MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

July 18, 2017

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

Subject: Good Samaritan Society - Bethany - IDR
Provider # 245500
Project # S5500027

Dear Mr. Cerney:

This is in response to your letter of March 3, 2017, in regard to your request of an informal dispute resolution (IDR) for the federal deficiency at tag F431 issued pursuant to the survey event G24W11, completed on February 9, 2017.

The information presented with your letter, the CMS 2567 dated February 9, 2017 and corresponding Plan of Correction, as well as survey documents and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

S/S-D
F431 (E) §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.

The facility asserts their Pharmacy prepared electronically dispensed medication packets for resident use which meets the minimum required information as set forth in F431. The facility asserts the prepackaged medications labeling met the requirements set forth in accordance with currently accepted professional standards such as those set for by Minnesota State Pharmacy Board Rules 6800.3200 Prepackaging and Labeling.

Summary of facts: During an observation of a medication pass on 2/6/17 at 6:14 p.m., licensed practical nurse (LPN)-A prepared medications for R60. R60's medications were retrieved from medication pouches that had been filled by an electronic medication dispensing unit. The first medication pouch label included the resident's name, date of dispensing, evening, and Percocet tablet 5-325 milligrams (mg) and Coumadin 1.5 milligrams (mg) orally daily, description of the medication (i.e.., medication is white and round with number 203 on it), the prescription number, the

name of the pharmacy and name of physician. However, the route of administration was not identified on the packet. The second medication pouch label included the same information: resident name, date and "evening" along with Sinemet 25-100 mg tablet and metformin 500 mg tablet, with a description of the medications, prescription number, physician and pharmacy name. The route of administration was not identified.

During the survey, the facility had provided surveyors with their policy Medication Ordering and Receiving from Pharmacy, Medication Labels dated 6/15. Under letter M of the policy was the following information: "Labels from automated dispensing units placed in the facility must comply with State Board of Pharmacy requirements. At a minimum, the package labeling from automated devices must contain the following:

1) Name of resident
2) Name of medication as ordered
3) Expiration date

Summary of findings: Following review of the CMS 2567, review of additional information received from the facility, and discussion with MDH survey staff, it is determined the facility's automated medication pouch labels meet the minimum required labeling requirements in accordance with the Minnesota Board of Pharmacy rules and the facility policy/procedure.

This is not a valid example of a deficient practice under this regulation and the findings will be removed from the CMS 2567 Statement of Deficiencies. In addition, MN Rule 4658.1345 will be removed from the State Licensure Form.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Gary Nederhoff, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Telephone: 507-206-2737 Fax: 507-206-2711

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Lyla Burkman, Bemidji District Office Unit Supervisor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	02/09/2017

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GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 279		3/13/17

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

Electronically Signed | 03/03/2017

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F 279	Continued From page 1 care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 2 Based on interview and document review, the facility failed to develop interventions for the use of anticoagulant medication (Coumadin) for 1 of 5 residents (R44) whose medication regimens were reviewed. Findings include: R44's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R44 was cognitively intact and had diagnoses which included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hypertension. The MDS also indicated R44 received anticoagulation (prevent or reduce coagulation of blood, prolonging the clotting time)medication daily. R44's undated Medication Review Report included an order for Coumadin 1.25 milligrams (mg) by mouth one time a day every Sunday, Monday, Tuesday, Wednesday, Friday and Saturday and 2.5 mg every Thursday for atrial fibrillation. R44's undated Care Plan indicated R44 had diagnoses which included long term (current) use of anticoagulants, however, lacked interventions related to the use of the medication and monitoring for potential adverse effects of the medication. On 2/9/17, at 2:37 p.m. registered nurse (RN)-G confirmed R44's care plan did not address the	F 279	1. Resident 44's care plan was updated to include interventions r/t the use of anticoagulant medication (Coumadin). Including the potential adverse effects of the medication. 2. All residents on anticoagulant therapy are at risk for having their care plans lack the identification of anticoagulant medications (Coumadin). All residents had their care plans reviewed and updated to include the use of anticoagulant medications (Coumadin) Including the potential adverse effects of the medication on 2/10/2017. 3. Licensed nursing staff were educated on care planning the use of anticoagulant medications (Coumadin) to ensure care plan has interventions listed r/t the use of anticoagulant medication (Coumadin). The education included education on the need for the potential adverse effects of the medication to be listed on the care plan. This took place on 3/1/2017 and 3/2/2017. 4. DNS or Designee to randomly audit the care plans for the residents on anticoagulation medications (Coumadin) to ensure that the care plan interventions related to the use of the medication and the monitoring for potential adverse effects. The audits will occur for a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 279	Continued From page 3 use of Coumadin and should have done so. RN-G stated they usually included all high risk medications on the care plan. RN-G indicated R44's care plan should have addressed monitoring for signs and symptoms of bleeding and interventions related to the event of a bleeding. The Plan Of Care policy and procedure revised 11/16, indicated a care plan would be developed to include medications and treatments and any other items, as appropriate.	F 279		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following: (k) Pain Management.	F 309		3/13/17

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F 309	Continued From page 4 The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer as needed (PRN) Lasix (a diuretic) according to physician orders for 1 of 1 resident (R16) reviewed who received PRN Lasix. Findings include: R16's annual Minimum Data Set (MDS) dated 1/10/17 indicated R16 was cognitively intact and required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene and was independent with eating. R16's undated Diagnosis Report indicated R16 had diagnoses which included edema (swelling), lymphedema (collection of fluid that causes swelling in the arms and legs), and hypertension (high blood pressure).	F 309	1. Resident 16's (PRN) Lasix (a diuretic) order is being followed and administered as ordered by licensed facility staff. 2. All residents on (PRN) Lasix (a diuretic) are at risk of the same deficient practice. 3. Licensed staff were educated on 3/1/2017 and 3/2/2017 on the administration of (PRN) Lasix (a diuretic) to ensure the medications are being administered according to the order. 4. DNS or Designee to randomly audit the administration of (PRN) Lasix (a diuretic) to ensure that the medications are being administered as prescribed. The audits will occur at a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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R16's undated Medication Review Report included the following physician orders:

--daily weight one time a day for edema. Administer PRN Lasix if above 212.
--Lasix Tablet 40 milligrams (mg) by mouth as needed for increased (2+) edema for weight over 212. Notify physician if no weight change after 3 days of administration. The order start date was 1/9/17.
The Report also included a nursing order to monitor bilateral lower extremities for edema one time a day. If edema noted refer to PRN Lasix order.

Review of R16's medical record revealed the follow weights:

1/9/17: 212.2
1/12/17: 212.8
1/14/17: 212.5
1/16/17: 212.7
1/21/17: 213.6
1/24/17: 212.2
1/25/17: 212.5
1/26/17: 213.5
1/30/17: 212.5
1/31/17: 212.7
2/4/17: 212.8
2/5/17: 213.4
2/6/17: 212.8

The Consultant Pharmacist Drug Regimen Reviews included a recommendation from the pharmacist dated 1/12/17, which read: "Please make sure the Lasix PRN weight based parameter is followed. Also has edema

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F 309	Continued From page 6	F 309		

parameter. Would document a daily edema check per parameter." A hand written note next to the recommendation dated 1/16/17, indicated "noted" with staff initials next to it.

R16's Medication Records Dated 1/1/17-1/31/17 and 2/1/17-2/28/17 indicated R16 had received no PRN doses of Lasix.

R16's undated care plan identified R16 received diuretic therapy for edema and hypertension and directed staff to monitor of interactions and adverse consequence of the medication. The care plan also directed staff to weigh R16 daily.

On 2/8/17, at 12:59 a.m. R16 was observed seated in her recliner, in her room. The foot of the recliner was elevated. R16 was wearing trousers, compression stockings and slipper type shoes. The legs of the trouser were raised above the ankle and R16's lower legs and ankles were not observed to be swollen. Slight swelling was observed to the top of R16's feet above the slipper type shoes. R16 stated she did at times have swelling in her lower extremities but it was much better than it used to be. R16 also stated she had special stockings she wore and kept her feet elevated in her recliner. R16 stated she did not take any medication for the swelling.

On 2/8/17, at 1:37 p.m. registered nurse RN-F stated he would have to check the order to determine when PRN Lasix was to be administered to R16. After consulting the electronic record, RN-F stated he would give it for

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F 309	Continued From page 7 edema measuring 2+ or for a weight over 212. RN-F indicated R16's current weight was 211.6 so she did not receive PRN Lasix that day. However, RN-F confirmed the previous weights as written above and confirmed R16 had not received any PRN Lasix in January or February. RN-F stated R16 should have received PRN Lasix on the days when the weights were 213 and above. On 2/8/17, at 2:09 p.m. RN-G confirmed R16's order for PRN Lasix for a weight over 212 and verified R16 should have received PRN Lasix on the days the weight was over 212 as ordered. The Medication Administration Policy dated 5/2016, indicated the purpose was to administer medication correctly and timely and directed medications would be administered to the resident according to the "Six Rights". [patient, drug, dose, time, route, documentation].	F 309		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically	F 322		3/13/17

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F 322	Continued From page 8 indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure medication was administered as directed by facility policy for 1 of 1 resident (R204) observed to receive a cocktail of medications via a percutaneous endoscopic gastrostomy tube. Findings include: R204's Medical Diagnosis report printed 2/6/17, identified R204's diagnoses as dysphasia (difficulty swallowing) gastro-esophageal reflux disease (GERD), hyperlipidemia (abnormally elevated lipid levels in the blood), chronic kidney disease, and Type II diabetes mellitus. R204's quarterly Minimum Data Set (MDS) dated 1/20/17, indicated R204 had a feeding tube and was on a mechanically altered diet. R204's Medication Review Report dated 2/6/17, directed staff to administer 204's medications via a percutaneous endoscopic gastrostomy (G-Tube/PEG) tube (tube place into the stomach	F 322	1. Resident 204 now has an order allowing medications to be administered in cocktail form via PEG tube. 2. All residents with assisted nutrition and hydration who receive their medications through the enteral tube are at risk for the same deficient practice. All residents who are affected by this currently have orders for cocktailing medications. 3. All nursing staff were educated on 3/1/2017 and 3/2/2017 in regard to the need for orders to cocktail medications given via an enteral tube. 4.Staff to audit all residents with assisted nutrition and hydration via enteral tube. Audits to be completed weekly for 4 weeks with results to QAPI committee for further recommendations.	

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F 322	Continued From page 9 for feeding), however the report lacked an order and justification for cocktailing (mixture of liquid and crushed medications) the medications. On 2/6/17, at 6:31 p.m. registered nurse (RN)-H was observed to wash her hands and open a sealed packet containing one tablet of Metoprolol 50 milligrams (mg) (treats hypertension and angina), one tablet of Mirtazapine 7.5 mg (antidepressant) and one tablet of Oxybutynin 10 mg (treats overactive bladder). The packet identified the medications, however, lacked directions for use/route of administration. RN-H combined the medications and placed them into a 30 cubic centimeter (cc) plastic medication cup, poured the tablets into a plastic sleeve packet, inserted the packet into a manual pill crusher and crushed the tablets together. Once crushed, RN-H placed the tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H proceeded into R204's room with the medications, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and a 60 cc syringe. -At 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug, connected the syringe and checked for placement. RN-H drew up 20 cc of tap water into the syringe and flushed the tube with the water. RN-H withdrew the syringe, withdrew the plunger from the syringe, reinserted the syringe only into the g-tube port and proceeded to pour the medication cocktail mixture with 20 cc of water down the g-tube followed by another 30 cc of water. RN-H removed the syringe, closed the port of the tube, readjusted 204's clothing and exited the room. RN-H failed to administer the medications	F 322		

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F 322	Continued From page 10 individually and flush the tube after each individual medication, per policy directive. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications together and give them through the g-tube. RN-H reviewed R204's current medication administration record (MAR) and was unable to find an order to cocktail R204's medications. RN-H stated during training she was taught to administer each medication individually and flush between medications. On 2/6/17, at 6:51 p.m. the director of nursing (DON) reviewed R204's medication orders and verified R204 did not have an order to cocktail medications. The Don confirmed the facility policy directed staff to administer each medication separately and flush in between each medication. The DON verified her expectation was for staff to follow facility policy. The facility Medication Administration Policy revised 5/16, directed staff to administer each medication separately via G-tube and flush the tubing between each medication.	F 322		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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:	F 441		3/13/17

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F 441	Continued From page 11 (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 (facility assessment implementation is Phase 2); (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 441		

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	245500	A. BUILDING _____ B. WING _____	02/09/2017

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F 441	Continued From page 12 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 staff failed to ensure appropriate infection control measures while providing direct resident contact wound care for 1 of 1 resident (R65) observed during wound care. Finding include: R65's quarterly Minimum Data Set (MDS) dated 12/27/16, indicated R65 had diagnoses including dementia, anxiety and methicillin resistant staphylococcal aureus (MRSA). The assessment indicated R65 was independent with bed mobility, required supervision with transfers and had a pressure ulcer which was unstageable.	F 441	1.Resident 65□s dressing is being changed following appropriate infection control measures. 2.All residents with wounds are at risk of not having their dressings changed following appropriate infection control measures. 3.Licensed Nursing staff educated on following appropriate infection control measures with dressing changes as it relates to proper isolation procedures based on residents individual infections and on communication r/t residents with infections on 3/1/2017 and 3/2/2017. 4.DNS or Designee to randomly audit residents dressing changes. The audits will also review effectiveness of communication r/t active infections in the facility. The audits will occur for a	

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F 441	Continued From page 13 R65's care plan dated 8/30/16, indicated R65 had MRSA infection to wound on the left lower leg. The plan directed staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard and to bag linens and close bag tightly before taking to laundry. On 2/8/17, at 11:21 a.m. licensed practical nurse (LPN)-B stated R65 liked to be involved with the dressing changes to his left lower leg and would be assisting with the dressing. Upon entering the room, R65 was observed seated in his wheelchair. R65 wore gloves while he used antiseptic wipes to clean the scissors, tweezers and his over the bed table. - At 11:25 a.m. LPN-B gathered supplies for the dressing and prepared the room. LPN-A placed a towel on the floor in front of R65's left leg. She then placed a second towel on the floor adjacent to R65. LPN-A placed a box of dressing supplies on the second towel and sat on the floor next to R65. LPN-A wore gloves as she removed the old dressing. R65 had two wounds on his lower left leg which were each approximately 2.5 centimeters (cm) in diameter. R65 stated the first wound was from pressure and the second wound was from an abscess. -At 11:30 a.m. LPN-B took a towel, dipped it into a basin of water and washed R65's leg. Once the leg was cleansed, LPN-B placed the towel on the floor next to her. LPN-B used hand sanitizer, donned fresh gloves and washed the wound out with aerosol saline wound wash (compressed wound cleaner). She gathered the wash basin, emptied it in the restroom and washed her hands. LPN-B returned to R65, donned fresh gloves and	F 441	minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 441	Continued From page 14	F 441		

applied a new dressing to the wound.
-At 11:40 a.m. LPN-B replaced the wound supplies in a clear plastic box and placed on R65's shelf. She picked up the towels and carried them down the hallway to the soiled utility room. At no time during the wound dressing was LPN-B observed to use personal protective equipment other than gloves and she was not observed to bag the towel prior to leaving R65's room.
-At 2:09 p.m. LPN-B stated R65 did not have an active infection, therefore, she did not need to utilize anything more than gloves during the dressing change. She confirmed she had not bagged the dirty towels which had been used to wash the wound prior to leaving the room.

On 2/8/16, at 2:10 p.m. registered nurse (RN)-A stated R65 had a history of MRSA and she would have to look to see if he needed any precautions at this time.

On 2/9/17, at 9:30 a.m. RN-B/infection control specialist stated any resident with MRSA would be under contact isolation. She stated the room was to have a sign on the door, a supply cart of personal protective equipment including gowns, gloves, and masks along with red bags for garbage and yellow bags for linens. She stated at this time, none of the residents in the facility were in contact precautions. RN-B reviewed R65's care plan and confirmed R65 was to be in isolation due to MRSA infection and the staff were to use gloves, gowns and possible masks when in direct contact with R65's wound site. RN-B reviewed R65's clinical record and confirmed R65's last wound culture obtained on 9/25/16, identified MRSA. She stated in order for contact isolation precautions to be removed, a second

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F 441	Continued From page 15 culture was to be obtained. Review of the Monthly Report of Resident Infections in Center / infection control log, revealed a form which identified the resident name, room number, admission dated, date of infection, site of infection, culture take, causative agents, treatment measures, cautionary measure, isolation precaution and directed the staff to identify if the infection was acquired in the facility or not. The infection control logs did not identify a resolution date. On 2/8/17, at 9:35 a.m. RN-B confirmed R65 was to be on contact isolation precautions and verified staff were to wear gowns, gloves and possibly masks during dressing changes and all linens were to be contained in yellow biohazard bags. On 2/9/16, at 9:40 a.m. the director of nurses (DON) confirmed R65's wounds contained MRSA and the staff were to be utilizing contact precautions during the dressing changes. The DON stated she was not aware the precautions had been removed and did not know when they would have been removed. The Multidrug-Resistant Organisms policy dated 11/2016, directed staff to place soiled laundry in a moisture-resistant container and not on the room surfaces or floor. It also directed the staff to utilize contact precautions when in contact with drainage known to contain the multidrug resistant organism. On 2/9/17, at 9:45 a.m. the DON reviewed the Multidrug-resistant organisms policy and confirmed the policy had not been followed. The DON stated R65 would only require contact	F 441		

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F 441	Continued From page 16 precautions during dressing changes and during linen changes if the dressing had not fallen off. The DON stated R65's dressings typically remained in place but gowns should be worn during dressing changes since aerosol wound cleanser was used to directly wash the wound bed which would cause potential splatter. On 2/9/17, at 12:35 a.m. LPN-B stated R65 had been hospitalized and had been cleared of all infections. However, RN-A interjected and stated R65 had been cleared of osteomyelitis, but had not been cleared from the MRSA. LPN-A stated she was unaware R65 was still active with MRSA and had she been aware of the continued infection, she would have worn a gown, not sat on the floor during the dressing change and would have bagged the linens in a yellow biohazard bag prior to leaving the room. LPN-B stated R65 wound status had not been communicated.	F 441		
F 465 SS=E	483.90(i)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 465	1. Residents R125 and R128 have had	3/13/17

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F 465	Continued From page 17 review, the facility failed to maintain resident wheelchairs and care equipment in good repair and/or a clean and sanitary condition for 6 of 6 residents (R125, R35, R128, R106, R236) whose wheelchairs and equipment were observed to be dirty and in need of cleaning and/or repair. Findings include: On 2/6/2017, at 6:30 p.m. R125 was observed in the dining room seated in a wheelchair. R125 was leaning over the right arm rest of the chair and spit onto the wheel of the wheelchair and the floor. The right wheel was observed coated in food debris and a dried white substance. On 2/7/2017, at 8:53 a.m. R35's wheelchair was noted to have an orange colored tape adhered to the wheelchair brake handles. The tape was tattered and peeling. The left arm rest of R35's wheelchair was noted to be cracked and peeling exposing the white foam padding. On 2/7/17, at 10:14 a.m. R128 was observed in his room, seated in an electric wheelchair. The right side of the wheelchair seat cushion and crevices along the right side of the chair and the foot rest were noted to have dried food debris and crumbs adhered to the surfaces. On 2/7/17, at 10:47 a.m. R106's left knee brace was observed to be covered in a food debris.	F 465	their wheelchairs and cushions cleaned. Resident R35 had tape and armrest replaced. Resident R106 had knee brace cleaned. Resident R236 had armrest replaced. 2. All residents are at risk for having soiled w/c's and are at risk for having these items in need of repair. Residents with braces are at risk of having the braces covered in food debris. All wheelchairs were audited for cleanliness and to determine if they were in need of repair. All braces were audited for cleanliness as well. Those items identified as in need of repair or in need of cleaning have been repaired and/or cleaned. 3. The system currently in place for cleaning the wheelchairs and braces at least weekly and checking for damage at that time has been reviewed and re-enforced. All Nursing staff educated on this process on 3/1/2017 and 3/2/2017. All staff educated at that time on how to report wheelchairs and braces in need of cleaning and/or repair. 4. DNS or Designee to randomly audit wheelchair and brace cleanliness and repair a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 465	Continued From page 18 On 2/7/17, at 2:19 p.m. R236 was observed in the dining room, seated in a wheelchair, drinking coffee with friends. The right arm of the wheelchair was observed to have a rip on the seam at the bottom which ran almost the entire length of the armrest. On 2/9/17 at 3:13 p.m. the director of environmental services (DES) stated nursing staff were responsible for the cleaning of resident wheelchairs and braces. However, DES confirmed environmental services would be responsible for maintaining wheelchairs in good working order/repair. DES indicated each nursing station had a work order book and could submit a work order for wheelchairs with ripped armrests or other issues. DES indicated environmental services staff completed work orders everyday. At the time of the tour, R35 and R236 were unavailable, however, DES indicated the tape on the wheelchair brakes would create a surface that was not able to be cleaned. DES also indicated a work order should have been placed and tears in wheelchair arm rests would have been repaired. DES indicated the wheelchairs would be examined and repaired as soon as possible. On 2/9/17 at 3:30 p.m. the director of nursing (DON) confirmed nursing staff were responsible for the cleaning of resident wheelchairs. The DON indicated each resident's wheelchair was cleaned on their bath day and as needed. The DON also indicated any other resident equipment, such as braces, were cleaned on an as needed basis and would expect the nursing assistants to let the station directors know of any unclean equipment so arrangements could be	F 465		

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F 465	Continued From page 19 made for cleaning. The DON confirmed the aforementioned observations and verified R125's wheelchair was dirty and needed to be cleaned, R106's knee brace was soiled and required cleaning, the tape on R35's wheelchair brake handles was put on by the therapy department to enhance visibility however, it was worn and tattered and needed to be replaced and confirmed the arm rest was cracked and required repair. The DON also verified R128's wheelchair and cushion were dirty and required cleaning. The Station 2 bath schedule dated 12/22/16, indicated wheelchair cleaning was to be done during the night hours of the 1st scheduled bath of the week and R125's wheelchair was to be cleaned on Tuesday and R128's wheelchair was to be cleaned on Monday. No further policies regarding cleaning or repair of resident equipment were provided.	F 465		
F 492 SS=B	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet	F 492		3/13/17

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F 492	Continued From page 20 the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure 1 of 4 residents (R105) who requested a demand bill was not billed for services while the decision was pending. Findings included: R105's SNF (skilled nursing facility) Determination of Continued Stay form indicated the facility determined services furnished would no longer qualify under Medicare on 12/23/16. The estimated cost for continued services was indicated as $327.29 per day. The form indicated R105's financial guarantor checked the box that read, "I do want my bill for service I continue to receive to be submitted to the intermediary for Medicare decision. You will be informed when the bill is submitted. You are not required to pay for services which could be Medicare until a Medicare decision has been made." R105 was	F 492	1. Resident 105 had their payment reimbursed as the demand bill was pending. 2. All residents who request a demand bill are at risk and these residents have been audited to ensure a bill was not sent. 3. Additional training occurred on 2/23/2017on billing practices for residents who have requested a demand bill. Training also occurred on 2/28/2017 related to the demand bill requests and submission of claims to Medicare. Staff were trained on the policy and procedures as it relates to the determination of continued stay notice and the need to not bill the resident if a demand bill has been requested until a determination has been made. 4. Facility to audit all demand bills for 4 weeks and bring results to the QAPI committee for further recommendations.	

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F 492	Continued From page 21 discharged from the facility on 1/6/17. R105's billing statements dated 1/20/17, 2/1/17 and 2/9/17, were reviewed. All indicated an amount owed and dates payment was due and if past due, would be subject to late payment charges. The statement dated 2/9/17, read: "Because you requested a Medicare Review of your bill, we filed a demand bill to Medicare for a decision. Please pay the statement amount at this time. If Medicare decides in our favor an additional amount would be due. On 2/9/17, at 2:36 p.m. accounts receivable staff member (AR)-A confirmed R105 requested a demand bill on 12/20/16, and stated R105 was not supposed to be billed for services until the final medicare decision was made. AR-A stated R105 was sent the wrong statement and should have received the statement which included the "interim billing" notice statement. AR-A explained R105's bill had been paid in full on 2/1/17, and a new statement and a refund was sent out on 2/7/17.	F 492		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically Delivered

July 18, 2017

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

Subject:
Provider # 245500
Project # S5500027

Dear Mr. Cerney:

This is in response to your letter received on March 3, 2017, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F1620 where corresponding correction orders were issued pursuant to the survey completed on February 9, 2017.

The information presented with your letter, the CMS and State 2567s dated February 9, 2017, and corresponding Plan of Correction, as well as survey documents and discussion with representatives of Licensing and Certification staff have been carefully considered and the following determination has been made:

State Tag ID Prefix – F1620 Labeling of Drugs

Choose from the following:

- This is not a valid correction order and will be removed from the 2567 State Form.
- The revised 2567 State Form is attached.

This concludes the Minnesota Department of Health informal dispute resolution process where corresponding correction orders were issued.

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

Sincerely,

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

cc: Office of Ombudsman for Long-Term Care
Maria King, Assistant Program Manager
Licensing and Certification File
Lyla Burkman, Bemidji District Office Unit Supervisor

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/6/17, 2/7/17, 2/8/17, and 2/9/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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	00087	A. BUILDING: _____ B. WING _____	02/09/2017

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for the use of anticoagulant medication (Coumadin) for 1 of 5 residents (R44) whose medication regimens were reviewed. Findings include: R44's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R44 was cognitively intact and had diagnoses which included atrial	2 555	Corrected	3/13/17

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2 555	Continued From page 3 fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hypertension. The MDS also indicated R44 received anticoagulation (prevent or reduce coagulation of blood, prolonging the clotting time)medication daily. R44's undated Medication Review Report included an order for Coumadin 1.25 milligrams (mg) by mouth one time a day every Sunday, Monday, Tuesday, Wednesday, Friday and Saturday and 2.5 mg every Thursday for atrial fibrillation. R44's undated Care Plan indicated R44 had diagnoses which included long term (current) use of anticoagulants, however, lacked interventions related to the use of the medication and monitoring for potential adverse effects of the medication. On 2/9/17, at 2:37 p.m. registered nurse (RN)-G confirmed R44's care plan did not address the use of Coumadin and should have done so. RN-G stated they usually included all high risk medications on the care plan. RN-G indicated R44's care plan should have addressed monitoring for signs and symptoms of bleeding and interventions related to the event of a bleeding. The Plan Of Care policy and procedure revised 11/16, indicated a care plan would be developed to include medications and treatments and any other items, as appropriate.	2 555		

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2 555	Continued From page 4 SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
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 administer as needed (PRN) Lasix (a diuretic) according to physician	2 830	Corrected	3/13/17

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2 830	Continued From page 5 orders for 1 of 1 resident (R16) reviewed who received PRN Lasix. Findings include: R16's annual Minimum Data Set (MDS) dated 1/10/17 indicated R16 was cognitively intact and required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene and was independent with eating. R16's undated Diagnosis Report indicated R16 had diagnoses which included edema (swelling), lymphedema (collection of fluid that causes swelling in the arms and legs), and hypertension (high blood pressure). R16's undated Medication Review Report included the following physician orders: --daily weight one time a day for edema. Administer PRN Lasix if above 212. --Lasix Tablet 40 milligrams (mg) by mouth as needed for increased (2+) edema for weight over 212. Notify physician if no weight change after 3 days of administration. The order start date was 1/9/17. The Report also included a nursing order to monitor bilateral lower extremities for edema one time a day. If edema noted refer to PRN Lasix order. Review of R16's medical record revealed the follow weights:	2 830		

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2 830	Continued From page 6 1/9/17: 212.2 1/12/17: 212.8 1/14/17: 212.5 1/16/17: 212.7 1/21/17: 213.6 1/24/17: 212.2 1/25/17: 212.5 1/26/17: 213.5 1/30/17: 212.5 1/31/17: 212.7 2/4/17: 212.8 2/5/17: 213.4 2/6/17: 212.8 The Consultant Pharmacist Drug Regimen Reviews included a recommendation from the pharmacist dated 1/12/17, which read: "Please make sure the Lasix PRN weight based parameter is followed. Also has edema parameter. Would document a daily edema check per parameter." A hand written note next to the recommendation dated 1/16/17, indicated "noted" with staff initials next to it. R16's Medication Records Dated 1/1/17-1/31/17 and 2/1/17-2/28/17 indicated R16 had received no PRN doses of Lasix. R16's undated care plan identified R16 received diuretic therapy for edema and hypertension and directed staff to monitor of interactions and adverse consequence of the medication. The care plan also directed staff to weigh R16 daily. On 2/8/17, at 12:59 a.m. R16 was observed	2 830		

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2 830	Continued From page 7 seated in her recliner, in her room. The foot of the recliner was elevated. R16 was wearing trousers, compression stockings and slipper type shoes. The legs of the trouser were raised above the ankle and R16's lower legs and ankles were not observed to be swollen. Slight swelling was observed to the top of R16's feet above the slipper type shoes. R16 stated she did at times have swelling in her lower extremities but it was much better than it used to be. R16 also stated she had special stockings she wore and kept her feet elevated in her recliner. R16 stated she did not take any medication for the swelling. On 2/8/17, at 1:37 p.m. registered nurse RN-F stated he would have to check the order to determine when PRN Lasix was to be administered to R16. After consulting the electronic record, RN-F stated he would give it for edema measuring 2+ or for a weight over 212. RN-F indicated R16's current weight was 211.6 so she did not receive PRN Lasix that day. However, RN-F confirmed the previous weights as written above and confirmed R16 had not received any PRN Lasix in January or February. RN-F stated R16 should have received PRN Lasix on the days when the weights were 213 and above. On 2/8/17, at 2:09 p.m. RN-G confirmed R16's order for PRN Lasix for a weight over 212 and verified R16 should have received PRN Lasix on the days the weight was over 212 as ordered. The Medication Administration Policy dated 5/2016, indicated the purpose was to administer medication correctly and timely and directed	2 830		

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2 830	Continued From page 8 medications would be administered to the resident according to the "Six Rights" [patient, drug, dose, time, route, documentation]. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced	2 930		3/13/17

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2 930	Continued From page 9 by: Based on observation, interview and document review, the facility failed to ensure medication was administered as directed by facility policy for 1 of 1 resident (R204) observed to receive a cocktail of medications via a percutaneous endoscopic gastrostomy tube. Findings include: R204's Medical Diagnosis report printed 2/6/17, identified R204's diagnoses as dysphasia (difficulty swallowing) gastro-esophageal reflux disease (GERD), hyperlipidemia (abnormally elevated lipid levels in the blood), chronic kidney disease, and Type II diabetes mellitus. R204's quarterly Minimum Data Set (MDS) dated 1/20/17, indicated R204 had a feeding tube and was on a mechanically altered diet. R204's Medication Review Report dated 2/6/17, directed staff to administer 204's medications via a percutaneous endoscopic gastrostomy (G-Tube/PEG) tube (tube place into the stomach for feeding), however the report lacked an order and justification for cocktailing (mixture of liquid and crushed medications) the medications. On 2/6/17, at 6:31 p.m. registered nurse (RN)-H was observed to wash her hands and open a sealed packet containing one tablet of Metoprolol 50 milligrams (mg) (treats hypertension and angina), one tablet of Mirtazapine 7.5 mg (antidepressant) and one tablet of Oxybutynin 10	2 930	Corrected	

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2 930	Continued From page 10 mg (treats overactive bladder). The packet identified the medications, however, lacked directions for use/route of administration. RN-H combined the medications and placed them into a 30 cubic centimeter (cc) plastic medication cup, poured the tablets into a plastic sleeve packet, inserted the packet into a manual pill crusher and crushed the tablets together. Once crushed, RN-H placed the tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H proceeded into R204's room with the medications, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and a 60 cc syringe. -At 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug, connected the syringe and checked for placement. RN-H drew up 20 cc of tap water into the syringe and flushed the tube with the water. RN-H withdrew the syringe, withdrew the plunger from the syringe, reinserted the syringe only into the g-tube port and proceeded to pour the medication cocktail mixture with 20 cc of water down the g-tube followed by another 30 cc of water. RN-H removed the syringe, closed the port of the tube, readjusted 204's clothing and exited the room. RN-H failed to administer the medications individually and flush the tube after each individual medication, per policy directive. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications together and give them through the g-tube. RN-H reviewed R204's current medication administration record (MAR) and was unable to find an order to cocktail R204's medications. RN-H stated during training she was taught to administer each medication	2 930		

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2 930	Continued From page 11 individually and flush between medications. On 2/6/17, at 6:51 p.m. the director of nursing (DON) reviewed R204's medication orders and verified R204 did not have an order to cocktail medications. The Don confirmed the facility policy directed staff to administer each medication separately and flush in between each medication. The DON verified her expectation was for staff to follow facility policy. The facility Medication Administration Policy revised 5/16, directed staff to administer each medication separately via G-tube and flush the tubing between each medication. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have their medications administered separately and according to facility policy. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375		3/13/17

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21375	Continued From page 12 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 staff failed to ensure appropriate infection control measures while providing direct resident contact wound care for 1 of 1 resident (R65) observed during wound care. Finding include: R65's quarterly Minimum Data Set (MDS) dated 12/27/16, indicated R65 had diagnoses including dementia, anxiety and methicillin resistant staphylococcal aureus (MRSA). The assessment indicated R65 was independent with bed mobility, required supervision with transfers and had a pressure ulcer which was unstageable. R65's care plan dated 8/30/16, indicated R65 had MRSA infection to wound on the left lower leg. The plan directed staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard and to bag linens and close bag tightly before taking to laundry. On 2/8/17, at 11:21 a.m. licensed practical nurse (LPN)-B stated R65 liked to be involved with the dressing changes to his left lower leg and would be assisting with the dressing. Upon entering the	21375	Corrected	

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21375	Continued From page 13 room, R65 was observed seated in his wheelchair. R65 wore gloves while he used antiseptic wipes to clean the scissors, tweezers and his over the bed table. - At 11:25 a.m. LPN-B gathered supplies for the dressing and prepared the room. LPN-A placed a towel on the floor in front of R65's left leg. She then placed a second towel on the floor adjacent to R65. LPN-A placed a box of dressing supplies on the second towel and sat on the floor next to R65. LPN-A wore gloves as she removed the old dressing. R65 had two wounds on his lower left leg which were each approximately 2.5 centimeters (cm) in diameter. R65 stated the first wound was from pressure and the second wound was from an abscess. -At 11:30 a.m. LPN-B took a towel, dipped it into a basin of water and washed R65's leg. Once the leg was cleansed, LPN-B placed the towel on the floor next to her. LPN-B used hand sanitizer, donned fresh gloves and washed the wound out with aerosol saline wound wash (compressed wound cleaner). She gathered the wash basin, emptied it in the restroom and washed her hands. LPN-B returned to R65, donned fresh gloves and applied a new dressing to the wound. -At 11:40 a.m. LPN-B replaced the wound supplies in a clear plastic box and placed on R65's shelf. She picked up the towels and carried them down the hallway to the soiled utility room. At no time during the wound dressing was LPN-B observed to use personal protective equipment other than gloves and she was not observed to bag the towel prior to leaving R65's room. -At 2:09 p.m. LPN-B stated R65 did not have an active infection, therefore, she did not need to utilize anything more than gloves during the dressing change. She confirmed she had not bagged the dirty towels which had been used to	21375		

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21375	Continued From page 14 wash the wound prior to leaving the room. On 2/8/16, at 2:10 p.m. registered nurse (RN)-A stated R65 had a history of MRSA and she would have to look to see if he needed any precautions at this time. On 2/9/17, at 9:30 a.m. RN-B/infection control specialist stated any resident with MRSA would be under contact isolation. She stated the room was to have a sign on the door, a supply cart of personal protective equipment including gowns, gloves, and masks along with red bags for garbage and yellow bags for linens. She stated at this time, none of the residents in the facility were in contact precautions. RN-B reviewed R65's care plan and confirmed R65 was to be in isolation due to MRSA infection and the staff were to use gloves, gowns and possible masks when in direct contact with R65's wound site. RN-B reviewed R65's clinical record and confirmed R65's last wound culture obtained on 9/25/16, identified MRSA. She stated in order for contact isolation precautions to be removed, a second culture was to be obtained. Review of the Monthly Report of Resident Infections in Center / infection control log, revealed a form which identified the resident name, room number, admission dated, date of infection, site of infection, culture take, causative agents, treatment measures, cautionary measure, isolation precaution and directed the staff to identify if the infection was acquired in the facility or not. The infection control logs did not identify a resolution date. On 2/8/17, at 9:35 a.m. RN-B confirmed R65 was to be on contact isolation precautions and verified staff were to wear gowns, gloves and possibly	21375		

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21375	Continued From page 15 masks during dressing changes and all linens were to be contained in yellow biohazard bags. On 2/9/16, at 9:40 a.m. the director of nurses (DON) confirmed R65's wounds contained MRSA and the staff were to be utilizing contact precautions during the dressing changes. The DON stated she was not aware the precautions had been removed and did not know when they would have been removed. The Multidrug-Resistant Organisms policy dated 11/2016, directed staff to place soiled laundry in a moisture-resistant container and not on the room surfaces or floor. It also directed the staff to utilize contact precautions when in contact with drainage known to contain the multidrug resistant organism. On 2/9/17, at 9:45 a.m. the DON reviewed the Multidrug-resistant organisms policy and confirmed the policy had not been followed. The DON stated R65 would only require contact precautions during dressing changes and during linen changes if the dressing had not fallen off. The DON stated R65's dressings typically remained in place but gowns should be worn during dressing changes since aerosol wound cleanser was used to directly wash the wound bed which would cause potential splatter. On 2/9/17, at 12:35 a.m. LPN-B stated R65 had been hospitalized and had been cleared of all infections. However, RN-A interjected and stated R65 had been cleared of osteomyelitis, but had not been cleared from the MRSA. LPN-A stated she was unaware R65 was still active with MRSA and had she been aware of the continued infection, she would have worn a gown, not sat on the floor during the dressing change and would	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 16 have bagged the linens in a yellow biohazard bag prior to leaving the room. LPN-B stated R65 wound status had not been communicated. Suggested methods of correction: The director of nursing or designee could review infection control policies and procedures while providing wound care with staff. The director of nursing or designee could then develop an auditing system as part of the facility's quality assurance program to ensure ongoing compliance. Time period for correction: Twenty one (21) days.	21375		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident wheelchairs and care equipment in good repair and/or a clean and sanitary condition for 6 of 6 residents (R125, R35, R128, R106, R236) whose wheelchairs and equipment were observed to be dirty and in need of cleaning and/or repair. Findings include:	21695	Corrected	3/13/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 17 On 2/6/2017, at 6:30 p.m. R125 was observed in the dining room seated in a wheelchair. R125 was leaning over the right arm rest of the chair and spit onto the wheel of the wheelchair and the floor. The right wheel was observed coated in food debris and a dried white substance. On 2/7/2017, at 8:53 a.m. R35's wheelchair was noted to have an orange colored tape adhered to the wheelchair brake handles. The tape was tattered and peeling. The left arm rest of R35's wheelchair was noted to be cracked and peeling exposing the white foam padding. On 2/7/17, at 10:14 a.m. R128 was observed in his room, seated in an electric wheelchair. The right side of the wheelchair seat cushion and crevices along the right side of the chair and the foot rest were noted to have dried food debris and crumbs adhered to the surfaces. On 2/7/17, at 10:47 a.m. R106's left knee brace was observed to be covered in a food debris. On 2/7/17, at 2:19 p.m. R236 was observed in the dining room, seated in a wheelchair, drinking coffee with friends. The right arm of the wheelchair was observed to have a rip on the seam at the bottom which ran almost the entire length of the armrest. On 2/9/17 at 3:13 p.m. the director of environmental services (DES) stated nursing staff were responsible for the cleaning of resident	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 18 wheelchairs and braces. However, DES confirmed environmental services would be responsible for maintaining wheelchairs in good working order/repair. DES indicated each nursing station had a work order book and could submit a work order for wheelchairs with ripped armrests or other issues. DES indicated environmental services staff completed work orders everyday. At the time of the tour, R35 and R236 were unavailable, however, DES indicated the tape on the wheelchair brakes would create a surface that was not able to be cleaned. DES also indicated a work order should have been placed and tears in wheelchair arm rests would have been repaired. DES indicated the wheelchairs would be examined and repaired as soon as possible. On 2/9/17 at 3:30 p.m. the director of nursing (DON) confirmed nursing staff were responsible for the cleaning of resident wheelchairs. The DON indicated each resident's wheelchair was cleaned on their bath day and as needed. The DON also indicated any other resident equipment, such as braces, were cleaned on an as needed basis and would expect the nursing assistants to let the station directors know of any unclean equipment so arrangements could be made for cleaning. The DON confirmed the aforementioned observations and verified R125's wheelchair was dirty and needed to be cleaned, R106's knee brace was soiled and required cleaning, the tape on R35's wheelchair brake handles was put on by the therapy department to enhance visibility however, it was worn and tattered and needed to be replaced and confirmed the arm rest was cracked and required repair. The DON also verified R128's wheelchair and cushion were dirty and required cleaning.	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21695	Continued From page 19 The Station 2 bath schedule dated 12/22/16, indicated wheelchair cleaning was to be done during the night hours of the 1st scheduled bath of the week and R125's wheelchair was to be cleaned on Tuesday and R128's wheelchair was to be cleaned on Monday. No further policies regarding cleaning or repair of resident equipment were provided. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to report damaged resident personal care equipment and ensure resident equipment is maintained in a sanitary condition. The administrator then could develop and auditing system as part of facility's quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21695		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: G24W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **114** (L18)
13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(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 :
Lyla Burkman, Unit Supervisor 03/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 06/27/2017 (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
01/01/1988
(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
04/06/2017
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245500

May 22, 2017

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

Dear Mr. Cerney:

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

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

Effective March 13, 2017 the above facility is certified for:

114 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
May 21, 2017

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: Project Number S5500027

Dear Mr. Cerney:

On February 22, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 9, 2017. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 9, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 13, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 9, 2017, effective March 13, 2017 and therefore remedies outlined in our letter to you dated February 22, 2017, 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 related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

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

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245500 Y1	A. Building B. Wing Y2	3/27/2017 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279	Correction	ID Prefix F0309	Correction	ID Prefix F0322	Correction
Reg. # 483.20(d);483.21(b)(1)	Completed	Reg. # 483.24, 483.25(k)(l)	Completed	Reg. # 483.25(g)(4)(5)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0431	Correction	ID Prefix F0441	Correction	ID Prefix F0465	Correction
Reg. # 483.45(b)(2)(3)(g)(h)	Completed	Reg. # 483.80(a)(1)(2)(4)(e)(f)	Completed	Reg. # 483.90(i)(5)	Completed
LSC	03/13/2017	LSC	03/13/2017	LSC	03/13/2017
ID Prefix F0492	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.70(b)(c)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	03/13/2017	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
[x]	LB/mm	05/22/2017	28035	03/27/2017
REVIEWED BY CMS RO [ ]	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
2/9/2017

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: G24W

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/09/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **114** (L18)
13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(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 :
Lisa Carey, HFE NEII 03/17/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/06/2017 (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
01/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 22, 2017

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

RE: Project Number S5500027

Dear Mr. Cerney:

On February 9, 2017, 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 a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

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 March 21, 2017, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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 May 9, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 9, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d);483.21(b)(1) DEVELOP COMPREHENSIVE CARE PLANS 483.20 (d) Use. A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan. 483.21 (b) Comprehensive Care Plans (1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive	F 279		3/13/17

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

Electronically Signed | 03/03/2017

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F 279	Continued From page 1 care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative (s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by:	F 279		

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F 279	Continued From page 2 Based on interview and document review, the facility failed to develop interventions for the use of anticoagulant medication (Coumadin) for 1 of 5 residents (R44) whose medication regimens were reviewed. Findings include: R44's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R44 was cognitively intact and had diagnoses which included atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hypertension. The MDS also indicated R44 received anticoagulation (prevent or reduce coagulation of blood, prolonging the clotting time)medication daily. R44's undated Medication Review Report included an order for Coumadin 1.25 milligrams (mg) by mouth one time a day every Sunday, Monday, Tuesday, Wednesday, Friday and Saturday and 2.5 mg every Thursday for atrial fibrillation. R44's undated Care Plan indicated R44 had diagnoses which included long term (current) use of anticoagulants, however, lacked interventions related to the use of the medication and monitoring for potential adverse effects of the medication. On 2/9/17, at 2:37 p.m. registered nurse (RN)-G confirmed R44's care plan did not address the	F 279	1. Resident 44's care plan was updated to include interventions r/t the use of anticoagulant medication (Coumadin). Including the potential adverse effects of the medication. 2. All residents on anticoagulant therapy are at risk for having their care plans lack the identification of anticoagulant medications (Coumadin). All residents had their care plans reviewed and updated to include the use of anticoagulant medications (Coumadin) Including the potential adverse effects of the medication on 2/10/2017. 3. Licensed nursing staff were educated on care planning the use of anticoagulant medications (Coumadin) to ensure care plan has interventions listed r/t the use of anticoagulant medication (Coumadin). The education included education on the need for the potential adverse effects of the medication to be listed on the care plan. This took place on 3/1/2017 and 3/2/2017. 4. DNS or Designee to randomly audit the care plans for the residents on anticoagulation medications (Coumadin) to ensure that the care plan interventions related to the use of the medication and the monitoring for potential adverse effects. The audits will occur for a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 279	Continued From page 3 use of Coumadin and should have done so. RN-G stated they usually included all high risk medications on the care plan. RN-G indicated R44's care plan should have addressed monitoring for signs and symptoms of bleeding and interventions related to the event of a bleeding. The Plan Of Care policy and procedure revised 11/16, indicated a care plan would be developed to include medications and treatments and any other items, as appropriate.	F 279		
F 309 SS=D	483.24, 483.25(k)(l) PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING 483.24 Quality of life Quality of life is a fundamental principle that applies to all care and services provided to facility residents. Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, consistent with the resident's comprehensive assessment and plan of care. 483.25 (k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. (l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered	F 309		3/13/17

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F 309	Continued From page 4 care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to administer as needed (PRN) Lasix (a diuretic) according to physician orders for 1 of 1 resident (R16) reviewed who received PRN Lasix. Findings include: R16's annual Minimum Data Set (MDS) dated 1/10/17 indicated R16 was cognitively intact and required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene and was independent with eating. R16's undated Diagnosis Report indicated R16 had diagnoses which included edema (swelling), lymphedema (collection of fluid that causes swelling in the arms and legs), and hypertension (high blood pressure). R16's undated Medication Review Report included the following physician orders: --daily weight one time a day for edema. Administer PRN Lasix if above 212. --Lasix Tablet 40 milligrams (mg) by mouth as needed for increased (2+) edema for weight over 212. Notify physician if no weight change after 3 days of administration. The order start date was 1/9/17.	F 309	1. Resident 16's (PRN) Lasix (a diuretic) order is being followed and administered as ordered by licensed facility staff. 2. All residents on (PRN) Lasix (a diuretic) are at risk of the same deficient practice. 3. Licensed staff were educated on 3/1/2017 and 3/2/2017 on the administration of (PRN) Lasix (a diuretic) to ensure the medications are being administered according to the order. 4. DNS or Designee to randomly audit the administration of (PRN) Lasix (a diuretic) to ensure that the medications are being administered as prescribed. The audits will occur at a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 309	Continued From page 5	F 309		

The Report also included a nursing order to monitor bilateral lower extremities for edema one time a day. If edema noted refer to PRN Lasix order.

Review of R16's medical record revealed the follow weights:

1/9/17: 212.2
1/12/17: 212.8
1/14/17: 212.5
1/16/17: 212.7
1/21/17: 213.6
1/24/17: 212.2
1/25/17: 212.5
1/26/17: 213.5
1/30/17: 212.5
1/31/17: 212.7
2/4/17: 212.8
2/5/17: 213.4
2/6/17: 212.8

The Consultant Pharmacist Drug Regimen Reviews included a recommendation from the pharmacist dated 1/12/17, which read: "Please make sure the Lasix PRN weight based parameter is followed. Also has edema parameter. Would document a daily edema check per parameter." A hand written note next to the recommendation dated 1/16/17, indicated "noted" with staff initials next to it.

R16's Medication Records Dated 1/1/17-1/31/17 and 2/1/17-2/28/17 indicated R16 had received no PRN doses of Lasix.

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F 309	Continued From page 6 R16's undated care plan identified R16 received diuretic therapy for edema and hypertension and directed staff to monitor of interactions and adverse consequence of the medication. The care plan also directed staff to weigh R16 daily. On 2/8/17, at 12:59 a.m. R16 was observed seated in her recliner, in her room. The foot of the recliner was elevated. R16 was wearing trousers, compression stockings and slipper type shoes. The legs of the trouser were raised above the ankle and R16's lower legs and ankles were not observed to be swollen. Slight swelling was observed to the top of R16's feet above the slipper type shoes. R16 stated she did at times have swelling in her lower extremities but it was much better than it used to be. R16 also stated she had special stockings she wore and kept her feet elevated in her recliner. R16 stated she did not take any medication for the swelling. On 2/8/17, at 1:37 p.m. registered nurse RN-F stated he would have to check the order to determine when PRN Lasix was to be administered to R16. After consulting the electronic record, RN-F stated he would give it for edema measuring 2+ or for a weight over 212. RN-F indicated R16's current weight was 211.6 so she did not receive PRN Lasix that day. However, RN-F confirmed the previous weights as written above and confirmed R16 had not received any PRN Lasix in January or February. RN-F stated R16 should have received PRN Lasix on the days when the weights were 213 and above.	F 309		

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F 309	Continued From page 7 On 2/8/17, at 2:09 p.m. RN-G confirmed R16's order for PRN Lasix for a weight over 212 and verified R16 should have received PRN Lasix on the days the weight was over 212 as ordered. The Medication Administration Policy dated 5/2016, indicated the purpose was to administer medication correctly and timely and directed medications would be administered to the resident according to the "Six Rights". [patient, drug, dose, time, route, documentation].	F 309		
F 322 SS=D	483.25(g)(4)(5) NG TREATMENT/SERVICES - RESTORE EATING SKILLS (g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- (4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and (5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced	F 322		3/13/17

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F 322	Continued From page 8 by: Based on observation, interview and document review, the facility failed to ensure medication was administered as directed by facility policy for 1 of 1 resident (R204) observed to receive a cocktail of medications via a percutaneous endoscopic gastrostomy tube. Findings include: R204's Medical Diagnosis report printed 2/6/17, identified R204's diagnoses as dysphasia (difficulty swallowing) gastro-esophageal reflux disease (GERD), hyperlipidemia (abnormally elevated lipid levels in the blood), chronic kidney disease, and Type II diabetes mellitus. R204's quarterly Minimum Data Set (MDS) dated 1/20/17, indicated R204 had a feeding tube and was on a mechanically altered diet. R204's Medication Review Report dated 2/6/17, directed staff to administer 204's medications via a percutaneous endoscopic gastrostomy (G-Tube/PEG) tube (tube place into the stomach for feeding), however the report lacked an order and justification for cocktailing (mixture of liquid and crushed medications) the medications. On 2/6/17, at 6:31 p.m. registered nurse (RN)-H was observed to wash her hands and open a sealed packet containing one tablet of Metoprolol 50 milligrams (mg) (treats hypertension and angina), one tablet of Mirtazapine 7.5 mg	F 322	1. Resident 204 now has an order allowing medications to be administered in cocktail form via PEG tube. 2. All residents with assisted nutrition and hydration who receive their medications through the enteral tube are at risk for the same deficient practice. All residents who are affected by this currently have orders for cocktailing medications. 3. All nursing staff were educated on 3/1/2017 and 3/2/2017 in regard to the need for orders to cocktail medications given via an enteral tube. 4.Staff to audit all residents with assisted nutrition and hydration via enteral tube. Audits to be completed weekly for 4 weeks with results to QAPI committee for further recommendations.	

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F 322	Continued From page 9 (antidepressant) and one tablet of Oxybutynin 10 mg (treats overactive bladder). The packet identified the medications, however, lacked directions for use/route of administration. RN-H combined the medications and placed them into a 30 cubic centimeter (cc) plastic medication cup, poured the tablets into a plastic sleeve packet, inserted the packet into a manual pill crusher and crushed the tablets together. Once crushed, RN-H placed the tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H proceeded into R204's room with the medications, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and a 60 cc syringe. -At 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug, connected the syringe and checked for placement. RN-H drew up 20 cc of tap water into the syringe and flushed the tube with the water. RN-H withdrew the syringe, withdrew the plunger from the syringe, reinserted the syringe only into the g-tube port and proceeded to pour the medication cocktail mixture with 20 cc of water down the g-tube followed by another 30 cc of water. RN-H removed the syringe, closed the port of the tube, readjusted 204's clothing and exited the room. RN-H failed to administer the medications individually and flush the tube after each individual medication, per policy directive. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications together and give them through the g-tube. RN-H reviewed R204's current medication administration record (MAR) and was unable to find an order to cocktail	F 322		

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F 322	Continued From page 10 R204's medications. RN-H stated during training she was taught to administer each medication individually and flush between medications. On 2/6/17, at 6:51 p.m. the director of nursing (DON) reviewed R204's medication orders and verified R204 did not have an order to cocktail medications. The Don confirmed the facility policy directed staff to administer each medication separately and flush in between each medication. The DON verified her expectation was for staff to follow facility policy. The facility Medication Administration Policy revised 5/16, directed staff to administer each medication separately via G-tube and flush the tubing between each medication.	F 322		
F 431 SS=E	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. (a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. (b) Service Consultation. The facility must employ or obtain the services of a licensed	F 431		3/13/17

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F 431	Continued From page 11 pharmacist who-- (2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and (3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. (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. (h) Storage of Drugs and Biologicals. (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. (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: Based on observation, interview and document review, the facility failed to ensure electronically dispensed medication packets were properly	F 431	1. Residents R60, 106, and 204's medications are now packaged individually with route and special	

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F 431	Continued From page 12 labeled with directions for use for 3 of 3 residents (R60, R106, R 204) observed to not have accurately labeled electronically dispensed medication packets. Findings include: On 2/6/17, at 6:14 p.m. licensed practical nurse (LPN)-A was observed to prepare medications for R60. The physicians orders dated 1/17/17, directed LPN-A to administer the following medications: -Coumadin 1.5 milligrams (mg) po (orally) daily -humalog insulin inject 5 units subcutaneous two times a day related to diabetes and give an additional 5 units per carbohydrate at lunch and supper -Metformin 500 mg po two times a day -metoprolol tartate 100 mg po twice a day give with food -Calcium Citrate +D 315-250 mg po give one with meals -Cranberry tablet 600 mg po three times a day -Percocet 5-325 mg po three times a day -Sinemet 25-100 mg po tab before meals and at bedtime. At 6:16 p.m. LPN-A reviewed R60's medication administration record (MAR) and proceeded to remove three 2 by 3 inch packets from the medication cart. The first packet identified R60's name, the date of 2/6/17, the time was identified as "evening" and a Percocet tablet 5-325 mg tab was in the packet. The packet label identified the medication as round and white with the number	F 431	instructions listed on the label. Medications are being administered according to the physicians order. 2. All residents are at risk of this occurring. Pharmacy has been individually packaging medications and adding the route and special instructions to the package to ensure the proper labeling is in place since 3/7/2017. 3. Licensed Nursing staff were educated on medication labeling, timing of medication administration, and administration of medication according to the order on 3/1/2017 and 3/2/2017. Pharmacy altered packaging of medications obtained from the Automated Dispensing Unit to include the route and special instructions on the package. 4. DNS/Designee to randomly audit the medication labels to ensure that the medication is being labeled appropriately including the missing items of route and special instructions. DNS/Designee to also audit timeliness of medication administration. The audits will occur for a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 431	Continued From page 13 203 on it. The prescription number, the name of the pharmacy and the name of the physician was on the packet, however, the directions for use including the route were not identified on the packet. LPN-A placed the tablet in a soufflé cup. When questioned why the directions for use were not on the label, RN-D, who overheard the question, responded by stating the staff were to follow the directions in the electronic MAR for each medication. She confirmed the directions for each medication were not on the printed packets. LPN-A explained the packet medications were printed and dispensed from a machine in the 100 unit medication room. She explained the day shift nurse had printed the packages for the evening shift medication pass and she would be printing the night shift medications prior to the end of her shift. The second packet contained R60's name, date, and evening. The packet contained one Sinemet 25-100 mg tablet described as round a logo 539 and yellow along with the prescription number, physician and pharmacy identification, a metformin 500 mg table was also in the package identified as number 102, round and white with the prescription number, pharmacy and physician identified. The second package did not direct the staff how to administer the medications. LPN-A placed the two medications in the soufflé cut. The third packet contained R60's name, date, and evening as time indicated to administer. It indicated the package contained metoprolol tartate 100 mg described as a round blue table with number 47 stamped on it, parmidpexole tabled 0.5 mg identified as a white oblong tablet	F 431		

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F 431	Continued From page 14 with PX2 stamped on it and oxybutynin 10 mg ER described as a round peach tablet with M 010 stamped on it. The package identified the prescription number, the pharmacy, the pharmacist and the prescribing physician but it did not identify the direction for each medication. LPN-A was observed to open the third packet, remove the metoprolol tartrate tablet, place it into the soufflé cup, left the two additional medications in the packet and returned the packet to the medication cart. LPN-A stated the other two medications in the packet would be administered during the next medication pass. She stated for some reason, the metoprolol was in the same package as the bedtime medications. At 6:20 p.m. LPN-A obtained a cranberry tablet from a bottle of medication, the coumadin tablet from a bubble packet (which contained a full prescription label including directions for use) and a humalog insulin pen and proceeded to go to R60's room. -At 6:22 p.m. LPN-A spoke with R60, confirmed R60 had eaten her meal and proceeded to administer R60's medications. -At 6:34 p.m. LPN-A stated some medications were printed on the small packets from the AlixaRX electronic medication dispensing machine and other medications were in bubble packages or bottles. She stated it just depended upon the medication whether it came in a blister pack, bottle or from the AlixaRX machine. She confirmed she had administered humalog insulin after R60 had eaten the meal and the Sinemet after the meal. Upon review of the MAR, LPN-A confirmed the Sinemet order directed the staff to administer the medication before the meal and the insulin was to be administered after the meal.	F 431		

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F 431	Continued From page 15 She confirmed the prescription label did not direct the staff to administer the sinemet before the meal as per the physician orders. She stated she usually gave R60 her medications after she had eaten the meal. On 2/8/17, at 12:50 p.m. LPN-B was observed in the 100 unit medication room. An AlixaRX medication dispensing machine was in the center of the room. LPN-A logged into a computer next to the machine and programmed the machine to print the 300 wing unit medications for the evening shift. When questioned as to how to change the time of the medication packages, LPN-A stated when a package was opened, all of the medications within that package were to be administered at the same time. If the medications were not being dispensed at the appropriate time, the nurse on duty was to call the pharmacy and have the dispensing machine reprogrammed. LPN-A stated she was not aware of any problems with the time of R60's evening medications. On 2/8/17, at 1:10 p.m. LPN-A confirmed the medication packets dispensed from the AlixaRX machine did not identify the route or the directions for use for each medication in the package dispensed. She stated the staff were to refer to the MAR for the directions to give. On 2/8/17, at 2:16 p.m. registered nurse (RN)-A confirmed the prescription labels on the packets from the AlixaRX machine did not include the route or the directions for the medication use. She stated the staff were to follow the directions	F 431		

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F 431	Continued From page 16 on the MAR. RN-A stated R60's Sinemet was to be given before meals and therefore should have been repackaged and not administered after the meal with the rest of her medications. She confirmed R60's prescription label did not direct the staff as to when to administer the medications. On 2/9/17, at 8:13 a.m. the director of nurses (DON) stated that in order for the staff to pass medications according to the facility policy, they were to be confirming the six rights of medication adminsitration which included the right medication, right dose, right resident, right route, right time and right documentation and to perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medications. The DON confirmed the staff who administered medications did not have the ability to compare the prescription label to the physician's order in the MAR because the directions for use were not on the prescription label. The DON confirmed she would have to contact the pharmacy for further directions. On 2/6/17, at 6:31 p.m. RN- H was observed to prepare the following medication for administration via a percutaneous endoscopic gastrostomy (G-Tube/PEG) tube (tube place into the stomach for feeding): -one tablet of Metoprolol 50 milligrams (mg) (treats hypertension and angina) -one tablet of Mirtazapine 7.5 mg (antidepressant) -one tablet of Oxybutynin 10 mg (treats overactive	F 431		

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F 431	Continued From page 17 bladder) RN-H washed her hands and open a sealed plastic packet approximately 2 by 3 inches which contained the above medications. The packet identified the medications, however, lacked directions for use and the route to which the medication was to be administered. RN-H combined the Metoprolol, Mirtazapine and Oxybutynin, into a 30 cc plastic medication cup, poured the tablets into a plastic sleeve packet, inserted the packet into a manual pill crusher and crushed the tablets together. RN-H placed the crushed tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H entered 204's room, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and 60 cc syringe -at 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug on the end of the G-tube, connected the syringe and confirmed proper placement. RN-H drew up 20 cc of tap water into syringe and flushed tube. RN-H withdrew the syringe and withdrew the plunger and proceeded to reinsert the syringe into g-tube port, poured the Metoprolol, Mirtazapine, and Oxybutynin mixed with 20 cc of water into the g-tube, poured 30 cc of water into a 30 cc medication cup and poured the water into the open ended syringe. RN-H -unattached the open ended syringe from the g-tube, closed the port on the tubing and readjusted 204's clothing and exited the room. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications and give them together through the g-tube. RN-H reviewed R204's	F 431		

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F 431	Continued From page 18 current MAR and was unable to find an order to cocktail R204's medications. RN-H verified the medication packets containing R204's Metoprolol, Mirtazapine and Oxybutynin lacked directions for use and route of administration. RN-H stated, the staff used the MAR to check for administration directives. RN-H stated she was unaware the medication packets lacked the direction and route information. RN-H stated she checked the MAR when administering medications. On 02/09/17, at 8:29 a.m. LPN-C was observed to obtain a sealed medication packet which measured approximately 2 by 3 inches which contained three medication tablets. The packet identified R106's name, date, and the following medications: 1- Lisinopril tablet- 5 mg-round 6-pink, 1 -Metformin tablet 500 mg- round H 102 -white-1 metoprolol tablet -round m 32-pink. The packet lacked direction for use. LPN-C opened the packet and placed the medications into a small souffle cup to administer to R106. LPN-C stated the labels did not have the directions for use on the packet therefore referred only to the MAR for directions. LPN-C stated she was not sure why the administration route or directions for administration was not identified on the electronically dispensed packet. When asked how to verify the right route, the right right dose and the right time medication was to be adminsitered, LPN-C stated she just looked at the MAR to see how the medications were to be administered because she was unable to compare the MAR directions to the medication packet label to ensure accurate administration of the medication.	F 431		

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F 431	Continued From page 19 On 02/08/2017, at 12:40 p.m. AlixaRX pharmacy service technician (FST), stated she was the technician that delivered the medications to the facility, stocked the pharmacy medication machines and assisted the facility with any problems regarding the medication administration process. The FST explained the machine dispensed medications by shift, three times daily and printed the medication labels on the individual packets and dispensed the medication tablets into the individual packets. The packets were then sealed and dispensed. The FST reviewed the medication packets provided for R204 and verified the directions for use and routes were not identified. The FST stated she was unaware the packets lacked the directions for use. The FST stated the machine had the capability to label the packets to include the directions for use and administration routes for example, when a resident went out on leave, the medications were dispensed into packets that identified the routes to administer the medications and the directions for use. The FST confirmed the lack of directions of the packets created an opportunity for medication administration inaccuracy. The FST verfied the directions for use should be indicated on the packets for verification purposes and stated this lack of information on the medication packets was a concern and she would bring this to her supervisor and to the pharmacist. On 2/9/17, at 8:41 a.m. the director of nursing (DON) verified the medication packets dispensed from the AlixaRx machine lacked the routes and directions for use of the medications and the stock medications lacked specific information for intended resident use and the staff were unable	F 431		

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F 431	Continued From page 20 to compare the directions for use with the MAR in order to ensure accurate medication administration. The DON stated she contacted the pharmacy in order to try and correct the issues. The DON verified the facility policy for medication administration was not followed. The facility Medication Administration policy revised 5/16, directed staff to review the MAR for medications due, and to follow the "Six Rights" of medication administration which included the right medication, right dose, right resident, right route, right time and right documentation and to perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medications. The AlixaRX Medication Ordering and Receiving from Pharmacy Medication Labels policy dated 06/15, indicated each prescription medication label included: Resident's name, Specific directions for use, medication name, strength, prescriber's name, date dispensed, quantity of medication, expiration date of medication, prescription number, Accessory labels indicating storage requirements and special procedures. Example: "Take on empty stomach, one hour before or 2 hours after meals.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program.	F 441		3/13/17

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F 441	Continued From page 21 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (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 (facility assessment implementation is Phase 2); (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	F 441		

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F 441	Continued From page 22 circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable 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. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 staff failed to ensure appropriate infection control measures while providing direct resident contact wound care for 1 of 1 resident (R65) observed during wound care. Finding include: R65's quarterly Minimum Data Set (MDS) dated 12/27/16, indicated R65 had diagnoses including dementia, anxiety and methicillin resistant staphylococcal aureus (MRSA). The assessment	F 441	1.Resident 65□s dressing is being changed following appropriate infection control measures. 2.All residents with wounds are at risk of not having their dressings changed following appropriate infection control measures. 3.Licensed Nursing staff educated on following appropriate infection control measures with dressing changes as it relates to proper isolation procedures based on residents individual infections and on communication r/t residents with infections on 3/1/2017 and 3/2/2017. 4.DNS or Designee to randomly audit	

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F 441	Continued From page 23 indicated R65 was independent with bed mobility, required supervision with transfers and had a pressure ulcer which was unstageable. R65's care plan dated 8/30/16, indicated R65 had MRSA infection to wound on the left lower leg. The plan directed staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard and to bag linens and close bag tightly before taking to laundry. On 2/8/17, at 11:21 a.m. licensed practical nurse (LPN)-B stated R65 liked to be involved with the dressing changes to his left lower leg and would be assisting with the dressing. Upon entering the room, R65 was observed seated in his wheelchair. R65 wore gloves while he used antiseptic wipes to clean the scissors, tweezers and his over the bed table. - At 11:25 a.m. LPN-B gathered supplies for the dressing and prepared the room. LPN-A placed a towel on the floor in front of R65's left leg. She then placed a second towel on the floor adjacent to R65. LPN-A placed a box of dressing supplies on the second towel and sat on the floor next to R65. LPN-A wore gloves as she removed the old dressing. R65 had two wounds on his lower left leg which were each approximately 2.5 centimeters (cm) in diameter. R65 stated the first wound was from pressure and the second wound was from an abscess. -At 11:30 a.m. LPN-B took a towel, dipped it into a basin of water and washed R65's leg. Once the leg was cleansed, LPN-B placed the towel on the floor next to her. LPN-B used hand sanitizer, donned fresh gloves and washed the wound out	F 441	residents dressing changes. The audits will also review effectiveness of communication r/t active infections in the facility. The audits will occur for a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

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F 441	Continued From page 24	F 441		

with aerosol saline wound wash (compressed wound cleaner). She gathered the wash basin, emptied it in the restroom and washed her hands. LPN-B returned to R65, donned fresh gloves and applied a new dressing to the wound.
-At 11:40 a.m. LPN-B replaced the wound supplies in a clear plastic box and placed on R65's shelf. She picked up the towels and carried them down the hallway to the soiled utility room. At no time during the wound dressing was LPN-B observed to use personal protective equipment other than gloves and she was not observed to bag the towel prior to leaving R65's room.
-At 2:09 p.m. LPN-B stated R65 did not have an active infection, therefore, she did not need to utilize anything more than gloves during the dressing change. She confirmed she had not bagged the dirty towels which had been used to wash the wound prior to leaving the room.

On 2/8/16, at 2:10 p.m. registered nurse (RN)-A stated R65 had a history of MRSA and she would have to look to see if he needed any precautions at this time.

On 2/9/17, at 9:30 a.m. RN-B/infection control specialist stated any resident with MRSA would be under contact isolation. She stated the room was to have a sign on the door, a supply cart of personal protective equipment including gowns, gloves, and masks along with red bags for garbage and yellow bags for linens. She stated at this time, none of the residents in the facility were in contact precautions. RN-B reviewed R65's care plan and confirmed R65 was to be in isolation due to MRSA infection and the staff were to use gloves, gowns and possible masks when in direct contact with R65's wound site. RN-B

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reviewed R65's clinical record and confirmed R65's last wound culture obtained on 9/25/16, identified MRSA. She stated in order for contact isolation precautions to be removed, a second culture was to be obtained.

Review of the Monthly Report of Resident Infections in Center / infection control log, revealed a form which identified the resident name, room number, admission dated, date of infection, site of infection, culture take, causative agents, treatment measures, cautionary measure, isolation precaution and directed the staff to identify if the infection was acquired in the facility or not. The infection control logs did not identify a resolution date.

On 2/8/17, at 9:35 a.m. RN-B confirmed R65 was to be on contact isolation precautions and verified staff were to wear gowns, gloves and possibly masks during dressing changes and all linens were to be contained in yellow biohazard bags.

On 2/9/16, at 9:40 a.m. the director of nurses (DON) confirmed R65's wounds contained MRSA and the staff were to be utilizing contact precautions during the dressing changes. The DON stated she was not aware the precautions had been removed and did not know when they would have been removed.

The Multidrug-Resistant Organisms policy dated 11/2016, directed staff to place soiled laundry in a moisture-resistant container and not on the room surfaces or floor. It also directed the staff to utilize contact precautions when in contact with drainage known to contain the multidrug resistant organism.

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F 441	Continued From page 26 On 2/9/17, at 9:45 a.m. the DON reviewed the Multidrug-resistant organisms policy and confirmed the policy had not been followed. The DON stated R65 would only require contact precautions during dressing changes and during linen changes if the dressing had not fallen off. The DON stated R65's dressings typically remained in place but gowns should be worn during dressing changes since aerosol wound cleanser was used to directly wash the wound bed which would cause potential splatter. On 2/9/17, at 12:35 a.m. LPN-B stated R65 had been hospitalized and had been cleared of all infections. However, RN-A interjected and stated R65 had been cleared of osteomyelitis, but had not been cleared from the MRSA. LPN-A stated she was unaware R65 was still active with MRSA and had she been aware of the continued infection, she would have worn a gown, not sat on the floor during the dressing change and would have bagged the linens in a yellow biohazard bag prior to leaving the room. LPN-B stated R65 wound status had not been communicated.	F 441		
F 465 SS=E	483.90(h)(5) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON (h) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. (h)(5) Establish policies, in accordance with applicable Federal, State, and local laws and regulations, regarding smoking, smoking areas, and smoking safety that also take into account	F 465		3/13/17

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F 465	Continued From page 27 non-smoking residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident wheelchairs and care equipment in good repair and/or a clean and sanitary condition for 6 of 6 residents (R125, R35, R128, R106, R236) whose wheelchairs and equipment were observed to be dirty and in need of cleaning and/or repair. Findings include: On 2/6/2017, at 6:30 p.m. R125 was observed in the dining room seated in a wheelchair. R125 was leaning over the right arm rest of the chair and spit onto the wheel of the wheelchair and the floor. The right wheel was observed coated in food debris and a dried white substance. On 2/7/2017, at 8:53 a.m. R35's wheelchair was noted to have an orange colored tape adhered to the wheelchair brake handles. The tape was tattered and peeling. The left arm rest of R35's wheelchair was noted to be cracked and peeling exposing the white foam padding. On 2/7/17, at 10:14 a.m. R128 was observed in his room, seated in an electric wheelchair. The right side of the wheelchair seat cushion and crevices along the right side of the chair and the foot rest were noted to have dried food debris and crumbs adhered to the surfaces.	F 465	1. Residents R125 and R128 have had their wheelchairs and cushions cleaned. Resident R35 had tape and armrest replaced. Resident R106 had knee brace cleaned. Resident R236 had armrest replaced. 2. All residents are at risk for having soiled w/c's and are at risk for having these items in need of repair. Residents with braces are at risk of having the braces covered in food debris. All wheelchairs were audited for cleanliness and to determine if they were in need of repair. All braces were audited for cleanliness as well. Those items identified as in need of repair or in need of cleaning have been repaired and/or cleaned. 3. The system currently in place for cleaning the wheelchairs and braces at least weekly and checking for damage at that time has been reviewed and re-enforced. All Nursing staff educated on this process on 3/1/2017 and 3/2/2017. All staff educated at that time on how to report wheelchairs and braces in need of cleaning and/or repair. 4. DNS or Designee to randomly audit wheelchair and brace cleanliness and repair a minimum of 3x/wk for 4 weeks with results to the QAPI committee for further recommendations.	

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F 465	Continued From page 28 On 2/7/17, at 10:47 a.m. R106's left knee brace was observed to be covered in a food debris. On 2/7/17, at 2:19 p.m. R236 was observed in the dining room, seated in a wheelchair, drinking coffee with friends. The right arm of the wheelchair was observed to have a rip on the seam at the bottom which ran almost the entire length of the armrest. On 2/9/17 at 3:13 p.m. the director of environmental services (DES) stated nursing staff were responsible for the cleaning of resident wheelchairs and braces. However, DES confirmed environmental services would be responsible for maintaining wheelchairs in good working order/repair. DES indicated each nursing station had a work order book and could submit a work order for wheelchairs with ripped armrests or other issues. DES indicated environmental services staff completed work orders everyday. At the time of the tour, R35 and R236 were unavailable, however, DES indicated the tape on the wheelchair brakes would create a surface that was not able to be cleaned. DES also indicated a work order should have been placed and tears in wheelchair arm rests would have been repaired. DES indicated the wheelchairs would be examined and repaired as soon as possible. On 2/9/17 at 3:30 p.m. the director of nursing (DON) confirmed nursing staff were responsible for the cleaning of resident wheelchairs. The DON indicated each resident's wheelchair was cleaned on their bath day and as needed. The DON also indicated any other resident	F 465		

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F 465	Continued From page 29 equipment, such as braces, were cleaned on an as needed basis and would expect the nursing assistants to let the station directors know of any unclean equipment so arrangements could be made for cleaning. The DON confirmed the aforementioned observations and verified R125's wheelchair was dirty and needed to be cleaned, R106's knee brace was soiled and required cleaning, the tape on R35's wheelchair brake handles was put on by the therapy department to enhance visibility however, it was worn and tattered and needed to be replaced and confirmed the arm rest was cracked and required repair. The DON also verified R128's wheelchair and cushion were dirty and required cleaning. The Station 2 bath schedule dated 12/22/16, indicated wheelchair cleaning was to be done during the night hours of the 1st scheduled bath of the week and R125's wheelchair was to be cleaned on Tuesday and R128's wheelchair was to be cleaned on Monday. No further policies regarding cleaning or repair of resident equipment were provided.	F 465		
F 492 SS=B	483.70(b)(c) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD (b) Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.	F 492		3/13/17

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F 492	Continued From page 30 (c) Relationship to Other HHS Regulations. In addition to compliance with the regulations set forth in this subpart, facilities are obliged to meet the applicable provisions of other HHS regulations, including but not limited to those pertaining to nondiscrimination on the basis of race, color, or national origin (45 CFR part 80); nondiscrimination on the basis of disability (45 CFR part 84); nondiscrimination on the basis of age (45 CFR part 91); nondiscrimination on the basis of race, color, national origin, sex, age, or disability (45 CFR part 92); protection of human subjects of research (45 CFR part 46); and fraud and abuse (42 CFR part 455) and protection of individually identifiable health information (45 CFR parts 160 and 164). Violations of such other provisions may result in a finding of non-compliance with this paragraph. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to ensure 1 of 4 residents (R105) who requested a demand bill was not billed for services while the decision was pending. Findings included: R105's SNF (skilled nursing facility) Determination of Continued Stay form indicated the facility determined services furnished would no longer qualify under Medicare on 12/23/16. The estimated cost for continued services was indicated as $327.29 per day. The form indicated R105's financial guarantor checked the box that read, "I do want my bill for service I continue to receive to be submitted to the intermediary for	F 492	1. Resident 105 had their payment reimbursed as the demand bill was pending. 2. All residents who request a demand bill are at risk and these residents have been audited to ensure a bill was not sent. 3. Additional training occurred on 2/23/2017on billing practices for residents who have requested a demand bill. Training also occurred on 2/28/2017 related to the demand bill requests and submission of claims to Medicare. Staff were trained on the policy and procedures as it relates to the determination of continued stay notice and the need to not bill the resident if a demand bill has been requested until a determination has been made.	

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F 492	Continued From page 31 Medicare decision. You will be informed when the bill is submitted. You are not required to pay for services which could be Medicare until a Medicare decision has been made." R105 was discharged from the facility on 1/6/17. R105's billing statements dated 1/20/17, 2/1/17 and 2/9/17, were reviewed. All indicated an amount owed and dates payment was due and if past due, would be subject to late payment charges. The statement dated 2/9/17, read: "Because you requested a Medicare Review of your bill, we filed a demand bill to Medicare for a decision. Please pay the statement amount at this time. If Medicare decides in our favor an additional amount would be due. On 2/9/17, at 2:36 p.m. accounts receivable staff member (AR)-A confirmed R105 requested a demand bill on 12/20/16, and stated R105 was not supposed to be billed for services until the final medicare decision was made. AR-A stated R105 was sent the wrong statement and should have received the statement which included the "interim billing" notice statement. AR-A explained R105's bill had been paid in full on 2/1/17, and a new statement and a refund was sent out on 2/7/17.	F 492	4. Facility to audit all demand bills for 4 weeks and bring results to the QAPI committee for further recommendations.	

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

F550026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**02/09/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Bethany 01 Main Building was found 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. The facility was inspected as one building. Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be Type II	K 000		

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

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

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K 000	Continued From page 1 (111) construction. In 1998 an 1- story addition was constructed to the north of the 1960 building and 1974 addition, was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90 minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system installed with quick response heads in the 1998 addition and standard response heads in all other areas. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is monitored for automatic fire department notification. The facility has a capacity of 114 beds and had a census of 94 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
February 22, 2017

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, Minnesota 56401

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5500027

Dear Mr. Cerney:

The above facility was surveyed on February 6, 2017 through February 9, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction

order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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.

Feel free to contact me if you have questions related to this eNotice.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	02/09/2017

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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	00087	A. BUILDING: _____ B. WING _____	02/09/2017

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/6/17, 2/7/17, 2/8/17, and 2/9/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 555	MN Rule 4658.0405 Subp. 1 Comprehensive Plan of Care; Development Subpart 1. Development. A nursing home must develop a comprehensive plan of care for each resident within seven days after the completion of the comprehensive resident assessment as defined in part 4658.0400. The comprehensive plan of care must be developed by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop interventions for the use of anticoagulant medication (Coumadin) for 1 of 5 residents (R44) whose medication regimens were reviewed. Findings include: R44's quarterly Minimum Data Set (MDS) dated 12/20/16, indicated R44 was cognitively intact and had diagnoses which included atrial	2 555	Corrected	3/13/17

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2 555	Continued From page 3 fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow) and hypertension. The MDS also indicated R44 received anticoagulation (prevent or reduce coagulation of blood, prolonging the clotting time)medication daily. R44's undated Medication Review Report included an order for Coumadin 1.25 milligrams (mg) by mouth one time a day every Sunday, Monday, Tuesday, Wednesday, Friday and Saturday and 2.5 mg every Thursday for atrial fibrillation. R44's undated Care Plan indicated R44 had diagnoses which included long term (current) use of anticoagulants, however, lacked interventions related to the use of the medication and monitoring for potential adverse effects of the medication. On 2/9/17, at 2:37 p.m. registered nurse (RN)-G confirmed R44's care plan did not address the use of Coumadin and should have done so. RN-G stated they usually included all high risk medications on the care plan. RN-G indicated R44's care plan should have addressed monitoring for signs and symptoms of bleeding and interventions related to the event of a bleeding. The Plan Of Care policy and procedure revised 11/16, indicated a care plan would be developed to include medications and treatments and any other items, as appropriate.	2 555		

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2 555	Continued From page 4 SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to develop a care plan to include appropriate interventions for all identified care needs. A monitoring program could be established in order to assure ongoing and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 555		
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 administer as needed (PRN) Lasix (a diuretic) according to physician	2 830	Corrected	3/13/17

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2 830	Continued From page 5 orders for 1 of 1 resident (R16) reviewed who received PRN Lasix. Findings include: R16's annual Minimum Data Set (MDS) dated 1/10/17 indicated R16 was cognitively intact and required extensive assistance of two staff for bed mobility, transfers, dressing, toilet use and personal hygiene and was independent with eating. R16's undated Diagnosis Report indicated R16 had diagnoses which included edema (swelling), lymphedema (collection of fluid that causes swelling in the arms and legs), and hypertension (high blood pressure). R16's undated Medication Review Report included the following physician orders: --daily weight one time a day for edema. Administer PRN Lasix if above 212. --Lasix Tablet 40 milligrams (mg) by mouth as needed for increased (2+) edema for weight over 212. Notify physician if no weight change after 3 days of administration. The order start date was 1/9/17. The Report also included a nursing order to monitor bilateral lower extremities for edema one time a day. If edema noted refer to PRN Lasix order. Review of R16's medical record revealed the follow weights:	2 830		

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2 830	Continued From page 6 1/9/17: 212.2 1/12/17: 212.8 1/14/17: 212.5 1/16/17: 212.7 1/21/17: 213.6 1/24/17: 212.2 1/25/17: 212.5 1/26/17: 213.5 1/30/17: 212.5 1/31/17: 212.7 2/4/17: 212.8 2/5/17: 213.4 2/6/17: 212.8 The Consultant Pharmacist Drug Regimen Reviews included a recommendation from the pharmacist dated 1/12/17, which read: "Please make sure the Lasix PRN weight based parameter is followed. Also has edema parameter. Would document a daily edema check per parameter." A hand written note next to the recommendation dated 1/16/17, indicated "noted" with staff initials next to it. R16's Medication Records Dated 1/1/17-1/31/17 and 2/1/17-2/28/17 indicated R16 had received no PRN doses of Lasix. R16's undated care plan identified R16 received diuretic therapy for edema and hypertension and directed staff to monitor of interactions and adverse consequence of the medication. The care plan also directed staff to weigh R16 daily. On 2/8/17, at 12:59 a.m. R16 was observed	2 830		

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2 830	Continued From page 7 seated in her recliner, in her room. The foot of the recliner was elevated. R16 was wearing trousers, compression stockings and slipper type shoes. The legs of the trouser were raised above the ankle and R16's lower legs and ankles were not observed to be swollen. Slight swelling was observed to the top of R16's feet above the slipper type shoes. R16 stated she did at times have swelling in her lower extremities but it was much better than it used to be. R16 also stated she had special stockings she wore and kept her feet elevated in her recliner. R16 stated she did not take any medication for the swelling. On 2/8/17, at 1:37 p.m. registered nurse RN-F stated he would have to check the order to determine when PRN Lasix was to be administered to R16. After consulting the electronic record, RN-F stated he would give it for edema measuring 2+ or for a weight over 212. RN-F indicated R16's current weight was 211.6 so she did not receive PRN Lasix that day. However, RN-F confirmed the previous weights as written above and confirmed R16 had not received any PRN Lasix in January or February. RN-F stated R16 should have received PRN Lasix on the days when the weights were 213 and above. On 2/8/17, at 2:09 p.m. RN-G confirmed R16's order for PRN Lasix for a weight over 212 and verified R16 should have received PRN Lasix on the days the weight was over 212 as ordered. The Medication Administration Policy dated 5/2016, indicated the purpose was to administer medication correctly and timely and directed	2 830		

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2 830	Continued From page 8 medications would be administered to the resident according to the "Six Rights" [patient, drug, dose, time, route, documentation]. SUGGESTED METHOD FOR CORRECTION: The director of nursing or designee could direct staff to comprehensively assess and implement interventions to ensure residents are provided care in a manner to promote their highest well-being. A monitoring program could be established in order to assure ongoing assessment and effective care plan interventions in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty one (21) days	2 830		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced	2 930		3/13/17

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2 930	Continued From page 9 by: Based on observation, interview and document review, the facility failed to ensure medication was administered as directed by facility policy for 1 of 1 resident (R204) observed to receive a cocktail of medications via a percutaneous endoscopic gastrostomy tube. Findings include: R204's Medical Diagnosis report printed 2/6/17, identified R204's diagnoses as dysphasia (difficulty swallowing) gastro-esophageal reflux disease (GERD), hyperlipidemia (abnormally elevated lipid levels in the blood), chronic kidney disease, and Type II diabetes mellitus. R204's quarterly Minimum Data Set (MDS) dated 1/20/17, indicated R204 had a feeding tube and was on a mechanically altered diet. R204's Medication Review Report dated 2/6/17, directed staff to administer 204's medications via a percutaneous endoscopic gastrostomy (G-Tube/PEG) tube (tube place into the stomach for feeding), however the report lacked an order and justification for cocktailing (mixture of liquid and crushed medications) the medications. On 2/6/17, at 6:31 p.m. registered nurse (RN)-H was observed to wash her hands and open a sealed packet containing one tablet of Metoprolol 50 milligrams (mg) (treats hypertension and angina), one tablet of Mirtazapine 7.5 mg (antidepressant) and one tablet of Oxybutynin 10	2 930	Corrected	

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2 930	Continued From page 10 mg (treats overactive bladder). The packet identified the medications, however, lacked directions for use/route of administration. RN-H combined the medications and placed them into a 30 cubic centimeter (cc) plastic medication cup, poured the tablets into a plastic sleeve packet, inserted the packet into a manual pill crusher and crushed the tablets together. Once crushed, RN-H placed the tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H proceeded into R204's room with the medications, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and a 60 cc syringe. -At 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug, connected the syringe and checked for placement. RN-H drew up 20 cc of tap water into the syringe and flushed the tube with the water. RN-H withdrew the syringe, withdrew the plunger from the syringe, reinserted the syringe only into the g-tube port and proceeded to pour the medication cocktail mixture with 20 cc of water down the g-tube followed by another 30 cc of water. RN-H removed the syringe, closed the port of the tube, readjusted 204's clothing and exited the room. RN-H failed to administer the medications individually and flush the tube after each individual medication, per policy directive. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications together and give them through the g-tube. RN-H reviewed R204's current medication administration record (MAR) and was unable to find an order to cocktail R204's medications. RN-H stated during training she was taught to administer each medication	2 930		

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2 930	Continued From page 11 individually and flush between medications. On 2/6/17, at 6:51 p.m. the director of nursing (DON) reviewed R204's medication orders and verified R204 did not have an order to cocktail medications. The Don confirmed the facility policy directed staff to administer each medication separately and flush in between each medication. The DON verified her expectation was for staff to follow facility policy. The facility Medication Administration Policy revised 5/16, directed staff to administer each medication separately via G-tube and flush the tubing between each medication. SUGGESTED METHOD OF CORRECTION: The DON or designee could develop, review, and/or revise policies and procedures to ensure residents with tube feedings have their medications administered separately and according to facility policy. The DON or designee could educate all appropriate staff on the policies and procedures. The DON or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing	21375		3/13/17

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21375	Continued From page 12 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 staff failed to ensure appropriate infection control measures while providing direct resident contact wound care for 1 of 1 resident (R65) observed during wound care. Finding include: R65's quarterly Minimum Data Set (MDS) dated 12/27/16, indicated R65 had diagnoses including dementia, anxiety and methicillin resistant staphylococcal aureus (MRSA). The assessment indicated R65 was independent with bed mobility, required supervision with transfers and had a pressure ulcer which was unstageable. R65's care plan dated 8/30/16, indicated R65 had MRSA infection to wound on the left lower leg. The plan directed staff to wear gowns and masks when changing contaminated linens, place soiled linens in bags marked biohazard and to bag linens and close bag tightly before taking to laundry. On 2/8/17, at 11:21 a.m. licensed practical nurse (LPN)-B stated R65 liked to be involved with the dressing changes to his left lower leg and would be assisting with the dressing. Upon entering the	21375	Corrected	

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21375	Continued From page 13	21375		

room, R65 was observed seated in his wheelchair. R65 wore gloves while he used antiseptic wipes to clean the scissors, tweezers and his over the bed table.
- At 11:25 a.m. LPN-B gathered supplies for the dressing and prepared the room. LPN-A placed a towel on the floor in front of R65's left leg. She then placed a second towel on the floor adjacent to R65. LPN-A placed a box of dressing supplies on the second towel and sat on the floor next to R65. LPN-A wore gloves as she removed the old dressing. R65 had two wounds on his lower left leg which were each approximately 2.5 centimeters (cm) in diameter. R65 stated the first wound was from pressure and the second wound was from an abscess.
-At 11:30 a.m. LPN-B took a towel, dipped it into a basin of water and washed R65's leg. Once the leg was cleansed, LPN-B placed the towel on the floor next to her. LPN-B used hand sanitizer, donned fresh gloves and washed the wound out with aerosol saline wound wash (compressed wound cleaner). She gathered the wash basin, emptied it in the restroom and washed her hands. LPN-B returned to R65, donned fresh gloves and applied a new dressing to the wound.
-At 11:40 a.m. LPN-B replaced the wound supplies in a clear plastic box and placed on R65's shelf. She picked up the towels and carried them down the hallway to the soiled utility room. At no time during the wound dressing was LPN-B observed to use personal protective equipment other than gloves and she was not observed to bag the towel prior to leaving R65's room.
-At 2:09 p.m. LPN-B stated R65 did not have an active infection, therefore, she did not need to utilize anything more than gloves during the dressing change. She confirmed she had not bagged the dirty towels which had been used to

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21375	Continued From page 14 wash the wound prior to leaving the room. On 2/8/16, at 2:10 p.m. registered nurse (RN)-A stated R65 had a history of MRSA and she would have to look to see if he needed any precautions at this time. On 2/9/17, at 9:30 a.m. RN-B/infection control specialist stated any resident with MRSA would be under contact isolation. She stated the room was to have a sign on the door, a supply cart of personal protective equipment including gowns, gloves, and masks along with red bags for garbage and yellow bags for linens. She stated at this time, none of the residents in the facility were in contact precautions. RN-B reviewed R65's care plan and confirmed R65 was to be in isolation due to MRSA infection and the staff were to use gloves, gowns and possible masks when in direct contact with R65's wound site. RN-B reviewed R65's clinical record and confirmed R65's last wound culture obtained on 9/25/16, identified MRSA. She stated in order for contact isolation precautions to be removed, a second culture was to be obtained. Review of the Monthly Report of Resident Infections in Center / infection control log, revealed a form which identified the resident name, room number, admission dated, date of infection, site of infection, culture take, causative agents, treatment measures, cautionary measure, isolation precaution and directed the staff to identify if the infection was acquired in the facility or not. The infection control logs did not identify a resolution date. On 2/8/17, at 9:35 a.m. RN-B confirmed R65 was to be on contact isolation precautions and verified staff were to wear gowns, gloves and possibly	21375		

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21375	Continued From page 15 masks during dressing changes and all linens were to be contained in yellow biohazard bags. On 2/9/16, at 9:40 a.m. the director of nurses (DON) confirmed R65's wounds contained MRSA and the staff were to be utilizing contact precautions during the dressing changes. The DON stated she was not aware the precautions had been removed and did not know when they would have been removed. The Multidrug-Resistant Organisms policy dated 11/2016, directed staff to place soiled laundry in a moisture-resistant container and not on the room surfaces or floor. It also directed the staff to utilize contact precautions when in contact with drainage known to contain the multidrug resistant organism. On 2/9/17, at 9:45 a.m. the DON reviewed the Multidrug-resistant organisms policy and confirmed the policy had not been followed. The DON stated R65 would only require contact precautions during dressing changes and during linen changes if the dressing had not fallen off. The DON stated R65's dressings typically remained in place but gowns should be worn during dressing changes since aerosol wound cleanser was used to directly wash the wound bed which would cause potential splatter. On 2/9/17, at 12:35 a.m. LPN-B stated R65 had been hospitalized and had been cleared of all infections. However, RN-A interjected and stated R65 had been cleared of osteomyelitis, but had not been cleared from the MRSA. LPN-A stated she was unaware R65 was still active with MRSA and had she been aware of the continued infection, she would have worn a gown, not sat on the floor during the dressing change and would	21375		

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21375	Continued From page 16 have bagged the linens in a yellow biohazard bag prior to leaving the room. LPN-B stated R65 wound status had not been communicated. Suggested methods of correction: The director of nursing or designee could review infection control policies and procedures while providing wound care with staff. The director of nursing or designee could then develop an auditing system as part of the facility's quality assurance program to ensure ongoing compliance. Time period for correction: Twenty one (21) days.	21375		
21620	MN Rule 4658.1345 Labeling of Drugs Drugs used in the nursing home must be labeled in accordance with part 6800.6300. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure electronically dispensed medication packets were properly labeled with directions for use for 3 of 3 residents (R60, R106, R 204) observed to not have accurately labeled electronically dispensed medication packets. Findings include: On 2/6/17, at 6:14 p.m. licensed practical nurse (LPN)-A was observed to prepare medications for R60. The physicians orders dated 1/17/17, directed LPN-A to administer the following	21620	corrected	3/13/17

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21620	Continued From page 17 medications: -Coumadin 1.5 milligrams (mg) po (orally) daily -humalog insulin inject 5 units subcutaneous two times a day related to diabetes and give an additional 5 units per carbohydrate at lunch and supper -Metformin 500 mg po two times a day -metoprolol tartate 100 mg po twice a day give with food -Calcium Citrate +D 315-250 mg po give one with meals -Cranberry tablet 600 mg po three times a day -Percocet 5-325 mg po three times a day -Sinemet 25-100 mg po tab before meals and at bedtime. At 6:16 p.m. LPN-A reviewed the medication administration record and proceeded to remove three 2 by 3 inch packets from the medication cart. The first packet identified R60's name, the date of 2/6/17, the time was identified as "evening" and a Percocet tablet 5-325 mg tab was in the packet. The packet label identified the medication as round and white with the number 203 on it. The prescription number, the name of the pharmacy and the name of the physician was on the packet, however, the directions for use including the route were not identified on the packet. LPN-A placed the tablet in a soufflé cup. When questioned why the directions for use were not on the label, RN-D, who overheard the question, responded by stating the staff were to follow the directions in the electronic medication administration record (MAR) for each medication. She confirmed the directions for each medication were not on the printed packets. LPN-A explained the packet medications were printed and dispensed from a machine in the 100 unit	21620		

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21620	Continued From page 18 medication room. She explained the day shift nurse had printed the packages for the evening shift medication pass and she would be printing the night shift medications prior to the end of her shift. The second packet contained R60's name, date, and evening. The packet contained one Sinemet 25-100 mg tablet described as round a logo 539 and yellow along with the prescription number, physician and pharmacy identification, a metformin 500 mg table was also in the package identified as number 102, round and white with the prescription number, pharmacy and physician identified. The second package did not direct the staff how to administer the medications. LPN-A placed the two medications in the soufflé cut. The third packet contained R60's name, date, and evening as time indicated to administer. It indicated the package contained metoprolol tartate 100 mg described as a round blue table with number 47 stamped on it, parmidpexole tabled 0.5 mg identified as a white oblong tablet with PX2 stamped on it and oxybutynin 10 mg ER described as a round peach tablet with M 010 stamped on it. The package identified the prescription number, the pharmacy, the pharmacist and the prescribing physician but it did not identify the direction for each medication. LPN-A was observed to open the third packet, remove the metoprolol tartrate tablet, place it into the soufflé cup, left the two additional medications in the packet and returned the packet to the medication cart. LPN-A stated the other two medications in the packet would be administered during the next medication pass. She stated for some reason, the metoprolol was in the same	21620		

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21620	Continued From page 19 package as the bedtime medications. At 6:20 p.m. LPN-A obtained a cranberry tablet from a bottle of medication, the coumadin tablet from a bubble packet (which contained a full prescription label including directions for use) and a humalog insulin pen and proceeded to go to R60's room. -At 6:22 p.m. LPN-A spoke with R60, confirmed R60 had eaten her meal and proceeded to administer R60's medications. -At 6:34 p.m. LPN-A stated some medications were printed on the small packets from the AlixaRX electronic medication dispensing machine and other medications were in bubble packages or bottles. She stated it just depended upon the medication whether it came in a blister pack, bottle or from the AlixaRX machine. She confirmed she had administered humalog insulin after R60 had eaten the meal and the Sinemet after the meal. Upon review of the MAR, LPN-A confirmed the Sinemet order directed the staff to administer the medication before the meal and the insulin was to be administered after the meal. She confirmed the prescription label did not direct the staff to administer the sinemet before the meal as per the physician orders. She stated she usually gave R60 her medications after she had eaten the meal. On 2/8/17, at 12:50 p.m. LPN-B was observed in the 100 unit medication room. An AlixaRX medication dispensing machine was in the center of the room. LPN-A logged into a computer next to the machine and programmed the machine to print the 300 wing unit medications for the evening shift. LPN-A began the pass when the machine ran out of packing materials. Pharmacy	21620		

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21620	Continued From page 20	21620		

technician (PT)-A assisted LPN-A to change the packaging materials in the machine. When questioned as to how to change the time of the medication packages, LPN-A stated when a package was opened, all of the medications within that package were to be administered at the same time. If the medications were not being dispensed at the appropriate time, the nurse on duty was to call the pharmacy and have the dispensing machine reprogrammed. LPN-A stated she was not aware of any problems with the time of R60's evening medications.

On 2/8/17, at 1:10 p.m. LPN-A confirmed the medication dispensed from the AlixaRX machine did not identify the route or the directions for use for each medication in the package dispensed. She stated the staff were to check the MAR for the directions to give.

On 2/8/17, at 2:16 p.m. registered nurse (RN)-A confirmed the prescription labels on the packets from the AlixaRX machine did not include the route or the directions for the medication use. She stated the staff were to follow the directions on the MAR. RN-A stated R60's sinemet was to be given before meals and therefore should have been repackaged and not administered after the meal with the rest of her medications. She confirmed R60's prescription label did not direct the staff as to when to administer the medications.

On 2/9/17, at 8:13 a.m. the director of nurses (DON) stated that in order for the staff to pass medications according to the facility policy, they were to be confirming the six rights of medication

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21620	Continued From page 21	21620		

adminsitration which included the right medication, right dose, right resident, right route, right time and right documentation and to perform three checks: read the label on the medication container and compare with the MAR when removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medications. The DON confirmed the staff who administered medications did not have the ability to compare the prescription label to the physician's order in the MAR because the directions for use were not on the prescription label. The DON confirmed she would have to contact the pharmacy for further direction.

On 2/6/17, at 6:31 p.m. RN- H was observed to prepare the following medication for administration via a percutaneous endoscopic gastrostomy (G-Tube/PEG) tube (tube place into the stomach for feeding):
-one tablet of Metoprolol 50 milligrams (mg) (treats hypertension and angina)
-one tablet of Mirtazapine 7.5 mg (antidepressant)
-one tablet of Oxybutynin 10 mg (treats overactive bladder)

RN-H washed her hands and open a sealed plastic packet approximately 2 inches by 3 inches, which contained the above medications. The packet identified the medications, however, lacked directions for use and the route to which the medication was to be administered. RN-H combined the Metoprolol, Mirtazapine and Oxybutynin, into a 30 cc plastic medication cup, poured the tablets into a plastic sleeve packet, inserted the packet into a manual pill crusher and crushed the tablets together. RN-H placed the

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21620	Continued From page 22 crushed tablets into a 30 cc plastic medication cup and added 20 cc of water. RN-H entered 204's room, washed hands, donned a pair of gloves and gathered supplies which included a graduate with tap water and 60 cc syringe -at 6:40 p.m. RN-H exposed R204's g-tube, unclamped and removed the plug on the end of the G-tube, connected the syringe and confirmed proper placement. RN-H drew up 20 cc of tap water into syringe and flushed tube. RN-H withdrew the syringe and withdrew the plunger and proceeded to reinsert the syringe into g-tube port, poured the Metoprolol, Mirtazapine, and Oxybutynin mixed with 20 cc of water into the g-tube, poured 30 cc of water into a 30 cc medication cup and poured the water into the open ended syringe. RN-H -unattached the open ended syringe from the g-tube, closed the port on the tubing and readjusted 204's clothing and exited the room. On 2/6/17, at 6:40 p.m. RN-H stated she was not sure if R204 had an order to crush and mix all of R204's medications and give them together through the g-tube. RN-H reviewed R204's current MAR and was unable to find an order to cocktail R204's medications. RN-H verified the medication packets containing R204's Metoprolol, Mirtazapine and Oxybutynin lacked directions for use and route of administration. RN-H stated, the staff used the MAR to check for administration directives. RN-H stated she was unaware the medication packets lacked the direction and route information. RN-H stated she checked the MAR when administering medications. On 02/09/17, at 8:29 a.m. LPN-C was observed to obtain a sealed medication packet	21620		

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21620	Continued From page 23 approximately 2 inches by 3 inches which contained three medication tablets. The packet identified R106's name, date, and the following medications: 1- Lisinopril tablet- 5 mg-round 6-pink, 1 -Metformin tablet 500 mg- round H 102 -white-1 metoprolol tablet -round m 32-pink. The packet lacked direction for use. LPN-C opened the packet and placed the medications into a small souffle cup to administer to R106. LPN-C stated the labels did not have the directions for use on the packet therefore referred only to the MAR for directions. LPN-C stated she was not sure why the administration route or directions for administration was not identified on the electronically dispensed packet. When asked how to verify the right route, the right right dose and the right time medication was to be adminsitered, LPN-C stated she just looked at the MAR to see how the medications were to be administered because she was unable to compare the MAR directions to the medication packet label to ensure accurate administration of the medication. On 02/08/2017, at 12:40 p.m. AlixaRX pharmacy service technician (FST), stated she was the technician that delivered the medications to the facility, stocked the pharmacy medication machines and assisted the facility with any problems regarding the medication administration process. The FST explained the machine dispensed medications by shift, three times daily and printed the medication labels on the individual packets and dispensed the medication tablets into the individual packets. The packets were then sealed and dispensed. The FST reviewed the medication packets provided for R204 and verified the directions for use and routes were not identified. The FST stated she	21620		

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21620	Continued From page 24 was unaware the packets lacked the directions for use. The FST stated the machine had the capability to label the packets to include the directions for use and administration routes for example, when a resident went out on leave, the medications were dispensed into packets that identified the routes to administer the medications and the directions for use. The FST confirmed the lack of directions of the packets created an opportunity for medication administration inaccuracy. The FST verfied the directions for use should be indicated on the packets for verification purposes and stated this lack of information on the medication packets was a concern and she would bring this to her supervisor and to the pharmacist. On 2/9/17, at 8:41 a.m. the DON verified the medication packets dispensed from the AlixaRx machine lacked the routes and directions for use of the medications and the stock medications lacked specific information for intended resident use and the staff were unable to compare the directions for use with the MAR in order to ensure accurate medication administration. The DON stated she contacted the pharmacy in order to try and correct the issues. The DON verified the facility policy for medication administration was not followed. The facility Medication Administration policy revised 5/16, directed staff to review the MAR for medications due, and to follow the "Six Rights" of medication administration which included the right medication, right dose, right resident, right route, right time and right documentation and to perform three checks: read the label on the medication container and compare with the MAR when	21620		

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21620	Continued From page 25 removing the container from the supply drawer, when placing the medication in an administration cup/syringe and just before administering the medications. The AlixaRX Medication Ordering and Receiving from Pharmacy Medication Labels policy dated 06/15, indicated each prescription medication label included: Resident's name, Specific directions for use, medication name, strength, prescriber's name, date dispensed, quantity of medication, expiration date of medication, prescription number, Accessory labels indicating storage requirements and special procedures. Example: "Take on empty stomach, one hour before or 2 hours after meals. Suggested methods of correction: The director of nursing or designee could review and revise policies and procedures related to medication labeling. Staff could be provided education related to the policies and a monitoring system could be initiated to ensure compliance. Time period for correction: Twenty one (21) days.	21620		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings.	21695		3/13/17

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21695	Continued From page 26 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to maintain resident wheelchairs and care equipment in good repair and/or a clean and sanitary condition for 6 of 6 residents (R125, R35, R128, R106, R236) whose wheelchairs and equipment were observed to be dirty and in need of cleaning and/or repair. Findings include: On 2/6/2017, at 6:30 p.m. R125 was observed in the dining room seated in a wheelchair. R125 was leaning over the right arm rest of the chair and spit onto the wheel of the wheelchair and the floor. The right wheel was observed coated in food debris and a dried white substance. On 2/7/2017, at 8:53 a.m. R35's wheelchair was noted to have an orange colored tape adhered to the wheelchair brake handles. The tape was tattered and peeling. The left arm rest of R35's wheelchair was noted to be cracked and peeling exposing the white foam padding. On 2/7/17, at 10:14 a.m. R128 was observed in his room, seated in an electric wheelchair. The right side of the wheelchair seat cushion and crevices along the right side of the chair and the foot rest were noted to have dried food debris and crumbs adhered to the surfaces. On 2/7/17, at 10:47 a.m. R106's left knee brace	21695	Corrected	

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21695	Continued From page 27 was observed to be covered in a food debris. On 2/7/17, at 2:19 p.m. R236 was observed in the dining room, seated in a wheelchair, drinking coffee with friends. The right arm of the wheelchair was observed to have a rip on the seam at the bottom which ran almost the entire length of the armrest. On 2/9/17 at 3:13 p.m. the director of environmental services (DES) stated nursing staff were responsible for the cleaning of resident wheelchairs and braces. However, DES confirmed environmental services would be responsible for maintaining wheelchairs in good working order/repair. DES indicated each nursing station had a work order book and could submit a work order for wheelchairs with ripped armrests or other issues. DES indicated environmental services staff completed work orders everyday. At the time of the tour, R35 and R236 were unavailable, however, DES indicated the tape on the wheelchair brakes would create a surface that was not able to be cleaned. DES also indicated a work order should have been placed and tears in wheelchair arm rests would have been repaired. DES indicated the wheelchairs would be examined and repaired as soon as possible. On 2/9/17 at 3:30 p.m. the director of nursing (DON) confirmed nursing staff were responsible for the cleaning of resident wheelchairs. The DON indicated each resident's wheelchair was cleaned on their bath day and as needed. The DON also indicated any other resident equipment, such as braces, were cleaned on an as needed basis and would expect the nursing	21695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00087	A. BUILDING: _____ B. WING _____	02/09/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21695	Continued From page 28 assistants to let the station directors know of any unclean equipment so arrangements could be made for cleaning. The DON confirmed the aforementioned observations and verified R125's wheelchair was dirty and needed to be cleaned, R106's knee brace was soiled and required cleaning, the tape on R35's wheelchair brake handles was put on by the therapy department to enhance visibility however, it was worn and tattered and needed to be replaced and confirmed the arm rest was cracked and required repair. The DON also verified R128's wheelchair and cushion were dirty and required cleaning. The Station 2 bath schedule dated 12/22/16, indicated wheelchair cleaning was to be done during the night hours of the 1st scheduled bath of the week and R125's wheelchair was to be cleaned on Tuesday and R128's wheelchair was to be cleaned on Monday. No further policies regarding cleaning or repair of resident equipment were provided. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to report damaged resident personal care equipment and ensure resident equipment is maintained in a sanitary condition. The administrator then could develop and auditing system as part of facility's quality assurance program to maintain compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days	21695		