity program that meets his preferences. 2. All residents were observed to ensure that they are receiving individualized activity preferences per the Activity Data Collection Tool. 3. Staff Development and Activity Director will re-educate activity staff on the importance of identifying resident activity preferences on an on-going basis and implementing activities to meet those preferences. Staff Development and Activity Director will re-educate activity staff on the importance of documentation of attendance and refusal of individualized activities. 4. Activity Director or Designee will complete Interview/Observation audits on R28 and 7 random residents weekly times 4 weeks and monthly times two months. Audit results will be reviewed by the QAPI	

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F 679	Continued From page 12 The Mood CAA dated 6/6/18, indicated R28 was depressed following a severe accident and was struggling to cope with his lack of independence. The severe pain from his injuries affected his ability to participate in activities he enjoyed. R28's Activity Interest Data Collection Tool dated 6/1/18, indicated R28 enjoyed hunting and fishing, watching television, Bingo, animals, and traveling. The assessment indicated R28 was able to make his own decision and was unable to transfer, ambulate or use a wheelchair. The Data Collection Tool did not include an assessment of how the facility would provide activities for R28. R28's Care Plan dated 6/1/18, indicated R28 had multiple fractures due to an accident. He was able to participate in one to one conversations, 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. 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.	F 679	Committee for further recommendations. 5. 8/3/2018	

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F 679	Continued From page 13	F 679		

- From 5:00 p.m. to 8:00 p.m. R28 was observed to remain in his room, in bed, with the door closed.

On 6/26/18, at 12:41 p.m. R28 stated he had watched more television in the past five weeks than he had in his entire life. R28 stated occasionally he was able to find a movie, but he was tired of game shows and the news.

On 6/27/18, at 7:54 a.m. R28 was observed eating breakfast in bed. R28 stated his fiance and dog would be visiting the facility soon and he was looking forward to seeing them.

On 6/27/18, at 12:27 p.m. R28 stated his fiance had left the facility but she would be back tomorrow and until then, he would be bored. R28 stated the staff members visited, came in to give him medications, assisted with cares, and delivered his meals. However, none of the staff members visited with him for any period of time. When asked if he had been offered alternative things to do in his room, R28 stated 'no" he just watched television, played on his computer or waited for the phone to ring.

- At 12:52 p.m. registered nurse (RN)-B stated R28 was bedridden and could not go to activities. RN-B stated R28's fiance visited him daily, he watched television and played on his computer. RN-B stated R28 preferred to keep the window shades closed and the door closed at all times. He would talk to the staff when they assisted him, but he did not participate in other activities.

Review of the Activity Documentation report dated 6/2018, indicated R28 had participated in 19 activities, however, the type of activity could not

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 679	Continued From page 14	F 679		

be determined from the documention.

Review of the Activity Progress Notes included a single note dated 6/1/18, which indicated R28 was confined to bed, watched television, was unable to read at this time due to inability to focus on the words. The note indicated R28 was unable to attend any type of group activities.

On 6/28/18, at 8:20 a.m the activity director (AD) stated R28 had been at the facility for approximately five weeks. Upon review of the activity documentation, the AD stated the 19 activities R28 participated in were when his fiance visited and not when the staff were providing activities for/with him. R28 spent his days with his fiance, watching television or playing on the computer. The AD stated R28 had not received one to one visits from the activity staff as he had not requested the visits. The AD confirmed R28 was a younger person and indicated 2-4 hours of family visits may be enough for an elderly person, however, it was not enough for a younger person. The AD stated the activity staff were in his room each day to drop of the morning activity calendar/menu paper, but they did not stay and visit with him. The AD confirmed R28 had not received an individualized activity program and the staff were dependent upon his family/friends to provide activities for him. The AD stated R28 had "gotten lost" in our day to day activities and a structured activity program had not been established for R28.

The One to One Activity Interventions policy dated 8/2015, directed staff to provide a one to one structured activity for individual resident that focused on needs, abilities , strength and interests during a staff to resident one to one

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

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F 679	Continued From page 15 situation. The policy directed staff to consider one to one interventions for a resident who was involved in a rehabilitation program and was focused on going home.	F 679		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to maintain and/or prevent further decline in ROM abilities for 4 of 4 residents (R3, R7, R16, R15) who had limitations in ROM and had not received ROM services according to their individualized assessed need. Findings include:	F 688	F688 Increase/ Prevent Decrease in ROM/ Mobility 1. R3, R7, R16, and R15 are receiving range of motion services according to individualized assessed need assessments were reviewed for accuracy, and necessary updates will be reflected on assessment. 2. All residents on ROM services are	8/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 16 R3's quarterly Minimum Data Set (MDS) dated 3/23/18, indicated R3 displayed moderate cognitive impairment and had diagnoses including diabetes mellitus and dementia. The MDS indicated R3 required extensive assistance with activites of daily living (ADLs) and was unable to ambulate. R3 did have functional limitations of ROM in the lower extremities. R3's significant change MDS dated 9/25/17, identified the same information as the quarterly MDS dated 3/23/18. R3's Activity of daily living Care Area Assessment (CAA) dated 9/28/17, indicated R3 was working with therapy but was not participating well or making progress with the therapy. R3's Care plan dated 9/26/17, indicated R3 required restorative interventions due to limited physical mobility. The plan directed R3 to participate in a functional maintenance program (FMP) up to three times per week. The program included: - NURSING REHAB #1: AAROM [active range of motion] to bilateral shoulder in all planes 10 reps up to 3 times per week. Do not range shoulder past 90 degrees for shoulder flex. - NURSING REHAB #2: Should blade squeezes, 5 repetitions up to three times per week - NURSING REHAB #3: Outward rotation with red theraband and shoulders snuggled up, 10 repetitions x 3 sets up to three times per week. - NURSING REHAB #4: Bilateral straight leg raises, 15 reps up to three items per week. - NURSING REHAB #5: Bilateral hip abductions, 15 repetitions up to three times per week. - NURSING REHAB #6: Bridges, 15 repetitions up to three times per week.	F 688	receiving range of motion services according to their individualized assessed needs. Restorative assessments were reviewed for accuracy, and any necessary updates will be reflected on assessment. 3. Director of Nursing/ Staff Development will re-educate all Nursing Assistants on how to provide range of motion services to ensure that ROM will be completed according to residents individualized assessed needs. 4. Director of Nursing/ Designee will observe/audit the medical record documentation of ROM services provided to 7 random residents weekly times three months to ensure services are being provided. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 17	F 688		

-NURSING REHAB #7: hamstring/heel cord stretches, 2 repetitions each foot x 30 second hold up to three times per week.

On 6/25/18, at 6:25 p.m. R3 stated his shoulders were stiff and he had not been able to walk in a year or so. R3 stated that he did participate in an exercise program.

During the survey conducted on 6/25/18, from 1:00 p.m. to 8:00 p.m., on 6/26/18, from 8:00 a.m. to 4:30 p.m., on 6/27/18, from 7:00 a.m. to 3:30 p.m. and on 6/28/18, from 8:00 a.m. to 1:30 p.m. R3 was not observed to participate in a restorative exercise program.

-Review of R3's restorative nursing flowsheet documentation revealed the following:

April 2018:
-nursing rehab #1- R3 participated in the exercises on 2 of 16 opportunities.
-nursing rehab #2- R3 participated in the exercises on 3 of 16 opportunities.
-nursing rehab #3- R3 participated in the exercises on 2 of 16 opportunities.
-nursing rehab # 4- R3 participated in the exercises on 3 of 16 opportunities.
-nursing rehab #5- R3 participated in the exercises on 3 of 16 opportunities.
-nursing rehab #6- R3 participated in the exercises on 1 of 16 opportunities.
-nursing rehab #7 - R3 participated in the exercises on 3 of 16 opportunities.

May 2018: no data was recorded.

June 2018:
-nursing rehab #1- R3 participated in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 18	F 688		

exercises on 6 of 16 opportunities.
-nursing rehab #2- R3 participated in the exercises on 6 of 16 opportunities.
-nursing rehab #3- R3 participated in the exercises on 6 of 16 opportunities.
-nursing rehab # 4- R3 participated in the exercises on 6 of 16 opportunities.
-nursing rehab #5- R3 participated in the exercises on 6 of 16 opportunities.
-nursing rehab #6- R3 participated in the exercises on 6 of 16 opportunities.
-nursing rehab #7 - R3 participated in the exercises on 6 of 16 opportunities

On 6/26/18, at 12:50 p.m. nursing assistant (NA)-B stated she completed the restorative programs for R3 earlier in the morning. NA-B stated she was to work at the facility four days a week as the restorative NA, however, she was frequently pulled to the floor to provide direct care instead of providing restorative services. NA-B stated she attempted to get all of the restorative programs done, however, was unable to due working the floor. NA-B stated the next two days, she would be providing direct care and not restorative programs.

On 6/27/18, at 9:10 a.m. registered nurse (RN)-A stated she provided oversite of the restorative program. RN-A stated when NA-B was reassigned to provide direct care, she was to assist to provide the ROM exercises, however, she too would also be reassigned to pass medications. RN-A stated, when both she and NA-B were providing direct care, the restorative programs were not completed. RN-A stated R3 was to participate in the restorative program up to three times a week, as directed by the care plan. Upon review of the restorative documentation,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 19	F 688		

RN-A confirmed R3 had not participated in the restorative program as directed by the care plan.

- At 11:27 a.m. RN-A cued R3 to lift his arms. R3 was observed to have limitations in both shoulders which prevented him from lifting his arms over his head. R3 stated his shoulders had been "frozen" for years and his ROM ability had not changed. R3 was observed to lift his legs and move them back and forth. R3 stated he could move his legs but he was not able to stand on them. RN-A confirmed R3 had limitations in his shoulder and had not received ROM services as directed by the care plan.

R7's quarterly MDS dated 4/9/18, indicated R7 was alert and oriented and had diagnoses including diabetes and schizoaffective disorder. The MDS indicated R7 required extensive assistance with bed mobility and transfers and required assistance of one to ambulate in her room and hallway. The assessment did not indicate R7 had any type of limitation in ROM.

R7's Care Plan dated 4/19/18, directed the staff to ambulate with a front wheeled walker. It also identified the following restorative nursing program:

-NURSING REHAB #1, Bilateral should shrugs. 5 repetitions up to 3 times per week.
-NURSING REHAB #2: AAROM to bilateral shoulder in all planes of normal joint movement 10 repetitions each up to three times per week.
-NURSING REHAB #3: Pull back with one pound dowel. Ten repetitions x 2 sets. Up to three times per week.
-NURSING REHAB: Ambulate with assist of one with front wheeled walker and wheelchair to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 20	F 688		

follow close behind twice a day. Goal 120 feet or as tolerates.

On 6/25/18, at 2:40 p.m. R7 stated she had not received assistance with ambulation as directed. R7 stated she was to walk twice a day every day, but she only received assistance to ambulate in the mornings Monday - Friday. R7 stated she was also to do exercises with her shoulders, except the nursing assistant assigned to restorative, was usually was pulled to provide direct care. R7 stated she did not routinely participate in the restorative program because the facility did not have enough staff.

-Review of R7's restorative nursing flowsheet documentation revealed the following:

April 2018:
-nursing rehab #1- R7 participated in the exercises on 4 of 16 opportunities.
-nursing rehab #2- R7 participated in the exercises on 4 of 16 opportunities.
-nursing rehab #3- R7 participated in the exercises on 4 of 16 opportunities.
-nursing rehab # 4-R7 ambulated 27 times out of 30 opportunities in the morning and 2 times out of 30 opportunities in the evening.

May 2018:
-nursing rehab #1- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #2- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #3- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab # 4-R7 ambulated 18 times out of 31 opportunities in the morning and 3 times out of 31 opportunities in the evening.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 21	F 688		

June 2018:
-nursing rehab #1- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #2- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #3- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab # 4-R7 ambulated 22 times out of 26 opportunities in the morning and 5 times out of 27 opportunities in the evening.

On 6/27/18, at 7:30 a.m. R7 stated she did not think she would be participating in her restorative program as NA-B was providing direct care. R7 stated sometimes she had time to help us with exercises, but sometimes she did not.

- At 11:00 am. RN-A ambulated R7 out of her room with a front wheeled walker. R7 was observed to ambulate 200 feet without difficulty.

-At 11:10 a.m. RN-A directed R7 to stretch her arm. R7 stated the left should had limitations in ROM for several years. R7 was observed to lift her left arm approximately half way up. R7 was not observed to have full ROM in the arm. RN-A confirmed R7 had limitations in the left shoulder.

-At 11:51 a.m. RN-A confirmed R7 had not been receiving ROM and ambulation services as directed by the care plan.

R16's quarterly MDS dated 5/2/18, identified R16 as being alert and oriented with diagnoses including atrial fibrillation and diabetes mellitus. The MDS indicated R16 required extensive assistance of one for activities of daily living and was able to ambulate in the hallway with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 22 extensive assistance. The MDS indicated R16 did not display functional ROM limitations. R16's Care Plan dated 4/19/18, indicated R16 was to participate in the following nursing rehab programs: -NURSING REHAB #1: AAROM to bilateral shoulders (has limited range in the right shoulder, use caution), five repetitions up to three times per week -NURSING REHAB #2: Bicep flexion with a two pound weight, 10 repetitions up to three times per week. -NURSING REHAB #3; Horizontal abduction/adduction with a one pound weight sung up elbow and push one pound across body, 10 repetitions x 2 sets, up to three times per week. -NURSING REHAB #4 Pull back with one pound dowel and red theraband 10 repetitions x 3 sets up to three times per week. -NURSING REHAB #5 while in bed: bilateral straight leg raises 15 repetitions up to 3 times per week -NURSING REHAB #6: while in bed bridges. 15 repetitions up to three times per week. -NURSING REHAB #7" While in bed: bilateral hip abductions. 15 repetitions up to three times per week. -NURSING REHAB #8: Bilateral hamstring/heel cord stretches 2 repetitions with second hold up to three times per week. -NURSING WALKING: Ambulate with assist of two with EZ walker and wheelchair to follow twice a day. Goal of 20 - 70 feet or as tolerates. On 6/25/18, at 7:45 p.m. R16 stated she was to receive assistance with ambulation twice a day,	F 688		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 23	F 688		

however, the facility did not have enough staff to assist her with ambulation, therefore, she had not walked in three days. R16 stated she liked to walk, however, they didn't have time. R16 also stated she was to participate in an exercise program but she had not received assistance with the program. R16 lifted her right arm with the left arm and stated her right arm was weak.

Review of R16's restorative nursing flowsheet documentation revealed the following:

April 2018:
-nursing rehab #1- #7 no data was available
-ambulation: R16 had ambulated four times in the morning and seven times in the evening. R16 had refused to participate in the program 29 times.

May 2018:
-nursing rehab #1- #7, R16 participated in the exercises on 1 of 16 opportunities.
-ambulation: R16 had ambulated 12 times in the morning and 12 times in the evening. R16 had refused to participate in the program 33 times.

June 2018:
-nursing rehab #1- #7: R16 participated in the exercises on four of 16 opportunities and had refused the program x 3.
-ambulation: R16 had ambulated eight times in the morning and four times in the evening. R16 had refused to participate in the program 40 times.

On 6/26/18, at 1:35 p.m. family member (FM)-B stated R16 was not assisted to walk enough. FM-B stated R16 had the ability to walk but there was not enough staff at the facility to ensure she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 24	F 688		

received the assistance to participate in the program. FM-B stated she would like to make sure R16 continued to ambulate.

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 toilet use and required extensive assist of two staff for bed mobility, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 688	Continued From page 25	F 688		

for all mobility and ADLs. She required a total lift for transfers, was non-ambulatory, and needed the total lift to sit up in bed. The CAA indicated R15 was at risk for contractures, increasing weakness, skin breakdown, and feelings of depression due to decreased independence.

R15's Care Plan provided 6/28/18, indicated R15 had a need for restorative intervention due to limited physical mobility related to multiple sclerosis and chronic back pain as evidenced by variable muscle weakness and decreased mobility. The care plan indicated R15 occasionally refused her FMP [functional maintenance program]. The care plan directed the following restorative interventions:

-NURSING REHAB #1: AAROM to bilateral shoulders in all planes of normal joint motion, 5 reps [repetitions] up to 3 times per week.
-NURSING REHAB #2: Squeeze yellow sponge with left hand, 10 reps up to 3 times per week
-NURSING REHAB #3: Squeeze red sponge with right hand, 10 reps up to 3 times per week
-NURSING REHAB #4: Left shoulder flex with green TheraBand (resistance band), 10 reps up to 3 times per week
-NURSING REHAB #5: Chest pulls with green TheraBand, 10 reps X 2 sets up to 3 times per week
-NURSING REHAB #7: Hip abduction/adduction with resistance, 10-20 reps (as tolerates) up to 3 times per week
-NURSING REHAB #8: Knee extensions with resident holding X 5 seconds, 10-20 reps (as tolerates) up to 3 times per week. Complete with rehab aide sitting in a chair and supporting resident's thigh up at a slight angle.
-NURSING REHAB #9: Resistive leg presses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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

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F 688	Continued From page 26 (with knee bent), 10-20 reps (as tolerates) up to 3 times per week. Complete with rehab sitting in a chair and supporting resident's thigh up at a slight angle. -NURSING REHAB #10: Heel cord stretch X up to 30 second hold, 1-2 reps up to 3 times per week. Complete with rehab aide sitting in a chair. (Do not combine with hamstring stretch) -NURSING REHAB #11: Hamstring stretch (knee extension with leg lift) X up to 30 second hold, 1-2 reps up to 3 times per week. Complete with rehab aide sitting in a chair. (Do not combine with heel cord stretch) On 6/25/18, at 5:48 p.m. R15 stated therapy was a joke. R15 stated she was supposed to work with ROM three times a week, however, had not received the services on a regular basis. R15 stated two weeks prior she had received ROM services on Monday and Tuesday and the previous week only received services on Tuesday. R15 stated the aid assigned to do it was often called to the floor because they didn't have enough help, therefore nobody got any type of therapy and the basic therapy was no longer done. R15 was able to lift her right arm but was unable to reach more than a few inches with her left arm. She stated her left arm was unable to move and she was only able to move her fingers of her left hand a little bit. R15 stated she had multiple sclerosis and was unable to walk. R15 was observed to have wraps to both of her lower legs and stated they were for edema. R15's Documentation Survey Report v2 dated April 2018, May 2018, and June 2018, revealed the following therapy was provided as follows: -June 2018: Completed x 3, Resident not	F 688		

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	245476	A. BUILDING _____ B. WING _____	06/28/2018

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F 688	Continued From page 27 available x 1, Blank x 22 -May 2018: Resident refused x 1, Completed x 2, Blank x 28 -April 2018: Resident refused x 2, Completed x 1, Blank x 27 On 6/28/18, at 9:01 a.m. R15's medical record was reviewed with RN-A who verified the above restorative participation documentation and stated the restorative aid was pulled to the floor to assist with resident cares therefore the service had not been provided. RN-A stated it was an issue the facility needed to fix. --At 10:11 a.m. R15 confirmed she had not received ROM services as directed and indicated she had only received ROM once this week. R15 stated she did not feel like she had experienced a decline but was about the same in her abilities. R15 stated she had good days and bad days related to her MS. --At 10:34 a.m. RN-A was observed to provide ROM services for R15. RN-A indicated she would not be able to do all of her exercises right now as R15 was in bed and some of the exercises were do be done while R15 sat up in a chair. R15 was observed to do sponge squeezes, left shoulder flexion exercises with a green band, chest pulls, AAROM to her shoulders and then hip adduction/abduction and leg presses. R15 tolerated the ROM well and denied pain. The Range of Motion and Ambulation policy dated 10/2017, directed the staff to provide ROM and ambulation as directed by the care plan and resident's ability.	F 688		

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F 695	Continued From page 28	F 695		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a continuous positive airway pressure (CPAP) machine was maintained in good repair and cleaned as directed for 1 of 1 resident (R28) who was to utilize a CPAP machine. Findings include: R28's admission Minnimum Data Set (MDS) dated 6/6/18, indicated R28 was alert and oriented and had diagnosis including multiple 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 MDS indicated R28 required the use of a CPAP machine daily. R28's Physican Order Summary Report dated 6/22/18, included an order for a CPAP machine to be utilized per home setting. The machine was to be placed on at bedtime and taken off in the	F 695	F695 Respiratory/ Tracheostomy Care and Suctioning 1. R28□s CPAP is being maintained and 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. 2. There are no other residents in the facility that require the use of a CPAP. 3. Director of Nursing will re-educate the Licensed Nurses and HIM on the Non-Invasive Respiratory Support Policy and Procedure. CPAP care directives will be added to R28□s Nursing Orders. 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	8/3/18

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F 695	Continued From page 29 morning. Review of R28's clinical record lacked documentation related to the use or care of the CPAP machine. R28's Care Plan dated 5/31/18, indicated R28 required the use of oxygen at time due to hisoty of respiratory failure. The plan directed the staff to apply oxygen as needed, however, the care plan did not address the use of a CPAP machine. On 6/25/18, at 5:13 p.m. a CPAP machine was observed on the bedside stand next to R28's bed. R28 stated he had been using the CPAP for several year and his fiance had brought it into the facility. R28 stated none of the staff members had washed the machine or assisted with the CPAP in any manner since coming to the facility. Upon inspection of the machine, the water reservoir was noted to have dried brown tinged residue on the inner aspect of the reservoir. The CPAP mask was noted to cover both the nose and mouth, however the edges of the mask were repaired with a 2-3 inch piece of electrical tape on both sides. The connection between the mask and the initial tubing was secured with black electrical tape and the connection between the initial tubing and the main tube of the CPAP was also held securely with black electrical tape. The velcro headgear used to hold the mask into place also had three areas of black electrical tape. R28 stated he had put the electrical tape on the mask and tubing to ensure they did not come apart during the night. The tape on the head gear was added because the headgear had stretched out and was not fitting correctly. R28 stated he had been using the same mask, headgear and tubing for years. While at home, R28 washed the CPAP	F 695	been cleaned 3 times per week for 2 weeks, then weekly for 4 weeks. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018.	

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F 695	Continued From page 30	F 695		

machine regularly, however, while at the facility, nobody had cleaned the machine.

On 6/26/18, at 1:50 p.m. nursing assistant (NA)-E stated R28 was able to put the CPAP machine on and off as he wished. NA-E stated she did not assist R28 with the CPAP machine.

On 6/27/18, at 7:40 a.m. the night shift NA-C stated R28 wore the CPAP machine when he wished and sometimes would wear it all night and other times he did not. NA-C stated R28 had not requested assistance with the CPAP machine.

-At 12:35 p.m. registered nurse (RN)-B stated R28's CPAP machine had been brought in from home and she did not know the machine was even in the building until she had to sign the electronic treatment record (ETAR) indicating it had been taken off in the morning. RN-B stated to her knowledge, the machine had never been inspected for proper function, the staff were not cleaning it and were only assisting R28 with is as he required. RN-B confirmed she had not observed the machine to ensure it was in good working order.

-At 1:05 p.m. RN-B inspected R28's CPAP machine. RN-B stated the mask and tubing was in need of replacement, the water reservoir was in need of cleaning and the headgear needed to be replaced. R28 stated he preferred to have distilled water added to the reservoir each night, however, he did not have access to the distilled water. RN-B stated the reservoir could be filled each night per his preference.

A copy of the manufacture instructions for the care and use of the CPAP was requested and

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F 695	Continued From page 31 none was provided. 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. On 6/28/18, at 8:55 a.m. R28 stated the staff had not assisted him with adding water the the humidifier and the machine had not yet been cleaned. The Non-Invasive Respirator Support policy dated 5/2016, indicated residents were able to utilize home CPAP devices. The systems were to be checked prior to use. Inspection of the tubing and connections was to be completed. The machines were to be cleaned at least once every two weeks.	F 695		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and	F 725		8/3/18

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F 725	Continued From page 32 diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement restorative nursing programs in accordance to the residents assessed need. This practice had the potential to affect all 23 residents who were to receive restorative nursing services. Findings include: See F688: The facility failed to provide range of motion (ROM) services in order to maintain and/or prevent further decline in ROM abilities for 4 of 4 residents (R3, R7, R16, R15) who had limitations in ROM and had not received ROM services according to their individualized assessed needs. Resident concerns:	F 725	F725 Sufficient Nursing Staffing 1. We are sufficiently staffed to ensure that R3, R7, R16, and R15 are receiving restorative nursing programs according to their assessed needs. 2. We are sufficiently staffed to ensure that all residents are receiving restorative nursing programs according to their assessed needs. 3. We are increasing the number of nursing staff that are now trained to provide ROM Services per Resident□s Care Plan□s. All resident□s restorative assessments will be reviewed for accuracy, and any necessary updates will be reflected on assessment. Completion	

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F 725	Continued From page 33 On 6/25/18, at 2:40 p.m. R7, an alert and orientated resident, stated she had not received assistance with ambulation as directed. R7 stated she was to walk twice a day every day, but she only received assistance to ambulate in the mornings Monday- Friday. R7 stated she was also to do exercises with her shoulders, except the nursing assistant assigned to restorative, usually was pulled to provide direct care. R7 stated she did not routinely participate in the restorative program because the facility did not have enough staff. -At 5:48 p.m. R15, an alert and orientated resident, stated therapy was a joke. R15 stated she was supposed to work with ROM three times a week, however, had not received the services on a regular basis. R15 stated two weeks prior she had received ROM services on Monday and Tuesday and the previous week only received services on that Tuesday. R15 stated the aid assigned to provide the services was often called to the floor because they did not have enough help, therefore nobody received any type of services. R15 stated the basic therapy was no longer done. R15 was able to lift her right arm but was unable to reach more than a few inches with her left arm. She stated her left arm was unable to move and she was only able to move her fingers of her left hand a little bit. R15 stated she had multiple sclerosis and was unable to walk. R15 was observed to have wraps to both of her lower legs and stated they were for edema. -At 6:25 p.m. R3, an alert and orientated resident, stated his shoulders were stiff and he had not been able to walk in a year or so. R3 stated that he did participate in an exercise program.	F 725	of ROM services will be monitored on an ongoing basis by Director of Nursing/ Designee to ensure completion of services per Care Plan. 4. Director of Nursing/ Designee will observe/audit the medical record documentation of ROM services provided to 7 random residents weekly times three months to ensure services are being provided. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018	

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F 725	Continued From page 34	F 725		

-At 7:45 p.m. R16, an alert and orientated resident, stated she was to receive assistance with ambulation twice a day, however, the facility did not have enough staff to assist her with ambulation, therefore, she had not walked in three days. R16 stated she liked to walk, however, the staff did not have the time. R16 also stated she was to participate in an exercise program but she had not received assistance with the program.

Family Concerns:

On 6/26/18, at 1:35 p.m. family member (FM)-B stated R16 was not assisted to walk enough. FM-B stated R16 had the ability to walk but there was not enough staff at the facility to ensure she received the assistance to participate in the waking program. FM-B stated she would like to make sure R16 continued to ambulate.

Staff concerns:

On 6/26/18, at 8:08 a.m. registered nurse (RN)-A stated the facility had a restorative aide scheduled to work 8 hours Monday - Thursday. RN-A stated if the restorative aide was pulled from restorative to provide direct care, then the restorative aide came to the facility on Friday to assist with the restorative programs. RN-A stated she provided oversite for the restorative program and assisted with providing the restorative programs as she was able.

On 6/26/18, at 12:50 p.m. nursing assistant (NA)-B stated she completed the restorative programs for the residents. NA-B stated she was to work at the facility four days a week as the

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F 725	Continued From page 35	F 725		

restorative NA, however, she was frequently pulled to the floor to provide direct care. NA-B stated the next two scheduled days, she would be providing direct care and not completing the restorative programs.

-At 1:48 p.m. NA-E stated the facility usually had enough staff to complete the basic cares, however, they did not have enough staff to ensure the restorative programs were provided to the residents. NA-E stated the restorative staff were pulled from restorative services in order to provide personal cares several times per week.

On 6/27/18, at 9:10 a.m. RN-A confirmed she provided oversite of the restorative program and stated when NA-B was reassigned to provide direct care, she was to assist to provide the ROM exercises. However, RN-A stated she too would be reassigned to pass resident medication therefore would not be able to provide the restorative serves. RN-A stated, when both she and NA-B were providing direct care, the restorative programs were not completed.

-At 12:04 p.m. the receptionist/staffing coordinator stated the facility was to have a restorative aide scheduled four days a week and that aide was allowed to pick an additional day if she had not completed all of the restorative programs during that four day time frame. The receptionist also stated the facility was to have three nursing assistants to provide direct cares during the day along with a bath aide and a restorative aide. However, the facility had been short direct care aides multiple times per week, therefore the restorative aide was pulled to provide direct care.

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F 725	Continued From page 36	F 725		

Review of the weekly restorative worksheet revealed the frequency of the restorative aide having been pulled from providing the services:

-Week of 4/20/18: NA-B was reassigned on one day.
-Week of 5/7/18: NA-B was ill for two days and was reassigned on one day.
-Week of 5/14/18: NA-B was reassigned two days, had a meeting one day and left early due to illness another day.
-Week of 5/21/18: NA-B was reassigned all or part of a shift all four days.
-week of 5/28/18: NA-B was reassigned two days and was off for holiday one day.
-Week of 6/4/18: NA-B was reassigned to provide direct care for two hours.
-Week of 6/11/18: NA-B was reassigned two days and was ill one day.
-Week of 6/18/18: NA-B was reassigned one day.

On 6/27/18, at 3:05 p.m. the director of nursing (DON) stated the resident care plans had been changed to direct the provision of restorative services to read up to three times a week, in case some weeks the staff did not have the time to complete the ROM services at least three times a week. The DON stated the facility expectation was for the restorative care to be done at least three times a week, but sometimes they were short staffed. The DON stated she was aware residents were not receiving the restorative programs as directed, however, basic resident care always came first. The DON confirmed the restorative aide was reassigned to the floor to provide direct care therefore sometimes the restorative exercises were not provided. The DON stated stated the facility was short of nursing assistants.

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F 725	Continued From page 37 The Nursing Services Staff policy dated 12/2015, directed the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, spiritual, mental and psychosocial well-being of each resident, as determined by the resident assessment and individual care plans.	F 725		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 761		8/3/18

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F 761	Continued From page 38 Based on observation, interview and document review, the facility failed to ensure medications were secured at all times in 1 of 2 medication carts used. This had the potential to affect 19 residents whose medications were stored in medication cart B. Findings include: During an observation on 6/25/18, at 7:25 p.m. medication cart B was observed unlocked and unattended with R4's vial of Lantus insulin and Systane solution eye drops laying on top of medication cart B, unsecured. At 7:29 p.m. licensed practical nurse (LPN)-A arrived at medication cart B from a resident's room at the end of the hall stating, "Oh, I left the cart unlocked, I had to answer a call light." On 6/25/18, at 7:31 p.m. LPN-A, stated "I'm sorry about the mess, leaving the cart unlocked and the medication on top." LPN - A went on to say she needed to answer a call light, and confirmed she should have put the mediations back in the medication cart and locked it prior to leaving the cart. LPN-A confirmed anyone walking though the hall could have had access to the mediation cart and its contents. On 6/28/18, at 10:19 a.m. the director of nursing (DON) stated the medication cart should have been locked and the medications should not have been left unattended. The facility provided Acquisition, Receiving, Dispensing and Storage of Medications Procedure revised 9/16, indicated medications would be stored in a locked medication cart, drawer or cupboard.	F 761	F761 Label/ Store Drugs and Biologicals 1. All medications are secure in medication cart B at all times per Good Samaritan Society Policy and Procedure Acquisition, Receiving, Dispensing and Storage of Medication. 2. All resident medications are secure in all medication carts at all times per Good Samaritan Society Policy and Procedure Acquisition, Receiving, Dispensing and Storage of Medication. 3. Director of Nursing provided education to the nurse on duty at the time. All Licensed Nurses will be re-educated on Good Samaritan Society Policy and Procedure Acquisition, Receiving, Dispensing and Storage of Medication. 4. Director of Nursing/ Designee will randomly audit through observation all medication carts ensuring that the carts are always secured per policy twice daily times two weeks, then weekly times six weeks, and one time per month times one month. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING _____ B. WING _____	06/28/2018

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F 838 SS=C	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures	F 838		8/3/18

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F 838	Continued From page 40 and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment of the facility needs to ensure an effective plan was in place to maintain the highest practicable care for all 31 residents residing at the facility. Findings include: Upon entrance to the facility on 6/25/18, at 1:00 p.m. the facility provided a copy of the facility assessment dated 4/6/18. During the course of the re-certification survey conducted on 6/25/18- 6/28/18, pattern level deficiencies were identified related to restorative	F 838	F838 Facility Assessment 1. The Facility Assessment includes the number of restorative staff members that are required to provide ROM services, the educational training, and how we will have sufficient resources to provide care to the residents. 2. The Facility Assessment includes the number of restorative staff members that are required to provide ROM services, the educational training, and how we will have sufficient resources to provide care to the residents.	

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F 838	Continued From page 41 nursing care which was not being provided due to insufficient staff (See F688 and F735) . Review of the Facility Assessment dated 4/6/18, revealed the facilty had identified multiple times in the assessment that they had the ability to provide residents residing at the facilty with restorative nursing programs. However, at no time in the assessment, did the facility identify the number of restorative staff members that were required to provide the aforementioned services, the educational training for restorative staff members or how they were to ensure they had sufficient resources to provide the care to the residents. The assessment indicated that the facility resources could be obtained from "Career Link and Tels" On 6/28/19, at 12:23 p.m. the administrator in training stated Career Link and Tels was not part of the facility assessment and confirmed the facility assessment did not identify the number of staff required to provide restorative care or how restorative care would be obtained for the residents. A policy related to the facilty assessment was requested and none was provided.	F 838	3. Administrator will re-educate all leaders on Good Samaritan Society Facility Assessment Policy & Procedure. 4. Administrator/ Designee will review the Facility Assessment to ensure that all requirements are met per Good Samaritan Society Facility Assessment Policy & Procedure. Facility Assessment will then be reviewed biannually and monitored through the QAPI Committee. 5. 8/3/18	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		8/3/18

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F 880	Continued From page 42 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable	F 880		

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F 880	Continued From page 43 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This 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). Findings include: On 6/25/18, at 7:29 p.m. licensed practical nurse (LPN)-A was observed to set up R4's medication which included Lantus insulin 40 units at bedtime. Without wiping the insulin vial with an alcohol pad, LPN-A obtained a syringe and inserted the needle into the rubber stopper of the vial, withdrew the insulin and proceeded to R4's room. LPN-A donned gloves and injected the Lantus into R4's right deltoid, without cleansing the skin with alcohol prior to the injection. LPN-A	F 880	F880 Infection Prevention and Control 1. R1 and R4 are receiving proper infection control techniques when receiving insulin. Licensed Nurses are using proper infection control techniques when preparing and administering insulin. 2. All residents receiving insulin have been observed to ensure nurses are using proper infection control techniques when preparing and administering their insulin. 3. Director of Nursing will provide re-education/ reminders to all licensed nurses on using proper infection control techniques when preparing and administering insulin.	

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F 880	Continued From page 44 removed her gloves, and without washing her hands proceeded to walk out of the room while touching the door knob of R4's room and the keys to the medication cart along with the drawers on the medication cart. On 6/25/18, at 7:45 p.m. LPN-A was observed to set up R1's medications which included Lantus insulin 8 units at bedtime. LPN-A drew up the Lantus injecting the needle into the insulin vial without wiping off the stopper with alcohol. LPN-A proceeded to was to R1's room, donned gloves and injected the Lantus into R1's left side of his abdomen without cleansing the skin with alcohol prior. Following the injection, LPN-A removed the gloves, and without washing her hands she touched the door knob, the keys to the medicaiton cart as well as the drawers to the cart as well as the mouse to the computer. On 6/25/18, at 7:55 p.m. LPN-A stated she tried not to wash her hands so much because her skin would break down. However, LPN-A confirmed employees hands should be washed after glove removal. When asked about wiping the rubber stopper with alcohol, she stated sometimes she did and thought using the alcohol wipe on the skin was preferred. On 6/28/18 at 10:19 a.m. the director of nursing (DON) confirmed the staff should wash their hands after glove removal, and also verified the rubber stopper on the insulin vials should have been swabbed with alcohol prior to inserting the needle and drawing up mediation. In addition, the DON stated the resident;s skin was also to be swabbed with an alcohol pad prior the the adminsitration of the injection.	F 880	4. Director of Nursing/ Designee through observation will audit insulin administration and aseptic technique on R4 and R1 and up to three other residents daily times one week, twice per week for three weeks, than monthly times two months. Audit results will be reviewed by the QAPI Committee for further recommendations. 5. 8/3/2018	

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F 880	Continued From page 45 The Procedure Injection-Subcutaneous revised 10/17, directed staff to cleanse the skin site with an antiseptic swab using circular motion, moving from center outward about two inches. Policy Injections dated 9/12, indicated injections would be administered to residents using sterile techniques and proper equipment. Procedure Hand Hygiene and Handwashing revised 1/18, indicated glove use required handwashing when donned and doffed.	F 880		

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	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**06/28/2018**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division. At the time of this survey, Good Samaritan Society Pine River was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY	K 000	EPOC	

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

Electronically Signed | 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.

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K 000	Continued From page 1 DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Inspected as one building: Good Samaritan Society of Pine River is a 1-story building with two basements. The building was constructed at five different times. In 1961 the nursing home was built and was determined to be of Type II(111) construction without a basement. In 1968 an addition was constructed to the north of the original building, that was determined to be of Type II(111) construction and has a basement. In 1985 an addition was constructed to the southwest of the 1961 building that was determined to be of Type II(111) construction and	K 000		

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K 000	Continued From page 2 has a partial basement. In 1993 an addition was constructed to the west of the 1985 addition that was determined to be of Type II(111) construction. In 1996 the last addition was added to the west of the 1993 addition that was determined to be of Type II(111) construction. The building is divided into 7 smoke zones by one and two hour fire barriers. The facility is separated by 2-hour fire barriers form an outpatient physical therapy building. The facility is fully fire sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, that is monitored for automatic fire department notification. The facility has a capacity of 50 beds and had a census of 31 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 321 SS=D	Hazardous Areas - Enclosure CFR(s): NFPA 101 Hazardous Areas - Enclosure Hazardous areas are protected by a fire barrier having 1-hour fire resistance rating (with 3/4 hour fire rated doors) or an automatic fire extinguishing system in accordance with 8.7.1 or 19.3.5.9. When the approved automatic fire extinguishing system option is used, the areas shall be separated from other spaces by smoke resisting partitions and doors in accordance with 8.4. Doors shall be self-closing or automatic-closing and permitted to have nonrated or field-applied protective plates that do not exceed 48 inches	K 321		8/3/18

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K 321	Continued From page 3 from the bottom of the door. Describe the floor and zone locations of hazardous areas that are deficient in REMARKS. 19.3.2.1, 19.3.5.9 Area Automatic Sprinkler Separation N/A a. Boiler and Fuel-Fired Heater Rooms b. Laundries (larger than 100 square feet) c. Repair, Maintenance, and Paint Shops d. Soiled Linen Rooms (exceeding 64 gallons) e. Trash Collection Rooms (exceeding 64 gallons) f. Combustible Storage Rooms/Spaces (over 50 square feet) g. Laboratories (if classified as Severe Hazard - see K322) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that the facility has failed to provide proper protection for 1 of several hazardous areas located throughout the facility in accordance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.3.2.1. This deficient conditions could in the event of a fire, allow smoke and flames to spread throughout the effected corridors and areas making them untenable, which could negatively affect 10 of 50 residents as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 06/28/2018, observations revealed the door to the soiled utility room that is located in the Birch wing across from resident room 209 has a door	K 321	1. Door to the soiled utility room that is located in the Birch Wing across from Resident Room 209 has been adjusted to fully close and latch into the frame per regulation. All other necessary doors have been observed when closing and adjusted if needed. Maintenance technician has been re-educated on the requirement regarding doors fully latching. To ensure that the correction is sustained, our maintenance technician or designee will conduct audits on all necessary doors to ensure that they latch appropriately. This will be done bi-weekly times two months, then monthly times two months. Audit results will be reviewed by the QAPI Committee for further recommendations. 2. 8/3/18	

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K 321	Continued From page 4 that did not fully close and latch into the frame at the time of the inspection. This deficient condition was confirmed by a Maintenance Staff Member.	K 321	3. Tonya Ehlers Administrator in Training	
K 923 SS=F	Gas Equipment - Cylinder and Container Storag CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet Storage locations are outdoors in an enclosure or within an enclosed interior space of non- or limited- combustible construction, with door (or gates outdoors) that can be secured. Oxidizing gases are not stored with flammables, and are separated from combustibles by 20 feet (5 feet if sprinklered) or enclosed in a cabinet of noncombustible construction having a minimum 1/2 hr. fire protection rating. Less than or equal to 300 cubic feet In a single smoke compartment, individual cylinders available for immediate use in patient care areas with an aggregate volume of less than or equal to 300 cubic feet are not required to be stored in an enclosure. Cylinders must be handled with precautions as specified in 11.6.2. A precautionary sign readable from 5 feet is on each door or gate of a cylinder storage room, where the sign includes the wording as a minimum "CAUTION: OXIDIZING GAS(ES) STORED WITHIN NO SMOKING." Storage is planned so cylinders are used in order of which they are received from the supplier.	K 923		8/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245476	A. BUILDING **01 - 1985 BUILDING AND ADDITIONS** B. WING _____	**06/28/2018**

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**

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K 923	Continued From page 5 Empty cylinders are segregated from full cylinders. When facility employs cylinders with integral pressure gauge, a threshold pressure considered empty is established. Empty cylinders are marked to avoid confusion. Cylinders stored in the open are protected from weather. 11.3.1, 11.3.2, 11.3.3, 11.3.4, 11.6.5 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, that the oxygen storage room was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012. This deficient practice could create an oxygen enriched atmosphere that could contribute to rapid fire growth. This could negatively affect 20 of 50 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 10:00 a.m. to 2:00 p.m. on 06/28/2018, observations revealed that in the oxygen storage room the oxygen cylinders were not separated by full and empty at the time of the inspection. This deficient condition was confirmed by a Maintenance Staff Member.	K 923	1. Signs have been placed in oxygen storage room to clearly separate full and empty oxygen cylinders. Second oxygen storage room in building was observed and corrected with signs to ensure proper separation of full and empty oxygen cylinders. All staff whom have access to oxygen storage rooms will be educated on the regulation regarding oxygen storage and the importance of placing cylinders on the appropriate side of the room. To ensure that the correction is sustained, our maintenance technician or designee will conduct audits on both oxygen storage rooms to ensure that signs specifying full and empty are still in place and oxygen cylinders are being placed on appropriate sides of the room. These audits will be done weekly times two months, then monthly times two months. Audit results will be reviewed by the QAPI Committee for further recommendations. 2. 8/3/18 3. Tonya Ehlers Administrator in Training	

DEPARTMENT OF HEALTH

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 only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm . 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.

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.

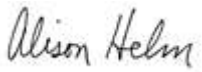
THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00058	A. BUILDING: _____ B. WING _____	06/28/2018

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On June 25 - June 28, 2018, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	
2 800	MN Rule 4658.0510 Subp. 1 Nursing Personnel; Staffing requirements Subpart 1. Staffing requirements. A nursing home must have on duty at all times a sufficient number of qualified nursing personnel, including registered nurses, licensed practical nurses, and nursing assistants to meet the needs of the residents at all nurses' stations, on all floors, and in all buildings if more than one building is involved. This includes relief duty, weekends, and vacation replacements.	2 800		8/3/18

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2 800	Continued From page 2 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was available in order to implement restorative nursing programs in accordance to the residents assessed need. This practice had the potential to affect all 23 residents who were to receive restorative nursing services. Findings include: See F688: The facility failed to provide range of motion (ROM) services in order to maintain and/or prevent further decline in ROM abilities for 4 of 4 residents (R3, R7, R16, R15) who had limitations in ROM and had not received ROM services according to their individualized assessed needs. Resident concerns: On 6/25/18, at 2:40 p.m. R7, an alert and orientated resident, stated she had not received assistance with ambulation as directed. R7 stated she was to walk twice a day every day, but she only received assistance to ambulate in the mornings Monday- Friday. R7 stated she was also to do exercises with her shoulders, except the nursing assistant assigned to restorative, usually was pulled to provide direct care. R7 stated she did not routinely participate in the restorative program because the facility did not have enough staff. -At 5:48 p.m. R15, an alert and orientated resident, stated therapy was a joke. R15 stated she was supposed to work with ROM three times a week, however, had not received the services on a regular basis. R15 stated two weeks prior	2 800	Licensing orders corrected.	

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2 800	Continued From page 3	2 800		

she had received ROM services on Monday and Tuesday and the previous week only received services on that Tuesday. R15 stated the aid assigned to provide the services was often called to the floor because they did not have enough help, therefore nobody received any type of services. R15 stated the basic therapy was no longer done. R15 was able to lift her right arm but was unable to reach more than a few inches with her left arm. She stated her left arm was unable to move and she was only able to move her fingers of her left hand a little bit. R15 stated she had multiple sclerosis and was unable to walk. R15 was observed to have wraps to both of her lower legs and stated they were for edema.

-At 6:25 p.m. R3, an alert and orientated resident, stated his shoulders were stiff and he had not been able to walk in a year or so. R3 stated that he did participate in an exercise program.

-At 7:45 p.m. R16, an alert and orientated resident, stated she was to receive assistance with ambulation twice a day, however, the facility did not have enough staff to assist her with ambulation, therefore, she had not walked in three days. R16 stated she liked to walk, however, the staff did not have the time. R16 also stated she was to participate in an exercise program but she had not received assistance with the program.

Family Concerns:

On 6/26/18, at 1:35 p.m. family member (FM)-B stated R16 was not assisted to walk enough. FM-B stated R16 had the ability to walk but there was not enough staff at the facility to ensure she received the assistance to participate in the waking program. FM-B stated she would like to

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2 800	Continued From page 4 make sure R16 continued to ambulate. Staff concerns: On 6/26/18, at 8:08 a.m. registered nurse (RN)-A stated the facility had a restorative aide scheduled to work 8 hours Monday - Thursday. RN-A stated if the restorative aide was pulled from restorative to provide direct care, then the restorative aide came to the facility on Friday to assist with the restorative programs. RN-A stated she provided oversite for the restorative program and assisted with providing the restorative programs as she was able. On 6/26/18, at 12:50 p.m. nursing assistant (NA)-B stated she completed the restorative programs for the residents. NA-B stated she was to work at the facility four days a week as the restorative NA, however, she was frequently pulled to the floor to provide direct care. NA-B stated the next two scheduled days, she would be providing direct care and not completing the restorative programs. -At 1:48 p.m. NA-E stated the facility usually had enough staff to complete the basic cares, however, they did not have enough staff to ensure the restorative programs were provided to the residents. NA-E stated the restorative staff were pulled from restorative services in order to provide personal cares several times per week. On 6/27/18, at 9:10 a.m. RN-A confirmed she provided oversite of the restorative program and stated when NA-B was reassigned to provide direct care, she was to assist to provide the ROM exercises. However, RN-A stated she too would be reassigned to pass resident medication therefore would not be able to provide the	2 800		

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2 800	Continued From page 5	2 800		

restorative serves. RN-A stated, when both she and NA-B were providing direct care, the restorative programs were not completed.

-At 12:04 p.m. the receptionist/staffing coordinator stated the facility was to have a restorative aide scheduled four days a week and that aide was allowed to pick an additional day if she had not completed all of the restorative programs during that four day time frame. The receptionist also stated the facility was to have three nursing assistants to provide direct cares during the day along with a bath aide and a restorative aide. However, the facility had been short direct care aides multiple times per week, therefore the restorative aide was pulled to provide direct care.

Review of the weekly restorative worksheet revealed the frequency of the restorative aide having been pulled from providing the services:

-Week of 4/20/18: NA-B was reassigned on one day.
-Week of 5/7/18: NA-B was ill for two days and was reassigned on one day.
-Week of 5/14/18: NA-B was reassigned two days, had a meeting one day and left early due to illness another day.
-Week of 5/21/18: NA-B was reassigned all or part of a shift all four days.
-week of 5/28/18: NA-B was reassigned two days and was off for holiday one day.
-Week of 6/4/18: NA-B was reassigned to provide direct care for two hours.
-Week of 6/11/18: NA-B was reassigned two days and was ill one day.
-Week of 6/18/18: NA-B was reassigned one day.

On 6/27/18, at 3:05 p.m. the director of nursing

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2 800	Continued From page 6 (DON) stated the resident care plans had been changed to direct the provision of restorative services to read up to three times a week, in case some weeks the staff did not have the time to complete the ROM services at least three times a week. The DON stated the facility expectation was for the restorative care to be done at least three times a week, but sometimes they were short staffed. The DON stated she was aware residents were not receiving the restorative programs as directed, however, basic resident care always came first. The DON confirmed the restorative aide was reassigned to the floor to provide direct care therefore sometimes the restorative exercises were not provided. The DON stated stated the facility was short of nursing assistants. The Nursing Services Staff policy dated 12/2015, directed the facility to have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, spiritual, mental and psychosocial well-being of each resident, as determined by the resident assessment and individual care plans. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure sufficient nurse staffing was available to complete restorative programs for residents who required restorative programs. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 800		

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2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a continuous positive airway pressure (CPAP) machine was maintained in good repair and cleaned as directed for 1 of 1 resident (R28) who was to utilize a CPAP machine. Findings include: R28's admission Minnimum Data Set (MDS) dated 6/6/18, indicated R28 was alert and oriented and had diagnosis including multiple 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 MDS indicated R28 required the use of a CPAP machine daily.	2 830	Licensing orders corrected.	8/3/18

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2 830	Continued From page 8 R28's Physican Order Summary Report dated 6/22/18, included an order for a CPAP machine to be utilized per home setting. The machine was to be placed on at bedtime and taken off in the morning. Review of R28's clinical record lacked documentation related to the use or care of the CPAP machine. R28's Care Plan dated 5/31/18, indicated R28 required the use of oxygen at time due to hisoty of respiratory failure. The plan directed the staff to apply oxygen as needed, however, the care plan did not address the use of a CPAP machine. On 6/25/18, at 5:13 p.m. a CPAP machine was observed on the bedside stand next to R28's bed. R28 stated he had been using the CPAP for several year and his fiance had brought it into the facility. R28 stated none of the staff members had washed the machine or assisted with the CPAP in any manner since coming to the facility. Upon inspection of the machine, the water reservoir was noted to have dried brown tinged residue on the inner aspect of the reservoir. The CPAP mask was noted to cover both the nose and mouth, however the edges of the mask were repaired with a 2-3 inch piece of electrical tape on both sides. The connection between the mask and the initial tubing was secured with black electrical tape and the connection between the initial tubing and the main tube of the CPAP was also held securely with black electrical tape. The velcro headgear used to hold the mask into place also had three areas of black electrical tape. R28 stated he had put the electrical tape on the mask and tubing to ensure they did not come apart during the night. The tape on the head gear was	2 830		

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2 830	Continued From page 9	2 830		

added because the headgear had stretched out and was not fitting correctly. R28 stated he had been using the same mask, headgear and tubing for years. While at home, R28 washed the CPAP machine regularly, however, while at the facility, nobody had cleaned the machine.

On 6/26/18, at 1:50 p.m. nursing assistant (NA)-E stated R28 was able to put the CPAP machine on and off as he wished. NA-E stated she did not assist R28 with the CPAP machine.

On 6/27/18, at 7:40 a.m. the night shift NA-C stated R28 wore the CPAP machine when he wished and sometimes would wear it all night and other times he did not. NA-C stated R28 had not requested assistance with the CPAP machine.

-At 12:35 p.m. registered nurse (RN)-B stated R28's CPAP machine had been brought in from home and she did not know the machine was even in the building until she had to sign the electronic treatment record (ETAR) indicating it had been taken off in the morning. RN-B stated to her knowledge, the machine had never been inspected for proper function, the staff were not cleaning it and were only assisting R28 with is as he required. RN-B confirmed she had not observed the machine to ensure it was in good working order.

-At 1:05 p.m. RN-B inspected R28's CPAP machine. RN-B stated the mask and tubing was in need of replacement, the water reservoir was in need of cleaning and the headgear needed to be replaced. R28 stated he preferred to have distilled water added to the reservoir each night, however, he did not have access to the distilled water. RN-B stated the reservoir could be filled each night per his preference.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00058	A. BUILDING: _____ B. WING _____	06/28/2018

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2 830	Continued From page 10 A copy of the manufacture instructions for the care and use of the CPAP was requested and none was provided. 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. On 6/28/18, at 8:55 a.m. R28 stated the staff had not assisted him with adding water the the humidifier and the machine had not yet been cleaned. The Non-Invasive Respirator Support policy dated 5/2016, indicated residents were able to utilize home CPAP devices. The systems were to be checked prior to use. Inspection of the tubing and connections was to be completed. The machines were to be cleaned at least once every two weeks. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to continuous positive airway pressure (CPAP) machines and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.	2 830		

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2 830	Continued From page 11 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide range of motion (ROM) services in order to maintain and/or prevent further decline in ROM abilities for 4 of 4 residents (R3, R7, R16, R15) who had limitations in ROM and had not received ROM services according to their individualized assessed need. Findings include: R3's quarterly Minimum Data Set (MDS) dated 3/23/18, indicated R3 displayed moderate cognitive impairment and had diagnoses including diabetes mellitus and dementia. The MDS indicated R3 required extensive assistance	2 895	Licensing orders corrected.	8/3/18

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2 895	Continued From page 12	2 895		

with activites of daily living (ADLs) and was unable to ambulate. R3 did have functional limitations of ROM in the lower extremities. R3's significant change MDS dated 9/25/17, identified the same information as the quarterly MDS dated 3/23/18.

R3's Activity of daily living Care Area Assessment (CAA) dated 9/28/17, indicated R3 was working with therapy but was not participating well or making progress with the therapy.

R3's Care plan dated 9/26/17, indicated R3 required restorative interventions due to limited physical mobility. The plan directed R3 to participate in a functional maintenance program (FMP) up to three times per week. The program included:

- NURSING REHAB #1: AAROM [active range of motion] to bilateral shoulder in all planes 10 reps up to 3 times per week. Do not range shoulder past 90 degrees for shoulder flex.
- NURSING REHAB #2: Should blade squeezes, 5 repetitions up to three times per week
- NURSING REHAB #3: Outward rotation with red theraband and shoulders snuggled up, 10 repetitions x 3 sets up to three times per week.
- NURSING REHAB #4: Bilateral straight leg raises, 15 reps up to three items per week.
- NURSING REHAB #5: Bilateral hip abductions, 15 repetitions up to three times per week.
- NURSING REHAB #6: Bridges, 15 repetitions up to three times per week.
-NURSING REHAB #7: hamstring/heel cord stretches, 2 repetitions each foot x 30 second hold up to three times per week.

On 6/25/18, at 6:25 p.m. R3 stated his shoulders were stiff and he had not been able to walk in a

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2 895	Continued From page 13 year or so. R3 stated that he did participate in an exercise program. During the survey conducted on 6/25/18, from 1:00 p.m. to 8:00 p.m., on 6/26/18, from 8:00 a.m. to 4:30 p.m., on 6/27/18, from 7:00 a.m. to 3:30 p.m. and on 6/28/18, from 8:00 a.m. to 1:30 p.m. R3 was not observed to participate in a restorative exercise program. -Review of R3's restorative nursing flowsheet documentation revealed the following: April 2018: -nursing rehab #1- R3 participated in the exercises on 2 of 16 opportunities. -nursing rehab #2- R3 participated in the exercises on 3 of 16 opportunities. -nursing rehab #3- R3 participated in the exercises on 2 of 16 opportunities. -nursing rehab # 4- R3 participated in the exercises on 3 of 16 opportunities. -nursing rehab #5- R3 participated in the exercises on 3 of 16 opportunities. -nursing rehab #6- R3 participated in the exercises on 1 of 16 opportunities. -nursing rehab #7 - R3 participated in the exercises on 3 of 16 opportunities. May 2018: no data was recorded. June 2018: -nursing rehab #1- R3 participated in the exercises on 6 of 16 opportunities. -nursing rehab #2- R3 participated in the exercises on 6 of 16 opportunities. -nursing rehab #3- R3 participated in the exercises on 6 of 16 opportunities. -nursing rehab # 4- R3 participated in the exercises on 6 of 16 opportunities.	2 895		

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2 895	Continued From page 14 -nursing rehab #5- R3 participated in the exercises on 6 of 16 opportunities. -nursing rehab #6- R3 participated in the exercises on 6 of 16 opportunities. -nursing rehab #7 - R3 participated in the exercises on 6 of 16 opportunities On 6/26/18, at 12:50 p.m. nursing assistant (NA)-B stated she completed the restorative programs for R3 earlier in the morning. NA-B stated she was to work at the facility four days a week as the restorative NA, however, she was frequently pulled to the floor to provide direct care instead of providing restorative services. NA-B stated she attempted to get all of the restorative programs done, however, was unable to due working the floor. NA-B stated the next two days, she would be providing direct care and not restorative programs. On 6/27/18, at 9:10 a.m. registered nurse (RN)-A stated she provided oversite of the restorative program. RN-A stated when NA-B was reassigned to provide direct care, she was to assist to provide the ROM exercises, however, she too would also be reassigned to pass medications. RN-A stated, when both she and NA-B were providing direct care, the restorative programs were not completed. RN-A stated R3 was to participate in the restorative program up to three times a week, as directed by the care plan. Upon review of the restorative documentation, RN-A confirmed R3 had not participated in the restorative program as directed by the care plan. - At 11:27 a.m. RN-A cued R3 to lift his arms. R3 was observed to have limitations in both shoulders which prevented him from lifting his arms over his head. R3 stated his shoulders had been "frozen" for years and his ROM ability had	2 895		

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2 895	Continued From page 15	2 895		

not changed. R3 was observed to lift his legs and move them back and forth. R3 stated he could move his legs but he was not able to stand on them. RN-A confirmed R3 had limitations in his shoulder and had not received ROM services as directed by the care plan.

R7's quarterly MDS dated 4/9/18, indicated R7 was alert and oriented and had diagnoses including diabetes and schizoaffective disorder. The MDS indicated R7 required extensive assistance with bed mobility and transfers and required assistance of one to ambulate in her room and hallway. The assessment did not indicate R7 had any type of limitation in ROM.

R7's Care Plan dated 4/19/18, directed the staff to ambulate with a front wheeled walker. It also identified the following restorative nursing program:

-NURSING REHAB #1, Bilateral should shrugs. 5 repetitions up to 3 times per week.
-NURSING REHAB #2: AAROM to bilateral shoulder in all planes of normal joint movement 10 repetitions each up to three times per week.
-NURSING REHAB #3: Pull back with one pound dowel. Ten repetitions x 2 sets. Up to three times per week.
-NURSING REHAB: Ambulate with assist of one with front wheeled walker and wheelchair to follow close behind twice a day. Goal 120 feet or as tolerates.

On 6/25/18, at 2:40 p.m. R7 stated she had not received assistance with ambulation as directed. R7 stated she was to walk twice a day every day, but she only received assistance to ambulate in the mornings Monday - Friday. R7 stated she was also to do exercises with her shoulders,

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2 895	Continued From page 16	2 895		

except the nursing assistant assigned to restorative, was usually was pulled to provide direct care. R7 stated she did not routinely participate in the restorative program because the facility did not have enough staff.

-Review of R7's restorative nursing flowsheet documentation revealed the following:

April 2018:
-nursing rehab #1- R7 participated in the exercises on 4 of 16 opportunities.
-nursing rehab #2- R7 participated in the exercises on 4 of 16 opportunities.
-nursing rehab #3- R7 participated in the exercises on 4 of 16 opportunities.
-nursing rehab # 4-R7 ambulated 27 times out of 30 opportunities in the morning and 2 times out of 30 opportunities in the evening.

May 2018:
-nursing rehab #1- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #2- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #3- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab # 4-R7 ambulated 18 times out of 31 opportunities in the morning and 3 times out of 31 opportunities in the evening.

June 2018:
-nursing rehab #1- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #2- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab #3- R7 participated in the exercises on 7 of 16 opportunities.
-nursing rehab # 4-R7 ambulated 22 times out of 26 opportunities in the morning and 5 times out of

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2 895	Continued From page 17 27 opportunities in the evening. On 6/27/18, at 7:30 a.m. R7 stated she did not think she would be participating in her restorative program as NA-B was providing direct care. R7 stated sometimes she had time to help us with exercises, but sometimes she did not. - At 11:00 am. RN-A ambulated R7 out of her room with a front wheeled walker. R7 was observed to ambulate 200 feet without difficulty. -At 11:10 a.m. RN-A directed R7 to stretch her arm. R7 stated the left should had limitations in ROM for several years. R7 was observed to lift her left arm approximately half way up. R7 was not observed to have full ROM in the arm. RN-A confirmed R7 had limitations in the left shoulder. -At 11:51 a.m. RN-A confirmed R7 had not been receiving ROM and ambulation services as directed by the care plan. R16's quarterly MDS dated 5/2/18, identified R16 as being alert and oriented with diagnoses including atrial fibrillation and diabetes mellitus. The MDS indicated R16 required extensive assistance of one for activities of daily living and was able to ambulate in the hallway with extensive assistance. The MDS indicated R16 did not display functional ROM limitations. R16's Care Plan dated 4/19/18, indicated R16 was to participate in the following nursing rehab programs: -NURSING REHAB #1: AAROM to bilateral shoulders (has limited range in the right shoulder, use caution), five repetitions up to three times per week	2 895		

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2 895	Continued From page 18 -NURSING REHAB #2: Bicep flexion with a two pound weight, 10 repetitions up to three times per week. -NURSING REHAB #3; Horizontal abduction/adduction with a one pound weight sung up elbow and push one pound across body, 10 repetitions x 2 sets, up to three times per week. -NURSING REHAB #4 Pull back with one pound dowel and red theraband 10 repetitions x 3 sets up to three times per week. -NURSING REHAB #5 while in bed: bilateral straight leg raises 15 repetitions up to 3 times per week -NURSING REHAB #6: while in bed bridges. 15 repetitions up to three times per week. -NURSING REHAB #7" While in bed: bilateral hip abductions. 15 repetitions up to three times per week. -NURSING REHAB #8: Bilateral hamstring/heel cord stretches 2 repetitions with second hold up to three times per week. -NURSING WALKING: Ambulate with assist of two with EZ walker and wheelchair to follow twice a day. Goal of 20 - 70 feet or as tolerates. On 6/25/18, at 7:45 p.m. R16 stated she was to receive assistance with ambulation twice a day, however, the facility did not have enough staff to assist her with ambulation, therefore, she had not walked in three days. R16 stated she liked to walk, however, they didn't have time. R16 also stated she was to participate in an exercise program but she had not received assistance with the program. R16 lifted her right arm with the left arm and stated her right arm was weak. Review of R16's restorative nursing flowsheet documentation revealed the following:	2 895		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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2 895	Continued From page 19 April 2018: -nursing rehab #1- #7 no data was available -ambulation: R16 had ambulated four times in the morning and seven times in the evening. R16 had refused to participate in the program 29 times. May 2018: -nursing rehab #1- #7, R16 participated in the exercises on 1 of 16 opportunities. -ambulation: R16 had ambulated 12 times in the morning and 12 times in the evening. R16 had refused to participate in the program 33 times. June 2018: -nursing rehab #1- #7: R16 participated in the exercises on four of 16 opportunities and had refused the program x 3. -ambulation: R16 had ambulated eight times in the morning and four times in the evening. R16 had refused to participate in the program 40 times. On 6/26/18, at 1:35 p.m. family member (FM)-B stated R16 was not assisted to walk enough. FM-B stated R16 had the ability to walk but there was not enough staff at the facility to ensure she received the assistance to participate in the program. FM-B stated she would like to make sure R16 continued to ambulate. 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.	2 895		

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2 895	Continued From page 20 -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 toilet use and required extensive assist of two staff for bed mobility, 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 for all mobility and ADLs. She required a total lift for transfers, was non-ambulatory, and needed the total lift to sit up in bed. The CAA indicated R15 was at risk for contractures, increasing weakness, skin breakdown, and feelings of depression due to decreased independence. R15's Care Plan provided 6/28/18, indicated R15 had a need for restorative intervention due to limited physical mobility related to multiple sclerosis and chronic back pain as evidenced by variable muscle weakness and decreased mobility. The care plan indicated R15	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 895	Continued From page 21 occasionally refused her FMP [functional maintenance program]. The care plan directed the following restorative interventions: -NURSING REHAB #1: AAROM to bilateral shoulders in all planes of normal joint motion, 5 reps [repetitions] up to 3 times per week. -NURSING REHAB #2: Squeeze yellow sponge with left hand, 10 reps up to 3 times per week -NURSING REHAB #3: Squeeze red sponge with right hand, 10 reps up to 3 times per week -NURSING REHAB #4: Left shoulder flex with green TheraBand (resistance band), 10 reps up to 3 times per week -NURSING REHAB #5: Chest pulls with green TheraBand, 10 reps X 2 sets up to 3 times per week -NURSING REHAB #7: Hip abduction/adduction with resistance, 10-20 reps (as tolerates) up to 3 times per week -NURSING REHAB #8: Knee extensions with resident holding X 5 seconds, 10-20 reps (as tolerates) up to 3 times per week. Complete with rehab aide sitting in a chair and supporting resident's thigh up at a slight angle. -NURSING REHAB #9: Resistive leg presses (with knee bent), 10-20 reps (as tolerates) up to 3 times per week. Complete with rehab sitting in a chair and supporting resident's thigh up at a slight angle. -NURSING REHAB #10: Heel cord stretch X up to 30 second hold, 1-2 reps up to 3 times per week. Complete with rehab aide sitting in a chair. (Do not combine with hamstring stretch) -NURSING REHAB #11: Hamstring stretch (knee extension with leg lift) X up to 30 second hold, 1-2 reps up to 3 times per week. Complete with rehab aide sitting in a chair. (Do not combine with heel cord stretch)	2 895		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00058	A. BUILDING: _____ B. WING _____	06/28/2018

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2 895	Continued From page 22 On 6/25/18, at 5:48 p.m. R15 stated therapy was a joke. R15 stated she was supposed to work with ROM three times a week, however, had not received the services on a regular basis. R15 stated two weeks prior she had received ROM services on Monday and Tuesday and the previous week only received services on Tuesday. R15 stated the aid assigned to do it was often called to the floor because they didn't have enough help, therefore nobody got any type of therapy and the basic therapy was no longer done. R15 was able to lift her right arm but was unable to reach more than a few inches with her left arm. She stated her left arm was unable to move and she was only able to move her fingers of her left hand a little bit. R15 stated she had multiple sclerosis and was unable to walk. R15 was observed to have wraps to both of her lower legs and stated they were for edema. R15's Documentation Survey Report v2 dated April 2018, May 2018, and June 2018, revealed the following therapy was provided as follows: -June 2018: Completed x 3, Resident not available x 1, Blank x 22 -May 2018: Resident refused x 1, Completed x 2, Blank x 28 -April 2018: Resident refused x 2, Completed x 1, Blank x 27 On 6/28/18, at 9:01 a.m. R15's medical record was reviewed with RN-A who verified the above restorative participation documentation and stated the restorative aid was pulled to the floor to assist with resident cares therefore the service had not been provided. RN-A stated it was an issue the facility needed to fix. --At 10:11 a.m. R15 confirmed she had not	2 895		

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2 895	Continued From page 23 received ROM services as directed and indicated she had only received ROM once this week. R15 stated she did not feel like she had experienced a decline but was about the same in her abilities. R15 stated she had good days and bad days related to her MS. --At 10:34 a.m. RN-A was observed to provide ROM services for R15. RN-A indicated she would not be able to do all of her exercises right now as R15 was in bed and some of the exercises were do be done while R15 sat up in a chair. R15 was observed to do sponge squeezes, left shoulder flexion exercises with a green band, chest pulls, AAROM to her shoulders and then hip adduction/abduction and leg presses. R15 tolerated the ROM well and denied pain. The Range of Motion and Ambulation policy dated 10/2017, directed the staff to provide ROM and ambulation as directed by the care plan and resident's ability. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for range of motion and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 895		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program	21375		8/3/18

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21375	Continued From page 24 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). Findings include: On 6/25/18, at 7:29 p.m. licensed practical nurse (LPN)-A was observed to set up R4's medication which included Lantus insulin 40 units at bedtime. Without wiping the insulin vial with an alcohol pad, LPN-A obtained a syringe and inserted the needle into the rubber stopper of the vial, withdrew the insulin and proceeded to R4's room. LPN-A donned gloves and injected the Lantus into R4's right deltoid, without cleansing the skin with alcohol prior to the injection. LPN-A removed her gloves, and without washing her hands proceeded to walk out of the room while touching the door knob of R4's room and the keys to the medication cart along with the drawers on the medication cart. On 6/25/18, at 7:45 p.m. LPN-A was observed to set up R1's medications which included Lantus insulin 8 units at bedtime. LPN-A drew up the Lantus injecting the needle into the insulin vial without wiping off the stopper with alcohol. LPN-A proceeded to was to R1's room, donned	21375	Licensing orders corrected.	

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21375	Continued From page 25	21375		

gloves and injected the Lantus into R1's left side of his abdomen without cleansing the skin with alcohol prior. Following the injection, LPN-A removed the gloves, and without washing her hands she touched the door knob, the keys to the medicaiton cart as well as the drawers to the cart as well as the mouse to the computer.

On 6/25/18, at 7:55 p.m. LPN-A stated she tried not to wash her hands so much because her skin would break down. However, LPN-A confirmed employees hands should be washed after glove removal. When asked about wiping the rubber stopper with alcohol, she stated sometimes she did and thought using the alcohol wipe on the skin was preferred.

On 6/28/18 at 10:19 a.m. the director of nursing (DON) confirmed the staff should wash their hands after glove removal, and also verified the rubber stopper on the insulin vials should have been swabbed with alcohol prior to inserting the needle and drawing up mediation. In addition, the DON stated the resident;s skin was also to be swabbed with an alcohol pad prior the the adminsitration of the injection.

The Procedure Injection-Subcutaneous revised 10/17, directed staff to cleanse the skin site with an antiseptic swab using circular motion, moving from center outward about two inches.

Policy Injections dated 9/12, indicated injections would be administered to residents using sterile techniques and proper equipment.

Procedure Hand Hygiene and Handwashing revised 1/18, indicated glove use required handwashing when donned and doffed.

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21375	Continued From page 26 SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for infection control practices and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21375		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess resident centered activity preferences and develop individualized interventions for 1 of 2 residents (R28) reviewed for activities.	21435	Licensing orders corrected.	8/3/18

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21435	Continued From page 27 Findings include: R28's admission Minnimum Data Set (MDS) dated 6/6/18, indicated R28 was alert and oriented and had diagnoses including multiple pelvic fractures, vertebral fracture and a left acetabulum fracture (socket portion of the "ball and socket" of the left hip). 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 assessment indicated it was very important for R28 to interact with family/friends and it was very important to be around animals. The Activities of Daily Living Care Area Assessment (CAA) dated 6/6/18, indicated R28 was unable to bear weight on his legs due to extensive pelvic fractures and pain. R28 was bedridden. The Mood CAA dated 6/6/18, indicated R28 was depressed following a severe accident and was struggling to cope with his lack of independence. The severe pain from his injuries affected his ability to participate in activities he enjoyed. R28's Activity Interest Data Collection Tool dated 6/1/18, indicated R28 enjoyed hunting and fishing, watching television, Bingo, animals, and traveling. The assessment indicated R28 was able to make his own decision and was unable to transfer, ambulate or use a wheelchair. The Data Collection Tool did not include an assessment of how the facility would provide activities for R28. R28's Care Plan dated 6/1/18, indicated R28 had multiple fractures due to an accident. He was able to participate in one to one conversations,	21435		

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21435	Continued From page 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.

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.

- From 5:00 p.m. to 8:00 p.m. R28 was observed to remain in his room, in bed, with the door closed.

On 6/26/18, at 12:41 p.m. R28 stated he had watched more television in the past five weeks than he had in his entire life. R28 stated occasionally he was able to find a movie, but he was tired of game shows and the news.

On 6/27/18, at 7:54 a.m. R28 was observed eating breakfast in bed. R28 stated his fiance and dog would be visiting the facility soon and he was looking forward to seeing them.

On 6/27/18, at 12:27 p.m. R28 stated his fiance had left the facility but she would be back tomorrow and until then, he would be bored. R28 stated the staff members visited, came in to give him medications, assisted with cares, and

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21435	Continued From page 29	21435		

delivered his meals. However, none of the staff members visited with him for any period of time. When asked if he had been offered alternative things to do in his room, R28 stated 'no" he just watched television, played on his computer or waited for the phone to ring.

- At 12:52 p.m. registered nurse (RN)-B stated R28 was bedridden and could not go to activities. RN-B stated R28's fiance visited him daily, he watched television and played on his computer. RN-B stated R28 preferred to keep the window shades closed and the door closed at all times. He would talk to the staff when they assisted him, but he did not participate in other activities.

Review of the Activity Documentation report dated 6/2018, indicated R28 had participated in 19 activities, however, the type of activity could not be determined from the documention.

Review of the Activity Progress Notes included a single note dated 6/1/18, which indicated R28 was confined to bed, watched television, was unable to read at this time due to inability to focus on the words. The note indicated R28 was unable to attend any type of group activities.

On 6/28/18, at 8:20 a.m the activity director (AD) stated R28 had been at the facility for approximately five weeks. Upon review of the activity documentation, the AD stated the 19 activities R28 participated in were when his fiance visited and not when the staff were providing activities for/with him. R28 spent his days with his fiance, watching television or playing on the computer. The AD stated R28 had not received one to one visits from the activity staff as he had not requested the visits. The AD confirmed R28 was a younger person and indicated 2-4 hours of

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21435	Continued From page 30 family visits may be enough for an elderly person, however, it was not enough for a younger person. The AD stated the activity staff were in his room each day to drop of the morning activity calendar/menu paper, but they did not stay and visit with him. The AD confirmed R28 had not received an individualized activity program and the staff were dependent upon his family/friends to provide activities for him. The AD stated R28 had "gotten lost" in our day to day activities and a structured activity program had not been established for R28. The One to One Activity Interventions policy dated 8/2015, directed staff to provide a one to one structured activity for individual resident that focused on needs, abilities , strength and interests during a staff to resident one to one situation. The policy directed staff to consider one to one interventions for a resident who was involved in a rehabilitation program and was focused on going home. SUGGESTED METHODS OF CORRECTION: The activity director or designee could develop, review, and /or revise policies and procedures for individualized activities and provide education to the staff. The activity director or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home	21610		8/3/18

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21610	Continued From page 31 must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medications were secured at all times in 1 of 2 medication carts used. This had the potential to affect 19 residents whose medications were stored in medication cart B. Findings include: During an observation on 6/25/18, at 7:25 p.m. medication cart B was observed unlocked and unattended with R4's vial of Lantus insulin and Systane solution eye drops laying on top of medication cart B, unsecured. At 7:29 p.m. licensed practical nurse (LPN)-A arrived at medication cart B from a resident's room at the end of the hall stating, "Oh, I left the cart unlocked, I had to answer a call light." On 6/25/18, at 7:31 p.m. LPN-A, stated "I'm sorry about the mess, leaving the cart unlocked and the medication on top." LPN - A went on to say she needed to answer a call light, and confirmed she should have put the mediations back in the medication cart and locked it prior to leaving the cart. LPN-A confirmed anyone walking though the hall could have had access to the mediation cart and its contents. On 6/28/18, at 10:19 a.m. the director of nursing (DON) stated the medication cart should have been locked and the medications should not have been left unattended.	21610	Licensing orders corrected.	

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21610	Continued From page 32 The facility provided Acquisition, Receiving, Dispensing and Storage of Medications Procedure revised 9/16, indicated medications would be stored in a locked medication cart, drawer or cupboard. SUGGESTED METHODS OF CORRECTION: The DON or designee could develop, review, and /or revise policies and procedures for medication storage and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21610		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record.	21840		8/3/18

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21840	Continued From page 33 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to identify the preference for Health Care Directives for 1 of 1 resident (R27) reviewed for advanced directives. Findings include: R27's admission Minimum Data Set (MDS) dated 6/5/18, indicated R27 was cognitively intact. R27's Diagnosis report provided 6/28/18, indicated R27 had diagnoses which included displaced intertrochanteric fracture of the left femur, acute respiratory failure with hypoxia (deficiency in the amount of oxygen reaching the tissues), and centrilobular and panlobular emphysema (irreversible lung diseases which consists of destruction of alveolar walls) R27's Admission Record provided 6/28/18, indicated R27 was admitted to the facility on 5/29/18, and the Advance Directive section indicated "resuscitate (CPR)" [cardiopulmonary resuscitation]. R27's Order Summary Report dated 6/27/18, included the following order: -Advance Directive: Resuscitate (CPR) dated 5/29/18. R27's Care Plan provided 6/28/18, did not address R27's preferences related to advance directive. R27's Social Service Assessment dated 6/26/18, indicated R27 was able to make her own decisions.	21840	Licensing orders corrected.	

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21840	Continued From page 34 On 6/27/18, at 9:56 a.m. the licensed social worker (LSW) indicated the facility policy for advance directives as well as the Physician Order for Life Sustaining Treatment (POLST) information was provided to residents upon admission. LSW indicated R27 declined completing a POLST at the time of admission as she had stated she was planning to discharge to home. --At 10:11 a.m. R27 confirmed she had spoken with the social worker upon her admission to the facility. R27 indicated she had established a living will 15 years ago and named two hospitals which she stated had copies of the living will. R27 stated her daughter had a copy of her living will and she had a copy herself, at home. R27 believed she had told the facility about it. R27 stated she did not want to be put on life support in the event of a health emergency. Review of R27 medical record revealed no evidence of R27's living will/advance directive. --At 12:21 p.m. LSW stated she did not remember if R27 had indicated she had an advance directive upon admission, however, indicated she interviewed for this during the admission process and it was her practice to request a copy. LSW indicated she would do her best to get a copy at the time of a resident's admission and stated if it was not in Resident Spaces (the facility's document imaging system), they probably did not have a copy of it. --At 1:42 p.m. family member (FA)-A confirmed R27 had a living will. FA-A stated she had been with R27 at the time of her admission to the facility and indicated no representative of the	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00058	A. BUILDING: _____ B. WING _____	06/28/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21840	Continued From page 35 facility had requested a copy of R27's living will. FM-A stated she was not certain exactly what R27's living will contained, but did know R27 did not want to be kept alive if there was no chance of recovery or if she would be hugely disabled in the event of an emergency. On 6/28/18, at 10:26 a.m. the director of nursing (DON) confirmed the facility should have obtained a copy of R27's living will to ensure her preferences were identified and carried out in the event of an emergency. SUGGESTED METHODS OF CORRECTION: The DON or designee could develop, review, and /or revise policies and procedures for advanced directives and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21840		
21860	MN St. Statute 144.651 Subd. 16 Patients & Residents of HC Fac.Bill of Rights Subd. 16. Confidentiality of records. Patients and residents shall be assured confidential treatment of their personal and medical records, and may approve or refuse their release to any individual outside the facility. Residents shall be notified when personal records are requested by any individual outside the facility and may select someone to accompany them when the records or information are the subject of a personal	21860		8/3/18

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21860	Continued From page 36 interview. Copies of records and written information from the records shall be made available in accordance with this subdivision and section 144.335. This right does not apply to complaint investigations and inspections by the Department of Health, where required by third party payment contracts, or where otherwise provided by law. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure confidential information was not readily available for all residents, staff and visitors to view for 3 of 6 residents (R5, R2, R16) observed to have private information posted in their rooms. Findings include: R5's care plan revised on 6/8/18, indicated R5 had impaired cognitive function related to dementia evidenced by inability to make needs known, behaviors, and was dependent on staff for mobility and activities of daily living. R5 required total assistance of two staff for transfers with a mechanical lift and large lift sling. R5's Care plan printed on 6/27/18, indicated R5 was dependent on staff for mobility and activities of daily living (ADL). R5 required assist of two with a total lift and large lift sling. On 6/25/18, at 6:41 p.m. a white dry erase board was observed hanging above R5's head of the bed. Written on the board was the following which was visible to all who entered the room:	21860	Licensing orders corrected.	

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21860	Continued From page 37 -total lift with large sling. R2's care plan revised 3/19/18, indicated R2 had impaired cognition related to dementia and Parkinson's disease. R2 was dependent on staff for all mobility and activity of daily living needs. R2 required assist of two with a total lift with a medium sling for transfers. On 6/25/18, at 7:09 p.m. a white, dry erase board hung on the wall above R2's head of the bed. Written on the board was the following which was visible to all who entered the room: -med sling full lift. On 6/27/18, at 1:07 p.m. nursing assistant (NA)-A explained the white boards informed the staff of how to transfer, the resident and what size sling to use. NA-A agreed this information was available to anyone who entered the rooms. NA-A stated a care sheet was not used to provide the information regarding resident care needs. R16's quarterly Minimum Data Set (MDS) dated 5/2/18, indicated R16 was alert and orientated and had diagnoses including dementia, anxiety and depression. The MDS indicated R16 required extensive assist of one staff for activites of daily living. On 6/25/18, at 7:45 p.m. and on 6/27/18, at 11:16 a.m. a white, dry erase board was observed hanging next to the bed in R16's room. The board revealed the following information which was visible to all who entered the room: -AO1 for transfer/toilet	21860		

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21860	Continued From page 38 - At 11:17 a.m. registered nurse (RN)-A stated the abbreviations meant to assist of one for transfers and toilet use. RN-A confirmed the information was private information used to assist R16 with cares and it was readily available to all residents, staff and visitors to R16's room. On 6/27/18, at 3:16 p.m. the director of nursing (DON) stated the facility had been using the white boards for the past three years or so. The DON indicated the facility had previous used slide boards called "hollisters", however at some point the facility changed to the white boards. The DON confirmed the information on the white boards was personal care information for the specific resident in the room and all visitors did not need access to that information. The DON stated the facility could find an alternative method of sharing care information with the staff. The Notice of Privacy Practices policy dated 9/2013, indicated the facility was required to keep medical information about residents private and secure. SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures for personal privacy and provide education to the staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21860		