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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KZFT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**

2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **04/05/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (L17)

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	43			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
LoAnn Degagne, HFE - NE II 04/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 04/13/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/14/1981
(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
03/06/2018
(L33)

DETERMINATION APPROVAL

CCN: 245237

A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5237013 was completed and was found to be substantiated at F607, F609, and F610.

On 3/7/2018 an onsite PCR was completed and this facility was found not to be in compliance. This facility continued to be non-complaint with F684 and F688. Investigation #H5237013 was found to be corrected.

On 4/5/2017 an onsite PCR was conducted and the facility was found to be in compliance.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245237

April 13, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Dear Ms. Amundson:

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 29, 2018 the above facility is recommended for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

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

cc: Licensing and Certification File

Electronically delivered
April 13, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

RE: Project Number S5237025

Dear Ms. Amundson:

On March 19, 2018, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective March 24, 2018. (42 CFR 488.422)

Also on March 19, 2017, we recommended the enforcement remedy listed below to the Centers for Medicare and Medicaid Services (CMS) for imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective April 11, 2018. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on January 11, 2018, that included an investigation of complaint number H5237013 which was found to be corrected, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on March 7, 2018. The deficiencies not corrected are as follows.

F0684 -- S/S: D -- 483.25 -- Quality Of Care
F0688 -- S/S: D -- 483.25(c)(1)-(3) -- Increase/Prevent Decrease In ROM/Mobility

The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 5, 2018, the Minnesota Department of Health completed an onsite PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on March 7, 2018. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on March 7, 2018, as of March 29, 2018. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective March 29, 2018.

In addition, this Department recommended to the CMS Region V Office the following actions related to

the remedies outlined in our letter of March 19, 2018. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 11, 2018 be rescinded. (42 CFR 488.417 (b))

In our letter of March 19, 2018, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)92)9B)(iii)9b) and 1919 (f)(2)(B(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or competency Evaluation Program (NATCEP) for two years from April 11, 2018, due to the denial of payment for new admissions. Since your facility attained substantial compliance on March 29, 2018, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective April 11, 2018, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective April 11, 2018, is to be rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

April 13, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Re: Reinspection Results - Project Number S5237025

Dear Ms. Amundson:

On April 5, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 7, 2018, with orders received by you on March 19, 2018. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: KZFT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**
2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **03/07/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (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
	43			
(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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Lisa Ciesinski, HFE- NF II 03/19/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 03/20/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/14/1981
(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
03/06/2018
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 245237

A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigati of complaint #H5237013 was completed and was found to be substantiated at F607, F609, and F610.

On 3/7/2018 a onsite PCR was completed and this facility was found not to be in complaince. This facility continued to be non complaint with F684 and F688. Investigation #H5237013 was found to be corrected.

On 4/5/2017 a onsite PCR was conducted and the facility was found to be in compliance.

Electronically delivered

March 19, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

RE: Project Number S5237025 and H5237013

Dear Ms. Amundson:

On January 26, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 11, 2018 that included an investigation of complaint number H5237013. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On March 7, 2018, the Minnesota Department of Health and on February 13, 2018, the Minnesota Department of Public Safety completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 11, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 9, 2018. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 11, 2018. The deficiencies not corrected are as follows:

F0684 -- S/S: D -- 483.25 -- Quality Of Care
F0688 -- S/S: D -- 483.25(c)(1)-(3) -- Increase/Prevent Decrease In ROM/Mobility

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

As a result of our finding that your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

- State Monitoring effective March 24, 2018. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the

following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective April 11, 2018. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective April 11, 2018. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective April 11, 2018. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Redwood Falls is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective April 11, 2018. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov .

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:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343
Fax: (320) 223-7348

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or 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 we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the

second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

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 April 11, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

RECEIPT OF LICENSING PENALTY ASSESSMENT NOTICE

On ,

I, _____, _____, received
(Name)(Please Print) (Title)(Please Print)
the Notice of Penalty Assessment dated and licensing orders issued to:

Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

The Penalty Assessments and licensing orders attached hereto have been corrected as of .

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

DELIVERY OF LICENSING PENALTY ASSESSMENT NOTICE

On ,

I, _____, _____, of the Health Regulation Division,

(Name)(Please Print) (Title)(Please Print)
Minnesota Department of Health, delivered the Notice of Penalty Assessment dated and issued to:

Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

The Notice of Penalty Assessment was handed to _____,
(Name)(Please Print)
_____, Date _____
(Title)(Please Print)

Signed: _____, _____, Date _____
(Name)(Please Print) (Title)(Please Print)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	R-C 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{E 000}	Initial Comments There were no citation issued in Emergency Preparedness at the recertification survey exited on 1-11-18.	{E 000}		
{F 000}	INITIAL COMMENTS An onsite post certification revisit (PCR) was completed on 03/06/2018 to 03/07/2018 and found to have NOT corrected all the citations issued on the survey exited 1/11/18. Based on the PCR, it was determined that the facility is not in substantial compliance. In addition, the complaint investigation found substantiated at the time of the recertification survey was reviewed for compliance. H5237013 was found to be corrected at the time of this visit. 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.	{F 000}		
{F 684} SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document	{F 684}	Preparation and execution of this	3/29/18

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

Electronically Signed | 03/26/2018

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

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	245237	A. BUILDING _____ B. WING _____	R-C 03/07/2018

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{F 684}	Continued From page 1 review the facility failed to comprehensively assess and provide interventions when a blister was identified on the buttocks for 1 of 1 residents (R7) reviewed for change of condition and non-pressure related skin concerns. Findings include: R7's Admission Record, dated 4/13/17, indicated diagnoses including weakness and amyotrophic lateral sclerosis (a rare neurological disease that mainly involves the nerve cells responsible for controlling voluntary muscle movement) and identified R7 was receiving hospice care. R7's significant change Minimum Data Set (MDS), dated 2/8/18, identified R7 was cognitively intact, required extensive assistance for activities of daily living (ADLs), was incontinent of bowel and bladder, and was at risk for pressure ulcers. During a review of R7's medical record, a Skin Observation, dated 2/28/18, identified a "blister" on the "left buttock," measuring "0.5 cm [centimeter] x 0.25 cm." The rest of the Skin Observation form was blank. There was no documentation that R7's physician was notified or an assessment was completed when the blister was identified. Review of R7's progress notes, lacked any documentation of the identified blister, until 3/2/18 which included, "Fax rec'd [received] ok for mepilex [foam dressing] to blister rt [right] buttock [previously identified on the left buttock] change every 3 days." A faxed physician order, dated 3/1/8, identified a concern of "Resident has a 0.25 cm x 0.5 cm blister area on R [right] buttock. Cleansed and applied mepilex. How would you like to treat?" The order also included under	{F 684}	response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operation Manual. The Interact, wound data collection policy and procedure has been reviewed on 3/20/18. R7 documents were corrected and wound data collection was completed on 3/7/18. This practice has the potential to affect residents care-planned with the potential for skin break down issues. Skin assessments have been reviewed for these residents and care-plans have been updated accordingly. To prevent further potential deficient practice that may affect other residents. Nursing department will be reeducated during meeting on 03/28/2018 on communication and documentation of skin breakdown issues. Which will include the implementation of completing the risk assessment, documentation of a progress note, faxing the primary care physician, family notification, and entering a notation into the communication dashboard. Audits will be done on communication and	

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{F 684}	Continued From page 2 physician comments, "Refaxed 3/2/18 at 1200. Can we use mepilex. Change Q [every] 3 d [days] & PRN [as needed]. The physician signed the order on 3/2/18, indicating, "As above. Ok till healed." R7's Clinical Physician Orders included an order with a start date of 3/2/18 for Mepilex to rt buttock, change every 3 days and as needed. Review of R7's Treatment Record, dated 3/1/18-3/31/18, indicated R7 had received Mepilex to her right buttock on 3/2/18 and 3/5/18. Review of R7's care plan, last revised on 2/15/18, identified R7 had a history of an open area on her spine, however, lacked information that a blister was identified on the buttock. During an interview on 3/7/18, at 9:20 a.m. registered nurse (RN)-B and RN-A stated they were responsible for completing wound rounds on residents with skin concerns, and were in the process of completing wound rounds at that time, as they did every Wednesday. RN-B and RN-A stated R7 was not on their list to see because they were not aware of any issues with her skin or that she had a blister on the buttocks. At 10:20 a.m. RN-B stated progress notes were reviewed for all residents every morning at "stand up," to identify any skin concerns. Staff were also directed to communicate with RN-A or RN-B if they identified a skin concern. RN-B stated R7 had a skin observation on 2/28/18, and the blister was noted, however, was not included in a progress note and was not communicated to RN-B or RN-A. RN-B stated, "This was missed. We should have seen it." RN-B stated they would be assessing R7's blister so that they could attempt to identify the cause of the blister and put interventions in to place.	{F 684}	completion of documentation of skin issues to ensure corresponding progress notes in the resident□s chart and notification of the physician has been completed timely. Audits will also include the completion of the risk assessment and communication on the dashboard. Audits will be done by DNS or designee on 10% of the population 1 time weekly for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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{F 684}	Continued From page 3	{F 684}		

On 3/7/18, at 12:42 p.m. RN-B and RN-A entered R7's room. R7 was lying in bed. Mepilex dressing was removed by RN-A and was noted to be saturated with a yellow substance that RN-A and RN-B identified as urine. A dark red area was identified on the upper right buttock, and RN-B described the area as flat, soft, not fluid filled, not open, and measured 0.5 cm x 0.25 cm. RN-B sprayed the area with Dermal Wound Cleanser, and dried with gauze. A Mepilex dressing was applied.

During an interview on 3/7/18, at 1:05 p.m. RN-A and RN-B stated, "We did not know about it [R7's blister] until you told us. We didn't get a note. The nurse that noted it, should have told us." RN-A and RN-B stated they would be updating the physician, would be calling hospice for direction and possibly a new mattress, and would consult with the dietician. RN-B stated, "I can't honestly say it was pressure," indicating the cause could have been a crease in her brief or wheelchair cushion.

On 3/7/18, at 1:30 p.m. the director of nursing (DON) was interviewed and stated, "I feel like there are too many steps in the process, they need to be refined." The DON indicated the nurse that identified the area should have notified the charge nurse and it should have been identified on the charge nurse communication sheet, and she or RN-A or RN-B should have been notified so R7's blister could have been assessed. DON further stated, "Notification was missed. Period."

Review of the facility's policy, Wound and Pressure Ulcer Management, dated 1/17, included, "Promotion of healing, pain management and prevention of complications is

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{F 684}	Continued From page 4 extremely important, as well as accurate assessment and documentation. Review of the facility's policy, Pressure Ulcers, dated 1/17, included, "Residents will receive appropriate assessments and services to promote and maintain skin integrity."	{F 684}		
{F 688} SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide restorative nursing for 2 of 3 residents (R1, R19) reviewed for restorative nursing. Findings Include: R1's Diagnosis Report, printed 3/7/18, identified a primary admitting diagnoses of, unspecified	{F 688}	GSS policy on restorative programs purpose is to provide appropriate restorative nursing care to each resident. R1 and R19 Restorative programs have been reviewed and care plans updated on 3-21-18 to reflect restorative needs of therapy recommended programs. Resident receiving restorative therapies and their documentation have been	3/29/18

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{F 688}	Continued From page 5 dementia without behavioral disturbance, unspecified osteoarthritis, unspecified site, pain unspecified. R1's comprehensive assessment, dated 1/8/18, identified severe cognitive impairment. R1's Functional Maintenance Restorative Program dated 1/25/17, identified a restorative program included daily passive range of motion (ROM) to: both arms, shoulder, elbows, hands, extension/ flexion to both legs, hips-side to side (knees apart), up and down (like marches), knees-(flex/extension). R1's current care plan, last revised 2/5/18, identified R1 has a need for restorative intervention to support midline posture in wheelchair/Broda chair (chair that allows for repositioning). Interventions included, Nursing Rehab: #1 Passive range of motion both arms, shoulders, elbow, hands, do extension and flexion. Both legs and hips, side to side, up and down, knees flex/extension and ankles flex/extension. Does 10 resp (repetitions) each exercise. R1's medical record lacked evidence a ROM program was being offered, implemented, and evaluated as the program prescribed R19's Diagnosis Report, printed 3/7/18, identified a primary admitting diagnosis of unspecified sequelae of unspecified cerebrovascular disease. R19's comprehensive assessment, dated 3/5/18, identified R19 was cognitively intact. R19's care plan, last review date of 2/6/18,	{F 688}	reviewed and a plan for reeducation of staff delivering care to these residents and the completion of documentation has been developed and will be completed by 03/28/2018. To prevent further potential deficient practice that may affect other residents, the restorative nursing aids have been reeducated on accuracy of charting tasks that were completed. Charting has been reviewed for any residents receiving restorative nursing care and training has been with restorative aides on charting. Chart audits will be completed on all residents receiving restorative nursing for proper documentation. Audits will be done by the DNS or designee 1 time a week for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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{F 688}	Continued From page 6	{F 688}		

indicated R19 has a need for restorative intervention due to limited physical mobility R/T (related to) CVA (cerebrovascular accident). Interventions identified: R19 should perform Scifit (exercise bicycle) at level 5 up to 10 minutes 3-5 x (times) per week, walking with cane, gait belt and CGA (care giver assist) up to 100 feet 3-5 xwk (times per week)

R19's Functional Maintenance Restorative Program, dated 2/6/18, indicated the overall goal was to maintain current level of mobility. Frequency of the restorative program was to occur 3-times per week. The program included to walk with cane, gait belt, and CGA up to 100 feet. Scifit level included 8 times for 10 minutes.

R19's medical record lacked documentation that ambulation and restorative nursing programs were being offered, implemented, and evaluated.

During interview on 3/7/18, at 12:25 p.m. when asked about the restorative program, R19 stated they offer the restorative program once in awhile but it hasn't been much lately. R19 went on to state the last time was 2 weeks ago. R19 stated the other day they asked, but was not feeling well and didn't want to go and have an accident.

The facility 3 ring binder labeled Restorative Nursing Documentation was reviewed for the available dates of 3/1/18- 3/6/18. The first page in the 3 ring binder was a page labeled March 2018. Down the left side of the page was a list of resident names who were to receive the restorative program. Across the top of the page were the days of the month 1-31. For each day was a corresponding box for each resident. Restorative program recommendations for R1

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{F 688}	Continued From page 7	{F 688}		

was daily, however, only the boxes for 3/5/18 and 3/6/18 were marked by a staff person. The boxes for 3/1,3/2,3/3, and 3/4 were blank. Restorative program recommendations for R19 was 3-5 times per week, however the box for 3/1,3/2, 3/3,3/4 and 3/6 were blank 3/5 had an R(refused). A copy of the document was requested but was not provided.

During interview on 3/7/18, at 12:10 p.m. the nursing assistant (NA)-A stated restorative nursing is documented in the 3 ring binder on the list for each month. NA-A stated if a square is blank, it means the restorative was not done for that date.

During interview on 3/7/18 at 12:20 p.m. registered nurse (RN)-A, stated they had updated the restorative therapy care plans. RN-A further stated she had set up the documentation in the 3 ring binder. RN-A also stated therapy aides document restorative nursing the 3 ring binder on the page with the residents names listed. If a square on a date is blank it means the restorative nursing did not occur that date.

During an interview on 3/7/18, at 12:30 p.m. the director of nursing (DON), stated she was working on the audits for restorative nursing and was finding blanks in the documentation for restorative nursing in the 3 ring binder. The DON stated the blanks in the documentation meant the restorative therapy was not done on those dates and gave no explanation as to why the documentation was not completed.

Facility policy titled Restorative nursing Program dated 6/12 identified "each resident will receive restorative nursing care to the extent possible

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{F 688}	Continued From page 8 based on individual strengths, needs,and problems as defined in nursing assessments."	{F 688}		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

NOTICE OF ASSESSMENT FOR NONCOMPLIANCE WITH CORRECTION ORDERS FOR NURSING HOMES

Hand Delivered on March 19, 2018.

March 19, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Re: Project # S5237025

Dear Ms. Amundson:

On March 7, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on January 11, 2018.

State licensing orders issued pursuant to the last survey completed on January 11, 2018, found not corrected at the time of this March 7, 2018 revisit and subject to penalty assessment are as follows:

20830 -MN Rule 4658.0520 Subp. 1 -- Adequate And Proper Nursing Care; General	$350.00
20895 - MN Rule 4658.0525 Subp. 2.B -- Rehab - Range Of Motion	$350.00

The details of the violations noted at the time of this revisit completed on March 7, 2018 (listed above) are on the attached Minnesota Department of Health Statement of Deficiencies-Licensing Orders Form. Brackets around the ID Prefix Tag in the left hand column, e.g., {2 ----} will identify the uncorrected tags. It is not necessary to develop a plan of correction, electronically acknowledge and date this form and submit to the Minnesota Department of Health if there are no new orders issued.

Therefore, in accordance with Minnesota Statutes, section 144A.10, you will be assessed an amount of $700.00 per day beginning on the day you receive this notice.

The fines shall accumulate daily until notification from the nursing home is received by the Department stating that the orders have been corrected. This written notification shall be mailed or delivered to the Department at the address below or to , Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, 3333 W Division, #212 St Cloud Mn 56301.

When the Department receives notification that the orders are corrected, a reinspection will be conducted to verify that acceptable corrections have been made. If it is determined that acceptable corrections have not been made, the daily accumulation of the fines shall resume and the amount of the fines which otherwise would have accrued during the period prior to resumption shall be added to the total assessment. The resumption of the fine can be challenged by requesting a hearing within 15 days of the receipt of the notice of the resumption of the fine.

If the accumulation of the fine is resumed, the fines will continue to accrue in the manner described above until a written notification stating that the orders have been corrected is verified by the Department.

The costs of all reinspections required to verify whether acceptable corrections have been made will be added to the total amount of the assessment.

You may request a hearing of any of the above noted penalty assessments provided that a written request is made within 15 days of the receipt of this Notice. Any request for a hearing shall be sent to Mary Henderson, Minnesota Department of Health, Licensing and Certification Program, Health Regulation Division, P.O. Box 64900, St. Paul, Minnesota 55164-0900.

Once the penalty assessments have been verified as corrected the facility will receive a notice of the total amount of the penalty assessment including the costs of any reinspections.

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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File
Shellae Dietrich, Licensing and Certification Program
Penalty Assessment Deposit Staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	R-C 03/07/2018

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{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on 03/06/2018 and 03/07/2018. During this visit it was determined that the following citations were NOT Corrected. The uncorrected citations will remain in effect and will be reviewed at the next onsite visit.	{2 000}		

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GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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{2 830}	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess and provide interventions when a blister was identified on the buttocks for 1 of 1 residents (R7) reviewed for change of condition and non-pressure related skin concerns. Findings include: R7's Admission Record, dated 4/13/17, indicated diagnoses including weakness and amyotrophic lateral sclerosis (a rare neurological disease that mainly involves the nerve cells responsible for controlling voluntary muscle movement) and identified R7 was receiving hospice care. R7's significant change Minimum Data Set (MDS), dated 2/8/18, identified R7 was cognitively intact, required extensive assistance for activities of daily living (ADLs), was incontinent of bowel and bladder, and was at risk for pressure ulcers.	{2 830}	Corrected	3/29/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	R-C 03/07/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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{2 830}	Continued From page 2 During a review of R7's medical record, a Skin Observation, dated 2/28/18, identified a "blister" on the "left buttock," measuring "0.5 cm [centimeter] x 0.25 cm." The rest of the Skin Observation form was blank. There was no documentation that R7's physician was notified or an assessment was completed when the blister was identified. Review of R7's progress notes, lacked any documentation of the identified blister, until 3/2/18 which included, "Fax rec'd [received] ok for mepilex [foam dressing] to blister rt [right] buttock [previously identified on the left buttock] change every 3 days." A faxed physician order, dated 3/1/8, identified a concern of "Resident has a 0.25 cm x 0.5 cm blister area on R [right] buttock. Cleansed and applied mepilex. How would you like to treat?" The order also included under physician comments, "Refaxed 3/2/18 at 1200. Can we use mepilex. Change Q [every] 3 d [days] & PRN [as needed]. The physician signed the order on 3/2/18, indicating, "As above. Ok till healed." R7's Clinical Physician Orders included an order with a start date of 3/2/18 for Mepilex to rt buttock, change every 3 days and as needed. Review of R7's Treatment Record, dated 3/1/18-3/31/18, indicated R7 had received Mepilex to her right buttock on 3/2/18 and 3/5/18. Review of R7's care plan, last revised on 2/15/18, identified R7 had a history of an open area on her spine, however, lacked information that a blister was identified on the buttock. During an interview on 3/7/18, at 9:20 a.m. registered nurse (RN)-B and RN-A stated they were responsible for completing wound rounds on residents with skin concerns, and were in the	{2 830}		

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{2 830}	Continued From page 3	{2 830}		

process of completing wound rounds at that time, as they did every Wednesday. RN-B and RN-A stated R7 was not on their list to see because they were not aware of any issues with her skin or that she had a blister on the buttocks. At 10:20 a.m. RN-B stated progress notes were reviewed for all residents every morning at "stand up," to identify any skin concerns. Staff were also directed to communicate with RN-A or RN-B if they identified a skin concern. RN-B stated R7 had a skin observation on 2/28/18, and the blister was noted, however, was not included in a progress note and was not communicated to RN-B or RN-A. RN-B stated, "This was missed. We should have seen it." RN-B stated they would be assessing R7's blister so that they could attempt to identify the cause of the blister and put interventions in to place.

On 3/7/18, at 12:42 p.m. RN-B and RN-A entered R7's room. R7 was lying in bed. Mepilex dressing was removed by RN-A and was noted to be saturated with a yellow substance that RN-A and RN-B identified as urine. A dark red area was identified on the upper right buttock, and RN-B described the area as flat, soft, not fluid filled, not open, and measured 0.5 cm x 0.25 cm. RN-B sprayed the area with Dermal Wound Cleanser, and dried with gauze. A Mepilex dressing was applied.

During an interview on 3/7/18, at 1:05 p.m. RN-A and RN-B stated, "We did not know about it [R7's blister] until you told us. We didn't get a note. The nurse that noted it, should have told us." RN-A and RN-B stated they would be updating the physician, would be calling hospice for direction and possibly a new mattress, and would consult with the dietician. RN-B stated, "I can't honestly say it was pressure," indicating the cause could

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{2 830}	Continued From page 4 have been a crease in her brief or wheelchair cushion. On 3/7/18, at 1:30 p.m. the director of nursing (DON) was interviewed and stated, "I feel like there are too many steps in the process, they need to be refined." The DON indicated the nurse that identified the area should have notified the charge nurse and it should have been identified on the charge nurse communication sheet, and she or RN-A or RN-B should have been notified so R7's blister could have been assessed. DON further stated, "Notification was missed. Period." Review of the facility's policy, Wound and Pressure Ulcer Management, dated 1/17, included, "Promotion of healing, pain management and prevention of complications is extremely important, as well as accurate assessment and documentation. Review of the facility's policy, Pressure Ulcers, dated 1/17, included, "Residents will receive appropriate assessments and services to promote and maintain skin integrity."	{2 830}		
{2 895}	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: B. a resident with a limited range of motion receives appropriate treatment and services to	{2 895}		3/29/18

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{2 895}	Continued From page 5 increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide restorative nursing for 2 of 3 residents (R1, R19) reviewed for restorative nursing. Findings Include: R1's Diagnosis Report, printed 3/7/18, identified a primary admitting diagnoses of, unspecified dementia without behavioral disturbance, unspecified osteoarthritis, unspecified site, pain unspecified. R1's comprehensive assessment, dated 1/8/18, identified severe cognitive impairment. R1's Functional Maintenance Restorative Program dated 1/25/17, identified a restorative program included daily passive range of motion (ROM) to: both arms, shoulder, elbows, hands, extension/ flexion to both legs, hips-side to side (knees apart), up and down (like marches), knees-(flex/extension). R1's current care plan, last revised 2/5/18, identified R1 has a need for restorative intervention to support midline posture in wheelchair/Broda chair (chair that allows for repositioning). Interventions included, Nursing Rehab: #1 Passive range of motion both arms, shoulders, elbow, hands, do extension and flexion. Both legs and hips, side to side, up and down, knees flex/extension and ankles flex/extension. Does 10 resp (repetitions) each	{2 895}	Corrected	

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{2 895}	Continued From page 6 exercise. R1's medical record lacked evidence a ROM program was being offered, implemented, and evaluated as the program prescribed R19's Diagnosis Report, printed 3/7/18, identified a primary admitting diagnosis of unspecified sequelae of unspecified cerebrovascular disease. R19's comprehensive assessment, dated 3/5/18, identified R19 was cognitively intact. R19's care plan, last review date of 2/6/18, indicated R19 has a need for restorative intervention due to limited physical mobility R/T (related to) CVA (cerebrovascular accident). Interventions identified: R19 should perform Scifit (exercise bicycle) at level 5 up to 10 minutes 3-5 x (times) per week, walking with cane, gait belt and CGA (care giver assist) up to 100 feet 3-5 xwk (times per week) R19's Functional Maintenance Restorative Program, dated 2/6/18, indicated the overall goal was to maintain current level of mobility. Frequency of the restorative program was to occur 3-times per week. The program included to walk with cane, gait belt, and CGA up to 100 feet. Scifit level included 8 times for 10 minutes. R19's medical record lacked documentation that ambulation and restorative nursing programs were being offered, implemented, and evaluated. During interview on 3/7/18, at 12:25 p.m. when asked about the restorative program, R19 stated they offer the restorative program once in awhile but it hasn't been much lately. R19 went on to	{2 895}		

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{2 895}	Continued From page 7 state the last time was 2 weeks ago. R19 stated the other day they asked, but was not feeling well and didn't want to go and have an accident. The facility 3 ring binder labeled Restorative Nursing Documentation was reviewed for the available dates of 3/1/18- 3/6/18. The first page in the 3 ring binder was a page labeled March 2018. Down the left side of the page was a list of resident names who were to receive the restorative program. Across the top of the page were the days of the month 1-31. For each day was a corresponding box for each resident. Restorative program recommendations for R1 was daily, however, only the boxes for 3/5/18 and 3/6/18 were marked by a staff person. The boxes for 3/1,3/2,3/3, and 3/4 were blank. Restorative program recommendations for R19 was 3-5 times per week, however the box for 3/1,3/2, 3/3,3/4 and 3/6 were blank 3/5 had an R(refused). A copy of the document was requested but was not provided. During interview on 3/7/18, at 12:10 p.m. the nursing assistant (NA)-A stated restorative nursing is documented in the 3 ring binder on the list for each month. NA-A stated if a square is blank, it means the restorative was not done for that date. During interview on 3/7/18 at 12:20 p.m. registered nurse (RN)-A, stated they had updated the restorative therapy care plans. RN-A further stated she had set up the documentation in the 3 ring binder. RN-A also stated therapy aides document restorative nursing the 3 ring binder on the page with the residents names listed. If a square on a date is blank it means the restorative nursing did not occur that date.	{2 895}		

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{2 895}	Continued From page 8 During an interview on 3/7/18, at 12:30 p.m. the director of nursing (DON), stated she was working on the audits for restorative nursing and was finding blanks in the documentation for restorative nursing in the 3 ring binder. The DON stated the blanks in the documentation meant the restorative therapy was not done on those dates and gave no explanation as to why the documentation was not completed. Facility policy titled Restorative nursing Program dated 6/12 identified "each resident will receive restorative nursing care to the extent possible based on individual strengths, needs,and problems as defined in nursing assessments."	{2 895}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: KZFT

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00063

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245237**
2.STATE VENDOR OR MEDICAID NO.
(L2) **385318700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - REDWOOD FALLS**
(L4) **200 SOUTH DEKALB STREET**
(L5) **REDWOOD FALLS, MN** (L6) **56283**

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 **01/11/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **43** (L18)
13.Total Certified Beds **43** (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
	43			
(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):
A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5237013 was completed and was found to be substantiated at F607, F609, and F610

17. SURVEYOR SIGNATURE Date :
Andrea Schmitz, HFE NE II 02/08/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Michaelyn Bruer, Enforcement Specialist 02/27/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/14/1981
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 26, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

RE: Project Number S5237025 and H5237013

Dear Ms. Amundson:

On January 16, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. In addition, at the time of the January 16, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H5237013 that was found to be substantiated at F607, F609 and F610.

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) and emergency preparedness deficiencies (those preceded by an “E” tag), i.e., the plan of correction should be:

Kathleen Lucas, Unit Supervisor
St. Cloud B Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: kathleen.lucas@state.mn.us
Phone: (320) 223-7343 Fax: (320) 223-7348

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 February 20, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by February 20, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 11, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 11, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

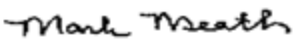
Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,



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

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 01/08/18 through 01/11/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted 1/8/18 through 1/11/18, and complaint investigation was also completed at the time of the standard survey. At the time of the survey, an investigation of complaint #H5237013 was completed and was found to be substantiated at F607, F609, and F610 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. 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.	F 000		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)	F 561		2/9/18

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

Electronically Signed | 02/03/2018

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F 561	Continued From page 1 (1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to identify a resident's preference for frequency of shaving for 1 of 2 residents (R30) reviewed for activities of daily living. Findings include: R30's significant change Minimum Data Set (MDS), dated 11/28/17, indicated R30 required physical assist of one staff for personal hygiene, including shaving. R30's Brief Interview for Mental Status (BIMS) indicated a score of 14, indicating he was cognitively intact.	F 561	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of	

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F 561	Continued From page 2 R30's Care Area Assessment, dated 12/12/17, identified R30 required limited assist with ADL's (activities of daily living.) The assessment did not identify R30's shaving frequency preference. R30's care plan, dated 12/19/17, indicated R30 required staff to comb hair, identifying can wash face, arms and hands after set up. The care plan did not identify R30's preference for frequency of shaving. During observation on 1/8/18, at 2:50 p.m. R30 was observed to have long gray facial hairs. R30 stated he needed help from staff to shave and used an electric razor. An electric razor was plugged into the wall and laying on top of the dresser in R30's room. R30 stated he liked to be clean shaven. R30 stated the last time he was assisted with shaving was "a couple three days ago". During observation on 1/9/18, at 11:09 a.m., R30's continued to have gray facial hair. R30 stated staff had never asked him how often he would like to be shaved, that he had not been shaved today and that he would like to be shaved daily. During observation on 1/9/18, at 2:12 p.m. nursing assistant (NA)-B assisted R30 with a shower. After the shower, NA-B assisted R30 back to his room. NA-B stated, "Let's get you shaved up." NA-B shaved R30, using the electric razor that was located on R30's dresser. During interview on 1/9/18, at 2:49 p.m. NA-B stated R30 receives weekly baths. NA-B stated she had assisted R30 with his bath the previous	F 561	compliance in accordance with section 7305 of the State Operation Manual. R30’s care plan and preference for shaving was reviewed and updated to meet his need on 1/11/18. Residents who have the potential to be affected by the deficient practice have had their care plans reviewed and update to meet their needs. Staff has been reeducated on the importance and policy and procedures on resident preference on shaving. To ensure that systemic changes are made that the deficient practices will not recur, random observation audits will be conducted on shaving preferences. Audits will be completed by DNS or designee 2x weekly for 4 weeks then 1x weekly for 4 weeks then every other week for 1. Audit results will be reviewed monthly by facility QAPI Committee for further recommendation.	

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F 561	Continued From page 3	F 561		

week as well. When asked about shaving, NA-B believed R30 was only shaved on his bath day. NA-B stated she did not know what R30's preference for frequency of shaving was. NA-B stated she followed the group sheet and the group sheet did not direct to shave R30 daily. NA-B stated if the group sheet did not indicate to shave daily, residents are shaved one time weekly on their shower day. NA-B stated when she assisted R30 with his shower the previous week, he had facial stubble as well.

During interview on 1/11/18, at 11:35 p.m. registered nurse (RN)-A stated she believed residents are asked upon admission about their shaving preferences, but couldn't say for sure. RN-A stated staff should be asking resident's, including R30, everyday if they wanted to be shaved. If resident's needed assistance with shaving, shaving needed to be addressed on the care plan. RN-A stated R30's care plan did not address the frequency of shaving.

During an interview on 1/11/18, at 12:34 p.m. the interim director of nursing (IDON) stated staff should ask residents about their shaving frequency preference when admitted and at each quarterly care conference. The shaving preference needed to be addressed on the care plan.

The facility's policy Activities of Daily Living, dated 6/14, directed "Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene." "General Personal, Daily Hygiene/Grooming: care of hair, hands, face, shaving, applying makeup, skin, nails and oral care."

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F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide	F 578		2/9/18

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F 578	Continued From page 5 the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure advance directives were updated to reflect resident participation and current wishes for 1 or 3 resident (R21) who received hospice services in the facility. Findings include: R21's significant change Minimum Data Set, dated 12/1/17, identified no cognitive impairment and had started to receive hospice services. R21's Provider Orders for Life-Sustaining Treatment (POLST), signed 11/10/17, indicated R21's wishes were for full treatment and to attempt resuscitation in the event of cardiac or respiratory arrest. R21's current face sheet and physician orders, printed 1/9/18, identified his advance directive as, "Attempt Resuscitation/CPR. Patient has not pulse and is not breathing." A facility progress note, dated 11/21/17, identified R21 had started hospice services. A corresponding advance directive, located in Resident Spaces (a separate system from the electronic medical record, but a part of the resident's chart), signed 11/21/17, indicated R21's code status was, "Do Not Resuscitate [DNR]... If my heart stops beating or if I stop breathing, no cardiopulmonary resuscitation (CPR) will be initiated." The advance directive further directed supportive care (treatment to alleviate suffering	F 578	R21 advance directives were updated on 1/9/18 and he has since expired. Current residents receiving hospice services have had their advanced directives reviewed and updated as needed add position on who did the review. Staff will be reeducated on the policy and procedure related to advance directives. Random audits of advance directives will be made on new hospice residents 1 times weekly for 4 weeks then every other week for 2 months . Audits results will be reviewed monthly by facility QAPI Committee for further recommendation.	

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F 578	Continued From page 6	F 578		

and promote comfort) would be provided.

A facility progress note, dated 12/8/17, identified R21's DNR code status was discussed and would be changed in his medical record.

R21's current care plan, dated 11/22/17, identified a terminal prognosis related to congestive heart failure. The care plan directed to, "Review [R21's] advance care planning choices; assist other to respect choices."

Although R21's advance directive was changed from "Attempt Resuscitation/CPR" to "Do Not Resuscitate," his POLST and electronic medical record were not updated to reflect his wishes.

During interview on 1/9/18, at 12:45 p.m. licensed practical nurse (LPN)-A stated in the event of the code (an emergency situation when a resident is in cardiopulmonary arrest requiring the initiation of CPR), a resident's code status could be checked pulling up the electronic medical record, Point Click Care. During interview, LPN-A opened R21's electronic medical record on the computer, pointing to the heading which identified to "Attempt Resuscitation/CPR." LPN-A further stated they also had a binder with every resident's POLST in the nurse's station. LPN-A pulled out the binder to R21's POLST, which identified R21 as a full code and to attempt resuscitation/CPR.

During interview on 1/9/18, at 1:01 p.m. registered nurse (RN)-A stated if a resident or representative express wishes to change an advance directive, they would get social services and an order from the doctor. RN-A further stated residents with hospice services were typically DNR, and the conversation about the code status

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F 578	Continued From page 7	F 578		

usually happened between hospice and social services. RN-A reported if a resident wanted to change their advance directive, a POLST form would be filled out, signed, and scanned into the medical record. RN-A reported she had called hospice and got a copy of R21's DNR advance directive, but didn't think social services was aware of the updated advance directive. RN-A stated the facility had updated all the residents' medical records, "a while back," to make sure POLST and advance directives were in the charts.

During interview on 1/9/18, at 2:22 p.m. the interim director of nursing (IDON) stated she had used the advance directive binder (binder located at the nurse's station) to update every resident medical record, ensuring everyone had a POLST on file. The IDON acknowledged she had not double checked that the POLST were current prior to updating the medical records. She reported, in the event of a code, nurses would look up a resident's advance directive on the computer in the electronic medical record. The IDON thought the facility nurses knew R21 was on hospice and didn't think they would start CPR; however, the IDON acknowledged the facility used pool nurses, who might not know R21, and there could be potential for them to start CPR. The IDON stated going forward, if a POLST was bought into the facility during off hours it would be given to the charge nurse to put into the medical record, and during business hours, the POLST would go to social services first, and then to a nurse leader who would put in the order.

During interview on 1/10/18, at 10:36 a.m. social services (SS)-A stated she went over advance directives on admission, and if the advance

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F 578	Continued From page 8 directive changed, they need a physician to sign off and/or a copy of a new POLST. SS-A stated when a resident was admitted to hospice services, sometimes hospice completed the advance directive and would give them a copy, and sometimes the facility staff would be present during the discussion with hospice. SS-A stated either way they needed a physician order and the advance directive would go to nursing, since she could not enter in the order. A facility policy entitled Advance Care Planning and Advance Directives, revised 4/16, directed, "Advance directive orders are to be reviewed with resident/healthcare decision-maker at each care plan meeting to ensure no changes are needed." The policy further instructed, "If a resident's condition deteriorates, review the current advance directive orders with the resident and family to determine if they wish to make changes. If there is a request for changes in the advance directive orders, contact physician for order."	F 578		
F 607 SS=D	Develop/Implement Abuse/Neglect Policies CFR(s): 483.12(b)(1)-(3) §483.12(b) The facility must develop and implement written policies and procedures that: §483.12(b)(1) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property, §483.12(b)(2) Establish policies and procedures to investigate any such allegations, and §483.12(b)(3) Include training as required at paragraph §483.95, This REQUIREMENT is not met as evidenced	F 607		2/9/18

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F 607	Continued From page 9 by: Based on interview and record review, the facility failed to implement their Abuse and Neglect policy related to reporting alleged abuse within 2 hours to the state agency and related to protecting residents from further abuse during investigation for 1 of 1 residents (R18) reviewed for abuse: Findings include: The facility's policy Abuse and Neglect, dated 11/16, directs if an employee witnesses suspected abuse, the employee will take measures to protect the resident and report the allegation to a supervisor. The charge nurse will be notified immediately and assess the situation. "If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, than it will be reported no later than two hours after the allegation is made to the administrator, and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care centers) in accordance with state law." If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident R18's annual Minimum Data Set (MDS) assessment, dated 8/25/18, indicated R18 required extensive assistance of one staff with the use of a wheelchair for locomotion on the unit.	F 607	R18 abuse allegations were reported to OHFC on 1/3/18. All incidents for the last 3 month have been reviewed and there were no additional abuse allegations that should have been reported to OHFC. Staff has been reeducated by 2/1/18 on abuse and neglect reporting policy and procedure. For 3 months all the location's incidents will be audited to ensure timely reporting to OHFC for suspected abuse/neglect allegations. Audit results will be reviewed monthly by facility QAPI committee for further recommendation. Timely reporting of OHFC suspected abuse allegations and incidences audits will be Completed 1 times weekly for 4 weeks then every other week for 2 months audits will be completed by May 1st 2018.	

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F 607	Continued From page 10	F 607		

R18 had physical behavioral symptoms directed towards others. R18's Brief Interview for Mental Status (BIMS) indicated a score of 3, severely cognitively impaired.

A facility Suggestion or Concern form, dated 1/2/18, (time not identified) indicated nursing assistant (NA)-C was attempting to give R18 a ride to the TV room from the dining room, when R18 planted her feet and wouldn't lift them to move forward. Nursing assistant (NA)-D approached R18 and tried to take R18's hand and coax R18 out of the dining room to make room for other residents to exit. Nursing assistant (NA)-E approached R18. NA-E put his foot behind R18's (legs) and forcefully lifted R18's feet up. R18 was not happy and became more agitated. The form indicated NA-C reported (time not identified) the incident to interim director of nursing (IDON) and mentioned the 2 hour time requirement to report to state to IDON. NA-C also reported the incident (time not identified) to the next shift nurse, licensed practical nurse (LPN)-C.

An incident report, dated 1/2/18, indicated the incident occurred on 1/2/18 between 5:45 pm and 6:00 p.m. NA-C notified IDON of the incident approximately 2 hours later, on 1/2/18 at 7:45 p.m. The report indicated inappropriate use of nursing assistant (NA-E) feet to move R18.

An Investigation Interview document, undated, with NA-C indicated R18 planted her feet before leaving the dining room because she wanted to fold her blanket. NA-C tried to coax R18 to lift up her feet. R18 would not lift up her feet. NA-E put his foot behind R18's legs and pushed them so they lifted. "(NA-E) didn't swing and kick her just

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 607	Continued From page 11	F 607		

lifted them forcefully." Incident occurred around 6 p.m. "I know I needed to report within 2 hours- so reported to (IDON) at 7:30-7:45 p.m. and she said 'okay' and then walked down to do the meds on the east."

An Incident Report Summary, on 1/3/18, identified the incident was reported to the state agency on 1/3/18 at 11:46 a.m., 18 hours after the incident was witnessed by NA-C. Although the report summary indicated NA-E was suspended pending investigation, NA-E's time sheet identified NA-E worked until 10:45 p.m. on 1/2/18, 4 hours and 45 minutes to 5 hours after the initial abuse allegation.

NA-E's time sheet further identified NA-E worked the following day, 1/3/18 from 2:15 p.m. to 10:45 p.m. and 1/4/18 from 5 p.m. to 9:00 p.m.

During an interview on 1/10/18 at 2:12 p.m. NA-E stated he was not suspended, but finished his shift on 1/2/18, independently working with residents, including assisting R18 to bed. NA-E stated he was unaware of the allegation until the following day, when IDON called to discuss the incident. NA-E stated he used his right foot to lift R18's feet onto the wheelchair pedals. NA-E stated he does not remember if he told R18 what he was going to do first. NA-E denied kicking R18's legs. NA-E went on to say he should have used his hands to lift R18's legs up, not his foot.

During interview on 1/10/18, at 1:52 p.m. social service director (SS)-A stated the process to report abuse was as follows: The nursing assistant reports to the nursing supervisor immediately. Nurses are to call the administrator immediately. Allegations of abuse are reported to

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 607	Continued From page 12 the state agency immediately. SS-A, the floor nurses, administrator, and the IDON all have the ability to report to the state agency. When asked about the incident related to R18, SS-A stated when she arrived at work on the morning of 1/3/18, staff (unknown) reported to her something had happened. The staff could not tell her what had happened and it took a while to find out the allegation was abuse. She reported the incident to the state agency at 11:46 a.m. SS-A stated the allegation should have been reported to the state agency immediately. During an interview on 1/11/18, at 12:34 p.m. the interim director of nursing (IDON) stated she was working on the floor on the evening of 1/2/18. IDON stated NA-C came to me with concerns of potential abuse. IDON stated NA-C stated NA-E came in the dining room and kicked up R18's feet. NA-C did not immediately report the incident to IDON. IDON stated she finished her med pass, then went and spoke with NA-E. NA-E said he put his feet under R18 and lifted up R18's feet. IDON went on to say I could not determine if he kicked her. IDON stated NA-E continued to work on 1/2/18 "because I thought it was un-substantiated." The next day, the consultant told me I should have sent NA-E home right away. IDON stated the state agency was not notified. "I should have." IDON added the administrator was not notified of the allegation at the time of the incident.	F 607		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must:	F 609		2/9/18

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F 609	Continued From page 13 §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to report an allegation of abuse to the state agency within 2 hours for 1 of 1 residents (R18) reviewed for abuse. Findings include: R18's annual Minimum Data Set (MDS), dated 8/25/17, indicated R18 required extensive assistance of one staff with the use of a wheelchair for locomotion on the unit. R18 had physical behavioral symptoms directed towards	F 609	R18 abuse allegations were reported to OHFC on 1/3/18 Judy Parvin Interim DNS. All incidents for the last 3 month have been reviewed and there were no additional abuse allegations that should have been reported to OHFC. Staff has been reeducated by 2/1/18 on abuse and neglect reporting policy and procedure. For 3 months all the location's incidents will be audited to ensure timely reporting to OHFC for suspected abuse/neglect	

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 609	Continued From page 14 others. R18's Brief Interview for Mental Status (BIMS) indicated a score of 3, severely cognitively impaired. R18's care plan, revised on 12/27/17, identified impaired cognitive functions. Interventions included: to provide R18 with necessary cues-stop and return if agitated. Re-direct R18 into other activities when showing signs of agitation. Approach and speak in a calm manner. Remove from situation and take to alternate location as needed. A facility Suggestion or Concern form, dated 1/2/18, (time not identified) indicated nursing assistant (NA)-C was attempting to give R18 a ride to the TV room from the dining room, when R18 planted her feet and wouldn't lift them to move forward. Nursing assistant (NA)-D approached R18 and tried to take R18's hand and coax R18 out of the dining room to make room for other residents to exit. Nursing assistant (NA)-E approached R18. NA-E put his foot behind R18's (legs) and forcefully lifted R18's feet up. R18 was not happy and became more agitated. The form indicated NA-C reported (time not identified) the incident to interim director of nursing (IDON) and mentioned the 2 hour time requirement to report to state to IDON. NA-C also reported the incident (time not identified) to the next shift nurse, licensed practical nurse (LPN)-C. An incident report, dated 1/2/18, indicated the incident occurred on 1/2/18 between 5:45 pm and 6:00 p.m. NA-C notified IDON of the incident approximately 2 hours later, on 1/2/18 at 7:45 p.m. The report indicated inappropriate use of nursing assistant (NA-E) feet to move R18.	F 609	allegations. Audit results will be reviewed monthly by facility QAPI committee for further recommendation. Timely reporting of OHFC suspected abuse allegations and incidences audits will be Completed 1 times weekly for 4 weeks then every other week for 2 months audits will be completed by May 1st 2018.	

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F 609	Continued From page 15	F 609		

A progress note on 1/3/18, 1:15 a.m. indicated R18's legs had no markings or bruising. No difference to lower legs. R18 stated she was okay, no distress noted. Resting in bed.

An Incident Report Summary, on 1/3/18, identified the incident was reported to the state agency on 1/3/18 at 11:46 a.m., 18 hours after the incident was witnessed by NA-C.

During interview on 1/10/18, at 1:52 p.m. social service director (SS)-A stated the process to report abuse was as follows: The nursing assistant reports to the nursing supervisor immediately. Nurses are to call the administrator immediately. Allegations of abuse are reported to the state agency immediately. Along with SS-A, the floor nurses, administrator, and the IDON all have the ability to report to the state agency. When asked about the incident related to R18, SS-A stated when she arrived at work on the morning of 1/3/18, staff (unknown) reported to her something had happened. The staff could not tell her what had happened and it took a while to find out the allegation was abuse. She reported the incident to the state agency at 11:46 a.m. SS-A stated the allegation should have been reported to the state agency immediately.

During interview on 1/11/18, at 12:34 p.m. the IDON stated she was working on the floor on the evening of 1/2/18. IDON stated NA-C came to her with concerns of potential abuse. IDON stated NA-C stated NA-E came in the dining room and kicked up R18's feet. NA-C did not immediately report the incident to IDON. IDON stated NA-C informed her of the allegation just shy of 2 hours after the incident. IDON stated she finished her medication pass, then went and spoke with NA-E.

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F 609	Continued From page 16 NA-E said he put his feet under R18 and lifted up her feet. IDON went onto say she could not determine he kicked her. IDON stated the state agency was not notified. "I should have." The IDON added the administrator was not notified of the allegation at the time of the incident. The facility's policy Abuse and Neglect, dated 11/16, directs if an employee witnesses suspected abuse, the employee will take measures to protect the resident and report the allegation to a supervisor. The charge nurse will be notified immediately and assess the situation. "If there is an allegation of abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, and/or there is serious bodily injury, than it will be reported no later than two hours after the allegation is made to the administrator, and to other officials (including the state survey agency and adult protective services where state law provides for jurisdiction in long-term care centers) in accordance with state law.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all	F 610		2/9/18

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F 610	Continued From page 17 investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: The facility failed to implement interventions to prevent further potential abuse during an abuse investigation for 1 of 1 residents (R18) reviewed for abuse. Findings include: R18's annual Minimum Data Set (MDS) assessment, dated 8/25/17, indicated R18 required extensive assistance of one staff with the use of a wheelchair for locomotion on the unit. R18 had physical behavioral symptoms directed towards others. R18's Brief Interview for Mental Status (BIMS) indicated a score of 3, severely cognitively impaired. R18's care plan, revised on 12/27/17, identified impaired cognitive functions. Interventions included: to provide R18 with necessary cues-stop and return if agitated. Re-direct R18 into other activities when showing signs of agitation. Approach and speak in a calm manner. Remove from situation and take to alternate location as needed. A Suggestion or Concern form, dated 1/2/18, (time not identified) indicated nursing assistant (NA)-C was attempting to give R18 a ride to the TV room from the dining room, when R18 planted her feet and wouldn't lift them to move forward. Nursing assistant (NA)-D approached R18 and	F 610	The policy and procedure has been reviewed in relation to the incident involving R18. Staff has been educated on 2/1/18 initiation of appropriate interventions during an abuse allegation. To prevent further potential deficient practice that may affect other residents. Staff will be reeducated on the abuse and neglect policy and procedure regarding appropriate interventions to be put into place during an abuse/neglect investigation to prevent further abuse. Audits for appropriate interventions during the investigation of suspected abuse allegations and incidences, will be Completed by DNS or designee every time there is an allegation for the next 3 months. Audits results will be reviewed monthly by facility QAPI committee for further recommendation.	

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F 610	Continued From page 18	F 610		

tried to take R18's hand and coax R18 out of the dining room to make room for other residents to exit. Nursing assistant (NA)-E approached R18. NA-E put his foot behind R18's (legs) and forcefully lifted R18's feet up. R18 was not happy and became more agitated. The form indicated NA-C reported (time not identified) the incident to interim director of nursing (IDON).

An incident report, dated 1/2/18, indicated the incident occurred on 1/2/18 between 5:45 pm and 6:00 p.m. NA-C notified IDON of the incident approximately 2 hours later, on 1/2/18 at 7:45 p.m. The report indicated inappropriate use of nursing assistant (NA-E) feet to move R18.

An untitled document of the interview with NA-D, indicated the interview occurred on 1/3/18, the day following the incident. The document indicated NA-E was needing to move R18's feet and "kicked" them out of the way. Upon further questioning stated NA-E used his foot to move R18's feet.

An Investigation Interview document, undated, with NA-C indicated R18 planted her feet before leaving the dining room because she wanted to fold her blanket. NA-C tried to coax R18 to lift up her feet. R18 would not lift up her feet. NA-E put his foot behind R18's legs and pushed them so they lifted. "(NA-E) didn't swing and kick her just lifted them forcefully." Incident occurred around 6 p.m. "I know I needed to report within 2 hours- so reported to (IDON) at 7:30-7:45 p.m. and she said 'okay' and then walked down to do the meds on the east."

Although a 1/3/18 Incident Report Summary indicate the staff member (NA-E) was suspended

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F 610	Continued From page 19	F 610		

pending investigation, NA-E's time sheet identified NA-E worked until 10:45 p.m. on the date of the incident, 4 hours and 45 minutes to 5 hours after the initial abuse allegation.

NA-E's time sheet further identified NA-E worked the following day, 1/3/18 from 2:15 p.m. to 10:45 p.m. and 1/4/18 from 5 p.m. to 9:00 p.m.

Investigation Report Summary, dated 1/10/18, indicated the facility's 5-day investigation report results were submitted to the state agency three days after the incident, on 1/5/18. The report indicated NA-E was educated on proper repositioning techniques.

During an interview on 1/10/18 at 2:12 p.m. NA-E stated he was not suspended, but finished his shift on 1/2/18, independently working with residents, including assisting R18 to bed. NA-E stated he was unaware of the allegation until the following day, when IDON called to discuss the incident. NA-E stated he used his right foot to lift R18's feet onto the wheelchair pedals. NA-E stated he does not remember if he told R18 what he was going to do first. NA-E denied kicking R18's legs. NA-E went on to say he should have used his hands to lift R18's legs up, not his foot.

During an interview on 1/11/18, at 12:34 p.m. the interim director of nursing (IDON) stated she was working on the floor on the evening of 1/2/18. IDON stated NA-C came to me with concerns of potential abuse. IDON stated NA-C stated NA-E came in the dining room and kicked up R18's feet. IDON stated she finished her med pass, then went and spoke with NA-E. NA-E said he put his feet under R18 and lifted up R18's feet. IDON went onto say I could not determine if he kicked

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 610	Continued From page 20 her. IDON stated NA-E continued to work on 1/2/18 "because I thought it was un-substantiated." The next day, the consultant told me I should have sent NA-E home right away. The facility's policy Abuse and Neglect, dated 11/16, directs the charge nurse or licensed nurse will be notified of abuse allegations immediately and assess the situation. "If this is an allegation of employee to resident abuse, the employee will be removed from providing direct care to all residents. Additionally, the employee will be placed on suspension pending the results of the internal investigation. Another employee will be assigned to complete the care of the resident.	F 610		
F 625 SS=D	Notice of Bed Hold Policy Before/Upon Trnsfr CFR(s): 483.15(d)(1)(2) §483.15(d) Notice of bed-hold policy and return- §483.15(d)(1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (e)(1) of this section, permitting a resident to return; and (iv) The information specified in paragraph (e)(1)	F 625		2/9/18

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F 625	Continued From page 21 of this section. §483.15(d)(2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (d)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were informed of the bed hold policy prior to hospitalizations for 1 of 1 resident (R38) who was transferred to the hospital. Findings include: R38's care plan, dated 10/26/17, identified she had been admitted for aftercare following a fall with a vertebral fracture. The care plan further identified R38 planned to discharge to her senior living facility after therapy. A Notification of Transfer or Discharge, dated 11/2/17, indicated R38 had been transferred to the hospital for a blood transfusion following an "acute condition status change." The Notification was filled out by social services (SS)-A and sent to the regional Ombudsman. A Discharge Summary, dated 11/3/17, identified R38 had been discharged from the facility. R38's medical record lacked evidence that the facility had informed her or her representative of the facility's bed hold policy.	F 625	GSS Sunwood provides a bed hold notice to all residents upon discharge per GSS policy and procedure. Current residents have the potential to be effected; any resident discharged will be provided a bed hold notice per GSS policy and procedure on 2/1/18. Staff has been educated on the bed hold policy and procedure. Random audits will be completed on timeliness and completion of bed holds by the DNS or designee. 1 times a week for 2 months then every other week for 1 month will be. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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F 625	Continued From page 22 During interview on 1/11/18, at 2:21 p.m. SS-A stated R38 was discharged from the hospital to a different facility. SS-A further stated nursing was responsible for notifying the resident or resident representative with bed hold information, and if the nurses forgot then she would come around the next day and give them the bed hold notice. SS-A reported the business office was a back up as well. SS-A further reported the bed hold notice was signed and scanned into the medical record, however, she was unable to find evidence a bed hold notice was provided to R38. During interview on 1/11/18, at 3:25 p.m. the interim director of nursing (IDON) stated a bed hold was needed when a resident was transferred to the hospital and changed to a different payment system. The facility's Notice of Bed-Hold Policy, dated 7/04, directed, "The Notice of Bed-Hold Policy is provided to the resident/financially responsible party upon admission and at the time time of transfer."	F 625		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(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 care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable	F 656		2/9/18

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F 656	Continued From page 23 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: Based on interview and record review, the facility failed to ensure comprehensive care plans which included medical needs were developed for 1 of 5 residents (R22) who were reviewed for unnecessary medications. Findings include: R22's admission Minimum Data Set (MDS), dated 10/18/17, identified a moderate cognitive	F 656	The policy and procedure has been reviewed in relation to the incident involving R22. R22 care plan was updated on 1/23/18. To prevent further deficient practice that may affect other resident staff have been reeducated on the comprehensive care plan and procedure. R22 was readmitted on 1/23/18 following a discharge on 1/18/18, upon review of the current	

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F 656	Continued From page 24 impairment, a diagnosis of Diabetes Mellitus, and was receiving therapy due to a hip fracture. The MDS further identified R22 was continent of bowel with no symptoms of constipation. R22's admission Care Area Assessments (CAA), dated 10/18/17, indicated she had pain after her recent hip surgery, using scheduled and as needed pain medications. R22's current physician orders, dated 1/11/18, identified the following medications: -Lantus SoloStar Solulion (insulin) 30 units in the morning for Diabetes Mellitus. -Prednisone (steroid medication which can increase blood sugar) 7 mg (milligrams) daily to taper down to 1 mg for left femur fracture. -Polyethylene Glycol (Miralax laxative) 17 gram twice a day for constipation. -Tylenol (pain reliever) 325 mg 2 tablets three times a day for pain. -Tramadol (pain reliever) 50 mg 1 tablet for pain rating 1-5 and 2 tablets pain rating 6-10 every 6 hours as needed. In addition, R22's physician orders directed to check her blood sugar before meals and at bedtime, noting blood sugars weekly and if greater than 200, increase Lantus insulin by 5 units. R22's physician communication forms and orders identified her Lantus had been increased twice during her stay, on 10/21/17 and again on 11/15/17, due to high blood sugars. R22's physician notes were reviewed and indicated the following: - On 10/27/17, noted R22 had a decrease in her bowel movements and increased her Miralax,	F 656	comprehensive care plan concerns were addressed on new admission comprehensive care plan. Random audits of comprehensive care plans in relation to medical needs are addressed, will audits 3 comprehensive care plans will be completed by DNS or designee 1 time weekly for 4 weeks then every other week for 2 months. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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further noting she also had used enemas and suppositories.
- On 12/13/17, noted R22's, "Biggest complaint is being constipated," and another laxative medication was ordered.

R22's current care plan, last revised 1/3/18, lacked diagnoses, goals, and interventions for her Diabetes Mellitus with Prednisone use and associated hyperglycemia (high blood sugar), bowel status with symptoms of constipation, and treatment of post operative pain.

During interview on 1/11/18, at 9:19 a.m. registered nurse (RN)-A stated any of the nurses could revise or update the care plan, further stating they had started to review care plans weekly with an interdisciplinary team (IDT) for short stay residents. RN-A stated the care plan usually contained a diagnosis of Diabetes Mellitus and noted if a resident was on insulin; however, she acknowledged R22's care plan was missing the diagnosis and interventions. RN-A reported R22 had not presented with constipation on admission, but had developed symptoms due to the pain medications, further stating R22's family had also mentioned a history of bowel issues after admission. RN-A further reported resident toileting plans and continence status were put on the care plan, noting R22's care plan only mentioned her bladder not her bowel status. When asked if bowel symptoms of constipation were typically care planned, RN-A reported, "It will in the future." RN-A further acknowledged R22's care plan did not address pain; she would expect the care plan to address a goal to be comfortable with the pain level after hip surgery along with the interventions of administering medications as ordered, offering alternatives like an ice pack or

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repositioning, and monitoring for signs of increased pain and to alert the physician.

During interview on 1/11/18, at 10:31 a.m. the interim director of nursing (IDON) was aware of concerns with the care plans and charting, noting not all of the care plans were current, basic charting was not getting done, and skilled residents were not being charted on. The IDON stated she had a nurse working on getting the care plans up to date that weekend. The IDON further stated the facility was not documenting reviews of the care plans prior to her coming to the facility, further noting she had implemented adding quality measure questions into the weekly IDT care plan reviews, a process they had just started the week prior.

During interview on 1/11/18, at 12:35 p.m. R22 stated the insulin was a new medication she had been put on after surgery while she was taking the Prednisone, stating the hip surgery had brought on Diabetes. R22 further stated she had been told the Prednisone would help with healing. R22 further stated her bowels were, "Not very good," noting she gets constipated easily and had been constipated the previous day. R22 stated the constipation made her feel uncomfortable. R22 reported she had pain, which could be real bad when she got up; however, further reported the pain killers helped a lot. R22 reported she had tried ice packs but didn't think they helped.

A facility policy entitled Care Plan, revised 11/16, directed, "Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical,

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F 656	Continued From page 27 nursing, physical, functional, spiritual, emotional, psychosocial and educational needs." The policy further directed the comprehensive care would be completed seven days after completing the assessment.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 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. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to assess and provide detailed information to the physician during an episode of acute illness for resident (R39) reviewed for death. Findings include: R39's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of gastrointestinal hemorrhage, unspecified (bleeding from the gastrointestinal tract either from mouth or rectum). R39's annual Minimum Data Set (MDS), dated 9/21/17, identified a severe cognitive impairment. The MDS further identified R39 had an active diagnoses of dementia and gastrointestinal hemorrhage, unspecified.	F 684	The eInteract policy and procedure has been reviewed on 2/1/18. R39 expired away on 10/15/17. To prevent further potential deficient practice that may affect other residents. Staff will be reeducated on our interact policy and procedure regarding appropriate notification of the physician. Audits will be done on notification of physician for residents with new illnesses, bruising or open areas and ensure corresponding progress note in the resident's chart and notification of the physician has been timely completed. Audits will be done by DNS or designee 1 time weekly for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	2/9/18

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R39's current physician orders, printed 1/11/18, contained the following:
-order for Protonix (medication used to treat acid reflux, prevent gastric ulcers, and prevent gastrointestinal hemorrhage), dated 1/5/17, for 40 mg (milligrams) daily for hemorrhage of gastrointestinal tract.

R39's care plan, last review 3/24/17, identified R39 had a cognitive problem related to dementia, noting she understood simple direct cues. The care plan further identified R39 had a communication problem related to dementia, noting she had difficulty expressing herself and directed staff, "Monitor/document for physical/nonverbal indicators of discomfort or distress, and follow up as needed." The care plan indicated R39 had, "bowel incontinence R/T [related to] hx. [history] of hemorrhage gastrointestinal trace[sic]." The care plan lacked identification of symptoms of gastrointestinal hemorrhage, nor did it indicate R39 received daily Protonix.

A facility progress note, written by LPN-B as a late entry, entered on 10/14/17, at 9:15 p.m. indicated, "Resident have emesis four times this shift. Vomit color dark brown and thick at this time. Bowel sounds present all four quad [quadrants] non-tender. Last BM [bowel movement] md [medium] noted on 10/12/17. Resident not wanting to eat at this time. Supplements held d/t [due to] vomiting. Resident has no c/o [complaints of] pain/discomfort noted at this time. Resident is self propelling around unit at this time. Resident having small sips of water at this time. Post changing resident vomited again."

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R39's physician orders, dated 10/15/17, at 2:00 a.m. indicated the on-call physician (OCP)-B gave a telephone order for:
- "Acetaminophen suppository 650 mg insert 650 mg rectally every 6 hours as needed for fever"
- "ondansetron HCL (anti-nausea medication) tablet 4 MG Give 1 tablet by mouth every 4 hours as needed for nausea/vomiting"

Although R39 had been having symptoms on 10/14/17, and had vomited four times by 9:15 p.m., there was no evidence that the resident received a comprehensive assessment due to the change in condition and no evidence of the physician being updated prior to 10/15/17, at 2:00 a.m. There were no other notes on 10/14/17 to indicate when the vomiting had started.

R39 Medication Administration Record (MAR), for 10/17, indicated licensed practical nurse LPN-B administered the anti-nausea medication ondansetron HCL tablet 4 MG on 10/15/17, at 2:20 a.m. The MAR identified the medication was effective. The MAR further indicated LPN-B administered acetaminophen suppository 650 mg on 10/15/17, at 3:13 a.m. The MAR identified the medication was effective.

A facility progress note, dated 10/15/17, at 3:19 a.m. indicated, "Resident had emesis this shift color dark brown thick. Vitals taken 136/81 HR [heart rate] 89 temp [temperature] 99.9. Resident had md [medium] soft BM [bowel movement] at this time. Dr [doctor] on-call notified, new order for Tylenol 650 mg rectally for increased temp and Zofran [ondansetron] 4 mg for vomiting. temp rechecked at this time. 98.7 temporal. Resident resting in bed at this time. call light within reach."

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Although the record indicated the physician was notified of the vomiting, the record did not indicate that the physician was notified of active diagnosis of gastrointestinal hemorrhage or that resident was vomiting brown, thick emesis.

A facility progress note on 10/15/17, at 3:44 a.m. indicated PRN (as needed) administration of ondansetron HCL tablet 4 MG was effective for nausea.

R39's MAR indicated LPN-B administered the scheduled Protonix tablet delayed release 40 mg, on 10/15/17, at 6:00 a.m.

A facility progress note, dated 10/15/17, at 7:18 a.m. identified LPN-A had found R39 expired while passing R39's morning medication.

R39's discharge summary, dated 1/15/17, indicated resident's date and time of death was 10/15/17, at 6:45 a.m. Discharge summary identified, "Disease related to resident functional, cognitive, mood or behavioral status medical treatments, nursing monitoring, or risk of death. gastrointestinal hemorrhage." The Discharge Summary indicated final diagnosis and cause of death as dementia.

R39's Certificate of Removal, dated 10/15/17, indicated R39's body was released to the mortician at 10/15/17, 8:45 a.m.

Review of a Communication to Physician fax, written by LPN-B on 10/15/17, 4:00 a.m. identified, "[R39]vomiting & [and] low grade temp. call on call, received new orders, please sign and return. Would you like to add anything?" R39 attending physician (AP)-C replied to the fax on

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10/16/17, asking how R39 condition was; however, R39 had already expired. The fax provided to the attending physician lacked information including active diagnosis of gastrointestinal hemorrhage, number of emesis, and did not identify the emesis were brown in color

During interview on 01/11/18, at 1:05 p.m. registered nurse (RN)-A stated she remembered a licensed practical nurse had gone to do a treatment and found R39 deceased. RN-A did not recall if an investigation was completed.

An incident report and/or investigation into R39's change in condition status and death was requested but was not received.

During interview 1/11/18, at 3:08 p.m. the interim director of nursing (IDON) stated R39's death had occurred prior to her coming to the facility. She stated, when a resident has a change of condition, she would expect the resident would be assessed and the physician and family notified. IDON further stated she expected the resident's change of condition and nursing interventions to address the change and that this would be documented in the resident's medical record. The IDON also stated, when talking to the physician regarding a resident's change in condition, she would expect the nurse to use SBAR [situation background assessment and response] communication to relay the resident's condition to the physician. SBAR is a communication tool, a form that is filled out and filed in the medical record. The IDON stated the SBAR tool was probably not filled out and reviewed R39's electronic health record, stating she did not find an SBAR communication tool in

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the record. The IDON stated documentation was an issue at this facility, was working with nursing staff to increase accountability, and providing education on documentation practices. The IDON reported an incident report and subsequent investigation was not necessarily done when a resident had a change in condition; it would depend on the situation. The IDON further reported there should have been an investigation into R39's death, especially since the resident had thick brown emesis. IDON stated nursing interventions should have been acted upon which she expected to include physician notification, a follow up phone call to to the family, the administrator and the director of nursing. IDON stated, when there is an unexpected death of a resident not on hospice, possibly offering an autopsy to family, depending on the scenario and if totally unexpected.

During interview on 1/11/18, at 3:49 p.m. OCP-B stated, "Let me look at my notes for 10/15. Yeah, I was on call, resident was vomiting, low grade temp, ordered Tylenol and Zofran." While looking at his notes, OCP-B further stated he did not recall if he was told R39 was having dark brown emesis, just that R39 was vomiting. OCP-B reported, "If had dark brown emesis, sure sounds like a GI bleed." OCP-B stated he expected nurses," To tell me if dark brown emesis, would probably have sent her to the ER and at least gotten a hemoglobin (HGB) level." OCP-B further stated R39 had a history of gastrointestinal (GI) bleed which sure could have contributed to her death if she was very anemic. OCP-B stated, "Getting a HGB would have helped."

During a telephone interview on 1/16/18, at 10:01 a.m. LPN-A stated, on 10/15/17, she would have

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come on duty at 6:00 a.m., and she had been told R39 had a couple of emesis overnight. LPN-A was told R39's vital signs had been fine. LPN-A stated, around 6:15 a.m., she and LPN-B had checked on R39, stated she was resting comfortably, also stating the nurses aides had reported, around 6:30 a.m., that R39 was seen moving around in bed. LPN-A stated at 6:45, she had gone back to R39's room to do a dressing change and found R39 deceased. LPN-A stated she had taken R39's vital signs and called the family. LPN-A stated she called the physician on call for an order to release the body to the mortuary. LPN-A further stated she would have documented R39's death and subsequent actions in the progress notes. LPN-A stated she would look for her notes and fax them if found.

On 1/16/17, at 10:42 a.m. a fax of R39 discharge summary was received from LPN-A, dated 10/15/17. Faxed discharge summary contained no new information.

During a telephone interview on 1/16/18, at 2:11 p.m. attending physician (AP)-C stated he was able to view the fax sent to him on 10/15/17, at 4:00 a.m. AP-C stated knowing the description of a resident's emesis and that it was dark brown would help in decision making. AP-C stated, since 10/15/17 was a weekend, the on call physician was notified.

Review of the facility policy entitled Interact-Change in Condition Evaluation (CICE), dated 5/16, indicated, "If resident is receiving skilled nursing services and condition change requires monitoring...Nursing judgement will determine at what point to call the provider. Review the residents medical record including

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F 684	Continued From page 34 diagnosis, medications, recent progress notes from a medical doctor/nurse/physicians assistant as well as most recent interdisciplinary notes. Continue to monitor the resident and update the Change in Condition Evaluation as appropriate."	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide consistent assessment and monitoring of a pressure ulcer for 1 of 2 residents (R28) reviewed for pressure ulcers. Findings include: R28's 12/19/17 admission minimum data set (MDS) indicated R28 required extensive assistance of 2 staff for bed mobility. R28 did not have a pressure ulcer, but was at risk for pressure ulcer development. A Brief Interview for Mental Status indicated a score of 6, severe	F 686	The policy and procedure has been reviewed in relation to the incident involving R28. To prevent further potential deficient practice that may affect other residents. Staff will be reeducated on the monitoring of the documentation procedure related to R28. Audits will be completed on daily wound data collection for completion and wound measures, completion of audits will be done by the DNS or designee 1 time a week for 2 months then every other week for 1 month. Audit results will be reviewed	2/9/18

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F 686	Continued From page 35 cognitive impairment. R28's Care Plan for pressure ulcers, initiated 12/12/17, indicated interventions of a pressure relieving device in the chair and pressure reducing mattress. The care plan directed staff to turn and reposition the resident every 2 hours. A 12/20/17 Wound RN Assessment identified R28 developed a stage 2 (partial-thickness skin loss with exposed dermis) pressure ulcer to the coccyx. Physician notified of pressure ulcer and care plan updated. The assessment lacked documentation of measurements and pressure ulcer characteristics On 12/20/17 the residents care plan updated to "actual stage 2 pressure ulcer." An intervention of medication and treatments as ordered was added to the care plan. R28's physician orders revealed a 12/21/17 order for Arginaid (nutritional supplement to promote healing) two times daily. A wound treatment dressing order, dated 12/23/17, directed to apply a Mepilex border dressing one time every 3 days. A 12/23/17 Wound Data Collection form indicated the coccyx Mepilex dressing was intact. Drainage present. Area surrounding dressing pink. The form indicated "Measurements-Required at least once every 7 days" however, the section for measurements and wound characteristics was blank. R28's medical record lacked a comprehensive assessment of the pressure ulcers measurements and characteristics of the pressure ulcer, until 12/26/17, 6 days after	F 686	monthly by facility QAPI committee for further recommendation.	

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development.

A 12/26/17 Wound Data Collection form identified a coccyx stage "2-3" pressure ulcer. Length 3 cm (centimeters). Width 1 cm. Open area measurements above with a pink red circular area around o/a (open area) witch measures 4 x 5 cm has a sm (small) white area of skin to rt (right) side of open area. 90% epithelialized (superficial tissue, new pink or shiny).

1/1/17, 1/3/17, and 1/4/17 Wound Data Collection forms revealed measurements of the pressure ulcer were unchanged. The record lacked a comprehensive assessment of the wound bed until 1/5/17, 10 days after the 12/26/17 assessment.

A 1/5/17, Wound Data Collection form identified the pressure ulcers length of 2.5 cm, 0.5 cm smaller than previous. The width remained unchanged at 1 cm. Wound bed characteristics changed to 90% slough (tissue yellow/white in appearance and adheres to the ulcer bed in strings or thick clumps) and 10% epithelialized tissue. Although slough was present, the pressure ulcer continued to be staged at a 2.

A review of R28's January 2018 electronic treatment record (ETAR) indicated the physicians order to change the Mepilex border dressing every 3 days. Documentation on the ETAR identified a Mepilex dressing change on 1/4/17. The ETAR and medical record lacked any further dressing changes until 1/10/17, 6 days later.

During observations on 1/10/17, at 8:43 a.m., registered nurse (RN)-A and RN-B entered R28's room to re-assess the pressure ulcer. R28's

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pressure ulcer lacked a dressing. RN-A stated the dressing "must have peeled off." No dressing was viewable in the bed. The pressure ulcer measurements remained unchanged from 1/5/17 at 2.5 cm x 0.5 cm. RN-B stated the pressure ulcer "looks very similar to last week" 90% slough with red granulation around the edges. RN-B cleansed the pressure ulcer with a wound cleaner and RN-A placed a Mepilex dressing over the pressure ulcer as ordered. Nursing assistant (NA)-J entered the room to assist getting R28 up for the day.

During an interview on 1/10/17, at 1:29 p.m., NA-J stated she did not find a wound dressing in R28's bed.

During an interview on 1/11/17, at 9:04 a.m. RN-A stated the previous director of nursing was supposed to be completing weekly wound rounds. It was recently discovered this was not being done. RN-A stated last Thursday, a weekly wound round schedule was initiated. RN-A stated pressure ulcer assessments were not being completed as they "should have" for R28. RN-A stated a clinical wound specialist (CWS)-G does come to the facility to advise on pressure ulcers. RN-A stated she sent an email to CWS-G on 1/3/17 for advise on treatment.

During a phone interview on 1/10/18, at 11:08 a.m., CWS-G stated she was coming to the facility today or tomorrow to assess R28's pressure ulcer. When informed the wound bed was 90% slough and 10% epithelial tissue, CWS-G stated it sounds like the pressure ulcer would be a stage 3 (Full-thickness skin loss). CWS-S stated the pressure ulcer was relatively new and likes to stay with the initial treatment of

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F 686	Continued From page 38 Mepilex for a least 2 weeks, to give it a chance to respond to treatment. With the recent development of slough, will now need to evaluate for treatment changes for debridement; however, would not have made any changes in the treatment prior to her evaluation today or tomorrow. During an interview on 1/11/17, at 12:34 p.m. when asked about the process for assessing and monitoring pressure ulcers the interim director of nurses (IDON) stated "I don't think there was one." Staff are to comprehensively assess pressure ulcers at a minimum of weekly. The staff were not doing weekly wound round assessments until last week. We do have a wound nurse who will be coming out do some teaching. The IDON stated the staging and assessments of R28's pressure ulcer were inconsistent. The facility's Pressure Ulcer Practice Guidelines policy, dated 9/16 indicated. "It is recommended that the Wound Data Collection UDA reflects the nurse's observation and management of wounds from a shift-to shift perspective and with each dressing change. At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. Once a resident experiences a pressure ulcer, an assessment should take place immediately.	F 686		
F 688 SS=E	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in	F 688		2/9/18

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F 688	Continued From page 39 range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide restorative nursing for 4 of 4 residents (R17, R19, R7, R1) reviewed for mobility. This had the potential to affect 17 of 36 residents who had therapy recommended programs. Findings Include: R17's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of pain in left hip, displaced intertrochanteric fracture left femur, subsequent encounter for closed fracture with routine healing, muscle weakness, and difficulty in walking. R17's quarterly Minimum Data Set (MDS), dated 11/17/17, identified no cognitive impairment and required staff assistance for ambulation. R17's Functional Maintenance Restorative Program dated 4/14/17, identified exercise and walking program 5 x/wk [five times a week].	F 688	GSS-Sunwood realizes the importance of restorative nursing program. R17, R19, R7 and R1 Restorative programs have been reviewed and care plan updated to reflect restorative needs of therapy recommended programs. R7 restorative care plan was updated on 2/1/18 due to going on hospice. R17, 19 and R7 care plan will be updated on 2/5/18. To prevent further potential deficient practice that may affect other residents, the restorative programs have been reviewed for residents who have had therapy recommended programs and restorative programs have been updated as needed. Audits will be completed on restorative programs. Audits will be done by the DNS or designee 1 time a week for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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R17's care plan, last reviewed 12/27/17, identified R17 needed restorative intervention due to weakness. R17 will improve current level of standing tolerance by next review date. Identified interventions included: "Nursing rehab: Ambulate with resident 3 x[times]/day with FWW [four wheeled walker], CGA [care giver assist] and W/C [wheelchair] to follow PRN [as needed], Scifit [a type of exercise bike] level 3 PRN, Seated bilateral leg kick, green band knees apart, green band pull back, 2 x 10 REPS [repetitions]each."

R17 physician progress note, dated 12/20/17, identified has pain in hip and radiates down his leg, stated he really does not walk.

R17's medical record lacked evidence that the restorative nursing program was being offered, implemented, and evaluated.

During observation on 1/09/18, at 10:03 a.m. R17 was sitting in his wheelchair in the hallway outside his room. No offers of ambulation by staff were observed.

During observation on 1/09/18, at 2:00 p.m. R17 self propelled in his wheelchair down the hallway towards the dining room.

During interview on 1/09/18, at 3:27 p.m. physical therapist (PT)-A stated R17 had been on a restorative walking program since 4/17. PT-A stated since then he has had a decline in ambulation due to increased pain in his legs and hip. PT-A stated R17 had increased apprehension with pain and often refused ambulation. PT-A stated with residents refusal,

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nursing may change the frequency of the walking program as needed. Nursing wouldn't necessarily let physical therapy know that. PT-A stated would expect that ambulating be offered and documented if refused.

During interview on 1/09/18, at 3:41 p.m. R17 stated he hadn't walked in about two weeks. R17 further stated staff had not offered ambulation.

During interview on 1/10/18, at 11:38 a.m. licensed practical nurse (LPN)-C stated R17 had a restorative walking program, but today was observed mainly in the wheelchair. LPN-C stated she would expect staff at least offer to walk everyday and document resident's refusal. LPC-C stated if walking isn't occurring would be reported to charge nurse who would report to physician, so it could be followed up on, so no decline in his ability to walk. LPN-C stated she reviewed notes back to 12/20/17 and found no documentation R17 had been offered restorative rehabilitation.

During interview on 1/11/18, at 8:33 a.m. registered nurse (RN)-A stated when the restorative aides are not working, R17 probably would not receive restorative interventions. RN-A reviewed R17's medical record and did not find any assessments or goals in his medical record regarding his restorative program.

R19's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of Unspecified sequelae of unspecified cerebrovascular disease.

R19's quarterly MDS, dated 11/20/17, identified no cognitive impairment. The MDS further

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identified R19 had an active diagnosis of hypertension and left sided hemiparesis (paralysis).

R19's care plan, last review 12/28/17, indicated R19 had limited physical mobility related to a history of stroke and would maintain current level of mobility. Interventions identified: "Ambulation able to ambulate 75'[feet] with CGA, gait belt and single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the w/c [wheelchair] behind." Also identified, R19 needed restorative intervention due to limited physical mobility related to CVA [cerebrovascular accident] left side weakness. Identified interventions included: R19 should perform Scifit[exercise bicycle] at level 5 up to 10 minutes 2-3 times per week. Leg press resistance 150 lbs[pounds]2 x 10 3 x/ [times]week.

A physician progress note, dated 8/17/17, identified R19 was getting around fairly well, used a cane to walk around despite left sided hemiparesis. R19's goal was to look into handicapped apartment. This will be very reasonable.

R19's progress note, dated 8/23/17, indicated continued weight gain is a concern, his activity level has decreased as he does not walk to diner as he did in the past.

R19's progress note, dated 12/30/17, physical therapy order clarification to discharge form physical therapy to SNF[skilled nursing facility].

R19's medical record lacked documentation that ambulation and restorative nursing programs

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were being offered, implemented, and evaluated.

During interview on 1/9/18, at 3:27 p.m. R19 stated he hadn't been walking the past couple of weeks. R19 further stated he had not seen the restorative aide staff for a couple of weeks and no one else had offered to walk him.

During interview on 1/9/18, at 3:30 p.m. PT-A stated R19 was in a restorative nursing program and should be walking everyday to breakfast as he could tolerate. R19 had limited mobility due to a stroke and if he was not ambulating, the RN care manager should have been notified.

During interview on 1/10/18, at 11:31 a.m. LPN-C stated R19 ambulated with assist of one staff. LPN-C also stated R19 had a restorative walking program, but whoever got him up can walk him to breakfast. LPN-C further stated R19 was pushed in his wheelchair to breakfast that morning.

During interview on 1/11/18, at 8:35 a.m. RN-A stated when the restorative aides were not working, R19 probably would not have received restorative interventions. RN-A reviewed R19's electronic medical record and stated there was no documentation on restorative programs being offered or assessed.

R7's admission Minimum Data Set (MDS), dated 4/9/17, identified no cognitive impairment, required extensive assistance of one staff to walk in her room, and did not identify any upper or lower body range of motion (ROM) limitations. The MDS also identified R1 was receiving occupational therapy (OT) and physical therapy (PT).

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R7's quarterly MDS, dated 10/18/17, indicated she continued to require extensive assistance of one staff with mobility, but had not ambulated in her room or outside her room during the assessment period, nor had she received OT or PT services during the assessment period.

R7's most recent Physical Therapy Discharge Summary, dated 10/5/17, indicated R7 had been working with therapy on increasing bilateral lower extremity strength and transfer ability. The discharge summary noted R7 did not meet the goals of therapy and, "Patient is discharged from skilled therapy intervention at this time due to patient's overall decline in health status and therefore slowed progress towards functional therapy goals. Patient referred to neurologist and will be appropriate for further skilled therapy intervention once the patient is more medically stable. Ath [sic] this time the patient is appropriate to DC [discharge] to RNP [restorative nursing program] to be performed on a daily basis to maintain therapy gains."

Functional Maintenance Restorative Programs were reviewed for R7, and identified the following:
-On 10/3/17, a new restorative program was recommended, which replaced R7's previous walking program. The overall goal was to, "maintain current LE [lower extremity] strength." R7's program included using the Scifit bike (type of exercise bike) 10 minutes five times a week.

A physician progress note, dated 11/14/17, identified R7 could no longer transfer and walk on her own, noting she was requiring a lift to transfer and had noticed gradually declining strength in her hands and feet. At that time, R7 had been diagnosed with "progressive neurological

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dysfunction of her extremities," and was to see a neurologist.

R7's current care plan, last revised 1/3/18, identified an ADL (activities of daily living) deficit requiring the sit to stand lift and staff assistance for transfers. The care plan also identified R7 had a musculoskeletal alteration related to left food drop and wore a brace. The care plan did not address R1 impaired mobility, new neurological decline, or restorative nursing program.

R7's medical record lacked evidence a restorative nursing program was being offered, implemented, and evaluated.

During observations on 1/9/18, from 10:35 a.m. to 3:45 p.m. R7 was consistently in her room and no restorative nursing program was provided.

During observations on 1/10/18, from 7:30 a.m. to 11:30 a.m. R7 was consistently in her room and no restorative nursing program was provided.

During observations on 1/11/18, from 7:36 a.m. to 12:02 p.m. R7 was consistently in her room and no restorative nursing program was provided.

During interview on 1/9/18, at 10:41 a.m. R7 stated she felt weaker especially in her hands and legs, noting staff used to walk with her, but didn't do that anymore and now used the sit to stand lift to transfer her. R7 stated she was seeing a neurologist for her weakness and foot drop.

During interview on 1/9/18, at 3:02 p.m. physical therapist (PT)-A stated she had seen R7 in October due to new onset right foot drop. PT-A

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stated R7 had had a very significant functional decline very quickly while in therapy, and she had discharged her from therapy thinking there was something more serious going on and referred R7 to a neurologist. PT-A stated, when R7 was discharged from therapy, she was no longer able to walk, and staff used the sit to stand lift for safety. PT-A reported she had discharged R7 with home ROM exercises that R7 could do herself and with a restorative bike program. PT-A further reported recommended restorative programs were given to the nurse case manager (registered nurse (RN)-A) who put them in the electronic chart. PT-A observed R7 in her room, stating she would've expected a decline in mobility, considering R7 had a rapid decline while in therapy. PT-A stated, if R7's transfer ability changed to needing the full body lift, then she would have declined. PT-A reported she had trained in several nursing aides on the restorative bikes, further reporting R7 needed a restorative aide with her while on the Scifit bike. PT-A was not sure if the restorative aides were completing the programs.

During interview on 1/10/18, at 9:30 a.m. nursing assistant (NA)-G was unaware of R7's restorative program, stating she was on a walking program at one time, but doesn't walk anymore.

During interview on 1/11/18, at 8:21 a.m. registered nurse (RN)-A reviewed R7's medical record and acknowledged she did not have a restorative nursing program listed.

R1's quarterly MDS, dated 9/29/17, identified a severe cognitive impairment with a diagnosis of Alzheimer's dementia. The MDS also identified R1 required extensive assistance to total

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dependence of two staff with mobility, but did not identify any upper or lower body ROM limitations.

R1's most recent Occupational Therapy Discharge Summary, dated 8/11/17, indicated R1 had been assessed for a left hand splint due to left hand tightness. The goal of therapy at the time was, "Patient will have increased tolerance of left resting hand splint to 8 hours during day or overnight in order to prevent contractures." The therapy discharge indicated R1 had behaviors of biting and hitting; however, the discharge plan/instructions included, "Discharged to to nursing splinting program at SNF [skilled nursing facility] where pt [patient] will reside long term...ROM [range of motion] program in place with added focus on hand ROM."

Functional Maintenance Restorative Programs were reviewed for R1, and identified the following:
-On 1/25/17, a new restorative program was recommended. The overall goal was to, "Prevent joint contractures and support midline posture in wheelchair." R1 program included daily passive ROM to both arms and both legs.
-On 8/4/17, a change to the restorative program was recommended. The overall goal was to, "decrease risk of contractures." R1's program was changed to include wearing the left hand splint at night.

R1's current care plan, last revised 1/2/18, identified an ADL deficit requiring staff assistance and identified the need for, "restorative intervention to support midline posture in wheelchair," however; the nursing rehab addressed interventions with pocketing food. The care plan did not address R1 impaired mobility, risk for contractures, or ROM program.

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R1's medical record lacked evidence a ROM program was being offered, implemented, and evaluated.

During observation on 1/10/18, at 9:09 nursing assistant (NA)-F and NA-G brought R1 back to her room and transferred her from her Broda chair (type of wheelchair) into bed. No behaviors were observed during transfer. R1's hands were observed to be clenched in fists. No ROM was provided by NA-F or NA-G. When interviewed directly after observation, NA-F stated she was unaware of a restorative program for R1 stating, "Not since I've been here," and NA-G stated R1 was currently on a ROM program; however, only the restorative aides completed ROM.

During interview on 1/10/18, at 11:38 occupational therapist (OT)-A stated she had seen R1 in August for a decline in ROM in R1 left hand. OT-A stated she had discharged R1 to a ROM program for contractures prevention. OT-A stated the restorative recommendations were written up and given to the director of nursing (DON), stating therapy also kept a copy in their restorative binder. OT-A looked in the restorative binder for R1's ROM program, couldn't find one for August stating the binder, "Isn't all comprehensive." OT-A looked at R1's ROM program from January and stating it would still be current. OT-A observed R1's hands, which were in fists, while R1 was lying in bed. OT-A was able to open R1's hands, stating there was no decline in ROM. OT-A reported NA-I was a trained restorative aide, who consistently completed ROM programs; however, OT-A further reported she had not seen NA-I, "For a while."

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During interview on 1/11/18, at 8:21 a.m. registered nurse (RN)-A reviewed R1's medical record and acknowledged she did not have a restorative ROM program listed.

During interview on 1/19/18, at 2:42 p.m. the interim director of nursing (IDON), when asked for documentation on restorative nursing programs, stated," You won't find any." The IDON further stated restorative programs were in their plan to implement, but they currently did not have any formal restorative programs in place. The IDON reported a while ago the restorative aides had been pulled out of their restorative roles due to staffing issues. The IDON further reported the facility was in the process of training nursing assistants to complete the restorative programs.

During interview on 1/10/18, at 8:14 a.m. licensed practical nurse (LPN)-A stated therapy had a binder with residents' restorative programs and the facility had two restorative aides, NA-I and NA-H. LPN-A stated usually one of them was working; however, that was NA-H's day off and NA-I was on vacation. When asked who completed restorative programs when NA-I and NA-H were gone, LPN-A reported they were the only two who had been trained on the restorative equipment.

During interview on 1/10/18, at 9:30 a.m. NA-G stated there were two restorative aides, NA-I and NA-H. NA-G stated they were the only two who went through the restorative training. NA-G stated the restorative aides also helped out on the floor and would get pulled to work on the floor. NA-G stated they weren't pulled everyday, just depended on how busy they were. NA-G stated NA-I was on vacation. When asked who

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completed restorative programs when NA-I and NA-H were gone or pulled to the floor, NA-G re-iterated that they were the only ones trained to do the restorative programs.

Neither NA-H and NA-I were available during the survey for comment.

The facility's staffing schedule, reviewed for the week of 1/7/18 to 1/13/18, identified neither NA-I or NA-H worked on 1/7/18, 1/10/18, and 1/11/18.

During interview on 1/11/18, at 8:21 a.m. RN-A, who had been at the facility since August, stated the facility had no formal restorative programs which included documenting on the program, the minutes or reps performed, and did not have formal programs in which resident's progress was evaluated. RN-A stated NA-I and NA-H were the only two aides trained to use the restorative equipment, while the rest of the staff, "We do some of the walking, but not the machines." RN-A stated, when therapy wrote restorative recommendations, some of the recommendations ended up on her desk and some on the DON's desk to put into the electronic medical record. RN-A went on to state there had been four DON's in the time she had been there, so was not sure if all recommendations were entered. RN-A reported the restorative aides were still being pulled to the floor, but it was getting better with them being pulled one to two days less. RN-A reported the facility was working on the process for completing and evaluating the restorative programs, further reporting ideally they would like all staff doing the programs. RN-A acknowledged, on specific days, yes restorative programs weren't getting done.

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F 688	Continued From page 51 A facility policy entitled Restorative Nursing Care, dated 6/12, directed, "Each resident will receive restorative nursing care to the extent possible, based on individual strengths, needs and problems as defined in nursing assessments. The restorative care will be outlined in the residents nursing care plan." The policy further directed the goal of restorative nursing would be to maintain independence and prevent decline.	F 688		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen administration was consistently monitored for 1 of 1 residents (R238) reviewed for oxygen. Findings include: R238's diagnosis report indicated, on 1/4/18, diagnoses of " Influenza due to unidentified influenza virus with other respiratory manifestations." R238's current physicians orders identified an order, dated 1/5/18, for " O2 (oxygen) to keep sats (saturation) greater than 90% (percent)."	F 695	GSS-Sunwood realizes the importance to ensure oxygen administration is done on a consistent basis. R238 oxygen needs have been reviewed and medical record has been updated to reflect consistent monitoring. To prevent further potential deficient practice that may affect other residents, residents with oxygen records have been reviewed and oxygen monitoring needs have updated as needed. Staff will be reeducated on policy and procedure related to oxygen administration and monitoring of usage of oxygen. Random audits will be completed on O2	2/9/18

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F 695	Continued From page 52 R238's medication administration record (MAR) and treatment administration record (TAR), for 1/18, lacked documentation of oxygen use or monitoring. R238's care plan, dated 1/6/18, directed to assess for shortness of breath and cyanosis (appearance of a blue or purple discoloration of the skin). The care plan lacked identification of oxygen use and interventions related to oxygen use or non-compliance. On 1/6/18, at 1:39 p.m. vital sign documentation identified R238 was on oxygen (lacked flow rate). Oxygen saturation 96% via nasal cannula. On 1/7/18, at 1:02 p.m. vial sign documentation indicated R238 was on oxygen (lacked flow rate) via nasal cannula. R238's oxygen saturation was 98%. A progress note dated 1/7/18, at 11:30 a.m. indicated oxygen at 2 liters (liters/min) via nasal cannula. Alert. Able to make needs known. A progress note dated 1/8/18, at 12:03 p.m. indicated R238 was alert and able to make needs known. Uses Oxygen at 2 L (liters) via nasal cannula. R 238's medial record lacked documentation of an oxygen saturation level on 1/8/18. A progress note dated 1/9/18, at 6:47 a.m. indicated R238 had O2 at 2L via nasal cannula. Regular, easy respirations. During observation on 1/9/18, at 11:15 a.m. R238 was laying in bed. An oxygen concentrator	F 695	monitoring documentation in the EMR, audits will be done by the DNS or designee 1 times a week for 2 months then every other week for 1 month. Random audits will be conducted to ensure tubing changes are done weekly. The audits will be done by the DNS or designee 1 times a week for 2 months then every other week for 1 month. . Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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located next to the head of the bed was turned off. The nasal cannula, which was connected to the concentrator was laying on the recliner in the room. The oxygen tubing was not dated. When asked when the oxygen was used, R238 replied, "Oh, when the nurse pokes her head in here." R238 stated he did take the oxygen tubing off at times. R238 was not short of breath. The oxygen tubing was not dated.

A progress note, dated 1/9/18, at 11:47 a.m. indicated R238 was alert, oriented, and pleasant. Will use call light for assistance.

During observation on 1/9/18, at 12:14 p.m. R238 was sitting on the side of his bed independently eating lunch. R238 was not receiving oxygen.

R238's medical record lacked documentation of an oxygen saturation level or monitoring to determine if R238's oxygen was above 90% per physicians order on 1/9/18. The record lacked documentation of the discontinuation of oxygen. The record from admission to 1/9/18 lacked documentation of R238 removing his oxygen tubing.

During observation on 1/10/18, at 7:06 a.m. R238 was sleeping in bed. The oxygen concentrator was on and set at 2L, however; R238 was not receiving oxygen. The nasal cannula was laying on the floor next to the bed. R238 did not appear short of breath.

On 1/10/18, at 9:06 a.m. vital sign documentation identified an oxygen saturation of 96%. Oxygen via nasal cannula.

During observation on 1/10/18, at 11:28 a.m.

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R238 was sitting in the recliner in his room with his feet elevated. The oxygen concentrator was on, and R238 was receiving oxygen via nasal cannula at 2L/min. When asked if he experienced shortness of breath, R238 replied, "Yeah, especially today." R238 went on to say he was short of breath earlier. When asked about oxygen administration, R238 stated he, "Loses the tubing." "If I could find the darn thing, I would put it on." Oxygen tubing continued to be undated.

During interview on 1/10/18, at 11:34 a.m. licensed practical nurse (LPN)-A stated oxygen concentrators are used in resident rooms and portable oxygen tanks are used outside of the resident's room. LPN-A stated R238 used oxygen at 2 liters. R238's oxygen saturations needed to be kept above 90%. When asked how staff monitor R238's oxygen, LPN-A replied that staff obtain daily oxygen saturations readings. LPN-A stated R238 would sometimes take his oxygen tubing off. When that happened, staff put the oxygen cannula back on. LPN-A stated earlier that day, she had put the oxygen cannula back on R238 after finding it off. LPN-A stated the day nurse changes all oxygen tubing weekly on "tubing Tuesday." The tubing is dated when changed. Tubing Tuesday was on 1/9/18. R238's tubing was not changed, as R238 had not resided at the facility for a week on 1/9/19. LPN-A stated R238's tubing should be dated, but was not.

During interview on 1/11/18, at 11:35 a.m. registered nurse (RN)-A stated R238's oxygen order directed to keep oxygen saturations above 90%. Staff were to monitor R238's oxygen saturation levels at least once daily. Oxygen administration was documented on the MAR or TAR. RN-A stated R238's MAR/TAR record did

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not contain documentation of oxygen administration. The record was inconsistent with monitoring of oxygen saturations levels, missing monitoring on 1/8/18 and 1/9/18. R238's oxygen use, as well as interventions, should be on the care plan. RN-A stated R238's care plan did not include oxygen therapy or interventions related to non-compliance.

During interview on 1/11/18, at 12:34 p.m. the interim director of nursing (IDON) stated when a resident had an order for continuous oxygen, staff were to monitor the oxygen saturations levels each shift and as needed. Additionally, staff were to obtain an oxygen saturation reading when a resident was found to have removed the oxygen tubing. Oxygen use was to be addressed on the care plan. All oxygen tubing should be dated and replaced weekly.

The facility's policy Oxygen Administration with Nasal Cannula, Face Mask or Face Tent, dated 10/17, identified the procedure for oxygen administration. The process included: verify physicians order. Observe for signs of tachycardia, hypoxia, dyspnea, confusion, anxiety, cyanosis, and restlessness. For resident on continuous oxygen therapy, give oral. nasal care every eight hours. Observe resident for tolerance of oxygen therapy and for any adverse symptoms. Disposable equipment should be changed weekly, or according to manufactures instructions, and marked with date and initials. Document on TAR or eAdmin note when these items are changed. Record when oxygen therapy started, type of administration used, flow rate and time when oxygen tanks are changed. Document resident's reaction and tolerance to therapy. Document as appropriate on the eMAR and TAR

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F 695	Continued From page 56 and on the progress note in the MAR or TAR.	F 695		
F 730 SS=D	Nurse Aide Peform Review-12 hr/yr In-Service CFR(s): 483.35(d)(7) §483.35(d)(7) Regular in-service education. The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of §483.95(g). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a performance review of a nurse aide at least once every 12 months for 1 of 3 nursing aides (NA)-C reviewed. Findings include: A personnel file review of NA-C on 1/11/18 revealed a hire date of 4/1/15. The personnel file lacked a performance review since date of hire. During an interview on 1/11/18, at 2:13 p.m. the human resource director (HRD) stated performance evaluations are to be completed yearly. HRD stated there was no performance evaluation in NA-C's file. During an interview on 1/11/18, at 3:02 p.m. the interim director of nursing (IDON) stated nursing assistants are to have yearly performance evaluations. Typically human resources gives the department head a monthly list of nursing assistants who are due for performance evaluations. IDON stated she has been at the facility for 2 weeks and has not received any	F 730	Nursing aide –C performance review was completed on 1/31/18. To prevent further potential deficient practice that may affect other nursing assistants we will be utilizing the new performance management process with a schedule developed by the Good Samaritan Society for evaluations. Staff was educated on the new staff evaluation process on 2/1/18 Audits will be completed on current nursing assistant's employee files to ensure that a yearly performance review has been done. Audits will be done by the DNS or designee will be completed by 2/9/18. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	2/9/18

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F 730	Continued From page 57 evaluations. The facility's policy Performance Management, dated 12/17, directed managers to meet with employees at least annually to formally review and document the entire year's performance.	F 730		
F 756 SS=E	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record.	F 756		2/9/18

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F 756	Continued From page 58 §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified and reported medication irregularities related to the lack of resident specific target behaviors for anti-psychotic and anti-anxiety medications for 2 of 5 residents (R22, R1) and side effect monitoring for psychotropic medications to the attending physician and the director of nursing for 5 of 5 residents (R22, R23, R1, R5 R13) reviewed for unnecessary medications. Findings include: R22's admission Minimum Data Set (MDS), dated 10/18/17, identified a moderate cognitive impairment and had been admitted to the facility due to a hip fracture. The MDS further identified R22 received anti-anxiety and anti-depressant medications. R22's admission Care Area Assessment(CAA), dated 10/18/17, indicated she used a daily anti-depressant and as needed anti-anxiety medications which would be reviewed during rounds. R22's current physician orders, dated 1/11/18, identified the following medications: -Xanax (anti-anxiety) 0.25 mg (milligram) three times a day for anxiety disorder	F 756	Policy and procedure has been reviewed related to pharmacist documentation in relation to R22 and R1. Their Records have been reviewed by the consulting pharmacist for irregularities related to psychotropic use. The DNS and physician have been notified of the irregularities R22, R5, R13 and R1 have been reviewed for unnecessary medications. R23 expired on 1/26/18. To prevent further potential deficient practice current residents who are receiving psychotropic medications, target behaviors and side effects have been reviewed by the consultant pharmacist with findings given to the DNS and physician. The pharmacist has been reeducated on expectations related to appropriate monthly review related to psychotropic medications, target behaviors and side effects. Audits of consultant pharmacy reports will be completed on residents receiving psychotropic medications for medication irregularities as related to target behaviors and side effect monitoring, any recommendation communication to the physician and DNS. Audits will be done by the DNS or designee after the consultant	

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F 756	Continued From page 59 -Wellbutrin SR (anti-depressant) 150 mg every morning and at bedtime for anxiety disorder -Remeron (anti-depressant) 7.5 mg daily for depression R22's current care plan, last revised 1/3/18, identified she received anti-anxiety medication related to anxiety and anti-depressant medication related to depression, noting a goal for R22 to be free of adverse effects. The care plan indicated interventions were, "Monitor [R22] condition based on clinical practice guidelines or clinical standards of practice," and, "Consult with pharmacy, health care provider, etc. to consider dosage reduction with clinically appropriate." R22's Monthly Pharmacy Reviews, reviewed from 10/17 to 12/17, identified the following: -on 10/16/17 denoted R22 was a, "New resident." No other entry was made indicating no irregularity. -on 11/28/17 and 12/22/17 entries were blank, indicating no irregularities. R22's medical record lacked target behaviors for anxiety and side effect monitoring. During interview on 1/11/18, at 9:19 a.m. registered nurse (RN)-A stated the facility was working on implementing target behaviors and side effect monitoring. RN-A reviewed R22's medical record and acknowledged it lacked target behaviors and side effect monitoring. R1's quarterly MDS, dated 9/29/17, identified a severe cognitive impairment and had active diagnoses of Alzheimers dementia, aphasia, depression, and psychotic disorder. The MDS further identified R1 received antipsychotic and	F 756	pharmacist does their monthly review, 1 time a month for 3 months. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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antidepressant medications.

R1's current physician orders, printed 1/11/18, contained the following:
-Zoloft dated 10/18/17, 75 mg, for depression
-Zyprexa dated 8/9/17, 2.5 mg for dementia with behavioral disturbance

R1's current care plan, last revised 1/2/18, identified R1 was on an anti-depressant with a goal to be free side effects, free of discomfort or adverse side effects from antipsychotic medication use. Non pharmacological interventions included redirect, offer a drink or snack, approach in a positive smiling manner, offer her personal items, (bunny, baby or dog).

R1's Monthly Pharmacy Reviews, from 12/16 to 12/22/17, contained the following:
-On 9/27/17, was started on low dose Zyprexa a few months back.

R23's annual MDS, dated 9/6/17, identified she received anti-depressant medications. R23's annual CAA, dated 9/6/17, identified she received anti-depressant medication for a history of depression and the medications were reviewed on rounds. The CAA indicated R23 had minimal depression, identifying she felt tired and had little energy for one day.

R23's current physician orders, dated 1/11/18, identified the following medications:
-duloxetine HCL (anti-depressant) 60 mg daily for depression and anxiety
-Trazadone (anti-depressant) 100 mg daily for sleep

R23's current care plan, last revised 1/2/18,

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identified she received anti-depressant medication related to depression, noting a goal for R23 to be free of adverse effects. The care plan indicated interventions were, "Monitor [R23] condition based on clinical practice guidelines or clinical standards of practice," and, "Consult with pharmacy, health care provider, etc. to consider dosage reduction with clinically appropriate."

R23's Consulting Pharmacist Reviews, reviewed from 2/17 to 12/17, identified on 2/20/17, the pharmacist requested to taper R23's fluoxetine medication. There was no indication the consulting pharmacist had identified the lack of side effect monitoring.

R23's medical record lacked side effect monitoring for the anti-depressant medications.

During interview on 1/10/18, at 1:53 p.m. trained medication aide (TMA)-A stated R1 was on antipsychotic medication, and she would look for the, "Black box warning, that means the big things to look for Zyprexa, mortality rate." TMA-A also stated they tried non pharmacological interventions like one on one, if grabbing, biting, or combative to give her a stuffed animal, which helped to soothe her, and if she continued, encouraged staff to take a step back and re-approach and maintain calm environment.

During interview on 1/11/18, at 8:44 a.m. RN-A stated she didn't see any target behaviors documented in R1's medical record.

R1's medical record lacked documentation of target behavior and side effect monitoring.

During telephone interview on 1/12/18, at 1:37

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p.m. the consulting pharmacist (CP) stated she focused on a different topic each month for the medication reviews, but looked at anti-psychotics and anti-depressants more frequently, at least every six months. When asked about target behaviors, CP stated, "Ya know they say behaviors, like in the notes will say resident is withdrawn and not coming out to dining room etc," however; CP stated the behaviors were not targeted toward the medications the resident was taking. CP reported in some of her facilities, she had targeted behaviors, but not at this facility. CP stated she hadn't had any concerns with the behaviors or medications. When asked about side effect monitoring, CP reported she used to see psychotropic consents, which would list the side effects the facility monitored for like sleepiness or lack of appetite, but further reported she hadn't seen them in about two years. CP admitted it had slipped her mind to look for them, and she would write herself a note to look the next time she was at the facility.

R5's admission MDS, dated 2/17/17, identified R5 as severely cognitively impaired. R5's admission CAA, dated 2/18/17, indicated the use of Sertraline (anti-depressant).

R5's quarterly MDS, dated 11/15/17, identified verbal behavioral symptoms towards others. The MDS further indicated R5 received antipsychotic and antidepressant medication.

Physician orders identified the following:
1/18/17- Cymbalta (anti-depressant) 60 milligrams (mg) daily for depressive episodes.
9/30/17-Seroquel (anti-psychotic) 100 mg daily for

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major depressive disorder.
1/8/18-Additional anti-depressant Sertraline (anti-depressant) 50 mg daily for depression.

R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning." Monitor for behavioral symptoms that present a danger to the resident and others. Updated 1/2/18 resident on antidepressant medication related to depression. "Monitor (R5's) condition based on clinical practice guidelines or clinical standards of practice related to use of antidepressants. Consult with pharmacy, health care provider to consider dose reduction when clinically appropriate.

R5's point of care history documentation identifies staff monitor and document every shift for the following target behaviors. Trouble falling or staying asleep, feeling bed about self, moving or speaking slowly, fidgeting, states life is not worth living, attempts to harm self, being short tempered.

R5's medical record lacked side effect monitoring of the psychotropic medication

R5's Monthly pharmacy reviews between 2/17 and 12/17 were reviewed. The reviews lacked recommendation for side effect monitoring.

R13's annual MDS, dated 2/17/17, identified R13 was severely cognitively impaired. R13's CAA, dated 2/18/17, identified R13 used an antidepressant medication.

R13's quarterly MDS, dated 11/15/17, identified

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R13 receives antipsychotic, antianxiety, and antidepressant medication .

Physician orders revealed the following:
8/9/17- Seroquel (antipsychotic medication) by mouth one time daily for dementia with behaviors.
11/27/17-Zoloft 75 mg one time daily for depression
12/5/17-Ativan 0.5 mg one time daily for anxiety disorder.

R13's care plan included the following:
1/2/18 -on antipsychotic medication. Monitor condition based on clinical standards of practice. Attempt non-pharmacological intervention redirections, offering snacks, blue comfort blanket.
1/2/18- on antidepressant. Monitor condition based on clinical standards of practice. Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate.
1/3/18-antianxiety medication. monitor condition based on clinical standards of practice. interventions for mood also included to keep resident separated from (R18) when agitated. When calling/yelling out, attempt non-pharmacological interventions of offering personal items and assist to bathroom. Offer the TV.

R13's point of care history documentation identified staff monitor and document every shift for the target behavior of calling out. R13's record lacked side effect monitoring for psychotropic medication.

R13's Monthly pharmacy reviews between 1/17 and 12/17 were reviewed. The reviews lacked

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F 756	Continued From page 65 recommendation for side effect monitoring. During an interview on 1/11/18, at 11:35 a.m., registered nurse (RN)-A stated "we don't have any official documentation on that" when asked about side effect monitoring for R5 and R13. A policy on psychotropic medication monitoring was requested but was not received.	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to monitor bruising and	F 757	The policy and procedure has been reviewed in relation to the incident	2/9/18

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F 757	Continued From page 66 notify the coumadin clinic of possible side effect of anticoagulant therapy for 1 of 2 residents (R19) reviewed for unnecessary medications. Findings include: R19's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of Unspecified sequelae of unspecified cerebrovascular disease, R19's quarterly Minimum Data Set (MDS), dated 11/20/17, identified no cognitive impairment. The MDS further identified R19 had an active diagnosis of hypertension, hemiparesis, seizure disorder or epilepsy. R19's current physician orders, printed 1/11/18, contained the following: -Recheck INR 1/16/2018, dated 1/9/18. -Coumadin tablet 2.5 mg (milligrams) every Monday, dated 12/4/17, for cerebrovascular disease, -Coumadin 2 mg every Sunday, Tuesday, Wednesday, Thursday, Friday and Saturday, dated 12/5/17, for cerebrovascular disease. -Aspirin 81 mg one tablet daily, dated 3/9/15, related to cerebrovascular disease. R19's Monthly Pharmacy Reviews, reviewed from 11/14 through 12/17, contained a note on 6/23/14 INR 2.4, a note on 5/22/15 INR 2.2, and a note on 9/22/17 on coumadin. R19's current care plan, revised 12/28/17, identified anticoagulant therapy related to heart disease and directed staff to, "Report observations of blood tinged or frank blood in urine, black tarry stools, darker bright red blood in	F 757	involving R19 with side effect monitoring implemented. To prevent further potential deficient practice that could affect other residents who are on Coumadin therapy. Staff has been reeducated to implement daily side effect monitoring and to report irregularities to the physician. Audits will be completed on side effect monitoring of residents who are currently on Coumadin, also any irregularities reported to primary care physician. Audits will be done by the DNS or designee 1 time a week for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB,[shortness of breath] loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs."

R19's Skin Observations, reviewed from 12/17 to 1/19, identified the following:
-On 12/11/17, no bruising observed, a skin tear was noted on R19's left hand.
-On 1/1/18, no bruising observed and no skin conditions observed.
-On 1/9/18, at 9:51 a.m. a right elbow-bruise measured 4 cm (centimeters) around was observed and was related to bumping stuff in his room. The back of right hand bruising in different stages of healing. R19 reported the bruising was related to the medicine. The back left hand bruising in different stages of healing. Treatment included wearing geri sleeves on both forearms.

During observation on 1/8/18, at 3:45 p.m. large bruising was noted above the elbow and on the back of both upper arms. The bruising was approximately 3-4 inches in diameter, in various shades of dark purple in color. R19 had sleeve protectors on both forearms covering to the elbow bend, but did not cover the upper arms where the bruised areas were located.

During interview on 1/10/18, at 8:08 a.m. R19 stated he got bruises on his arms from the coumadin, stating any little bump caused a bruise. He further stated the nurses told him about side effects and what to watch for; he let them know if there was bruising. R19 stated he wore sleeve protectors and tried to be careful. R19 stated, "Yeah, these bruise are from

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bumping my dresser." R19 thought the nurse looked at them.

A facility progress note, dated 1/9/18, at 12:18 p.m. indicated communication to physican, "resident had INR 1.9, no Coumadin changes at this time will recheck INR 1/16/18."

Although R19 was identified on 1/9/18 as having bruising on arms and elbow there is is no indication the physican was notified of the bruising.

During interview on 1/10/18, at 8:28 a.m. trained medication aide (TMA)-A stated R19 was on Coumadin, and they checked for any bruising or scabs. TMA-A reported, on the medication administration record (MAR), there was a list of side effects to look for. TMA-A further reported if R19 reported or noticed any bruising, she would go to the charge nurse, and would document it in the progress notes. TMA-A stated she wasn't aware of any bruising for R19. TMA-A further stated R19 had a bath on Monday and the nurse would have checked for any bruising then.

During an interview on 1/10/18, at 11:37 a.m. licensed practical nurse (LPN)-C stated she would expect the nursing assistants to report any open areas, any bleeding, or any major bruising. LPN-C stated she would get it reported to the doctor. LPN-C stated would also document the bruising. LPN-C further stated R19 wears the sleeves, to protect his arms.

During interview on 1/11/18, at 9:18 a.m. registered nurse (RN)-A stated the expectation was a weekly skin assessment for anticoagulant side effect monitoring. Nursing would address

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F 757	Continued From page 69 any bruising or any skin tears documented on the skin observation sheet. Serious bruising would be reported to the physican. RN-A observed R19's medical record, acknowledging his weekly skin assessments lacked documentation and monitoring of the bruising. A facility policy entitled Pro Time: Measuring Anticoagulation Values, dated 9/12, identified the purpose was to increase recognition of potential adverse effects and proper dosing of anticoagulation therapy, to decrease reporting time to the attending physican or health care practitioner.	F 757		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic	F 758		2/9/18

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F 758	Continued From page 70 drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents were monitored for target behaviors for 2 of 5 residents (R22, R1) and failed to monitored for side effects, and educated on the risks/benefits of psychotropic use prior to initiation for 5 of 5 residents (R22, R23, R1, R5 and R13) reviewed for unnecessary medications. Findings include: R22's admission Minimum Data Set (MDS), dated	F 758	GSS-Sunwood realizes the importance to monitor target behaviors, side effect monitoring and to provide education on the risk and benefits of psychotropic medication for residents receiving psychotropic medication. Care plan have been updated for target behavior and non-pharmacological interventions for R1 and R22. The policy and procedure on initiation of psychotropic medications has been reviewed for resident number 22, 23, 1, 5 and 13. Resident Number 23 had	

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F 758	Continued From page 71 10/18/17, identified a moderate cognitive impairment and had been admitted to the facility due to a hip fracture. The MDS further identified R22 received anti-anxiety and anti-depressant medications. R22's admission Care Area Assessment(CAA), dated 10/18/17, indicated she used a daily anti-depressant and as needed anti-anxiety medications which would be reviewed during rounds. R22's hospital discharge orders, dated 10/11/17, noted she was admitted to the nursing facility with orders for alprazolam (anti-anxiety medication) 0.25 mg (milligrams) as needed with indications for insomnia and anxiety. R22's discharge orders also included bupropion (anti-depressant) 150 mg with the indication of anxiety with depression. A Physician Communication fax, dated 11/2/17, indicated R22's alprazolam had been changed from as needed to scheduled three times a day. The fax identified the physician would evaluate at the next visit. R22's physician note, dated 11/15/17, identified, "[R22] does have a little significant anxiety as well...She is on Wellbutrin already. She does get some Xanax three times a day. After discussing with the daughter there was some concern about tremors she may be having but looking at her today she has no tremor of concern here. This may just be related to some anxiety that she may be having." At that time, R22's physician ordered Remeron 7.5 mg (ant-depressant) at night for anxiety. R22's current care plan, last revised 1/3/18, identified she received anti-anxiety medication related to anxiety and anti-depressant medication	F 758	expired on 1/26/18. To prevent further potential deficient practice that may affect other residents with monitoring of target behaviors, Staff has been reeducated on 2/1/18 for monitoring target behaviors, side effects, and notification of risk and benefits of psychotropic medication use resident representatives. Facility will be monitoring target behaviors by auditing the care plan related to non-pharmacological interventions. Audit care plans for target behaviors and side effects for any resident receiving psychotropic medications that they have a non-pharmacological intervention. Audits will be done by the DNS or designee 1 time a week for 1 months then every other week for 2 month. To prevent further potential deficient practice due to failed monitoring for side effects and education on the risk/benefits of psychotropic use prior to initiation. Facility will audit this by using the “permission for use of psychotropic medications” (GSS #478 form) of residents who are on psychotropic medication with appropriate interventions. To monitor the side effects we will use the abnormal involuntary movement scale (AIMs) per facility protocol. Side effects of psychotropic medications have been placed on those residents’ eTAR, who receive them, to be monitored daily. Audit will be done on GSS #478 of any new orders on psychotropic medications for residents before initiation of the medication and on the daily assessment and scheduled AIMS assessment. Audits	

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F 758	Continued From page 72 related to depression, noting a goal for R22 to be free of adverse effects. The care plan indicated interventions were, "Monitor [R22] condition based on clinical practice guidelines or clinical standards of practice," and, "Consult with pharmacy, health care provider, etc. to consider dosage reduction with clinically appropriate." Although R22's alprazolam was changed to scheduled and another psychotropic medication was added, R22's medical record lacked target behaviors for anxiety justifying the medication changes. Furthermore, R22's medical record lacked non-pharmacological approaches to anxiety and side effects monitoring for the anti-anxiety and anti-depressant medications. R22's medical record lacked evidence she was educated on the risks/benefits of psychotropics. During observation on 1/10/18, at 8:05 a.m. R22 was walking with therapy. R22 was conversing with the therapist and did not display anxiety or side effects. During observation on 1/10/18, at 2:25 p.m. R22 was again walking with therapy. R22 did not display anxiety or side effects. During observation on 1/11/18, at 9:14 a.m. R22 was in her room, talking on a cell phone. R22 did not display anxiety or side effects. During interview on 1/11/18, at 7:45 a.m. trained medication aide (TMA)-A stated R22 was on Xanax to help manage her anxiety. TMA-A reported R22 displayed, "The traditional signs," of anxiety, would be on her call light a lot, could get very restless, and worried herself to the point of hyperventilating. TMA-A further reported R22	F 758	will be done by the DNS or designee 1 time a week for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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didn't display those behaviors as much anymore, keeping her busy with occupational and physical therapy. TMA-A stated, when the Xanax was as needed, they documented R22's behaviors when giving it in the administration note, and would also chart whether or not if was effective. Now that the Xanax was scheduled, TMA-A thought the behaviors and effectiveness would be documented in R22's progress notes, but further stated she didn't think R22 was really having any behaviors. TMA-A stated side effects were listed in the, "Black box warning," which came up on every medication. TMA-A reported the black box warning meant there was something big to watch for. TMA-A stated if she saw new side effects, she would alert the nurse. TMA-A denied R22 having any side effects and had never seen any tremors.

During interview on 1/11/18, at 12:35 p.m. R22 stated her anxiety, "comes and goes." R22 stated she was on a little pill for her anxiety, and it really helped. R22 further stated she had been on a pill for anxiety at home too. R22 reported she wasn't feeling depressed; she just wanted to get back home. R22 denied having side effects from her medications. R22 denied getting education on the risks/benefits prior to initiation, stating, "The risk is if they give you too much can pass out but [staff] never told me that," reporting she had been on some psychotropic medications at home.

R23's annual MDS, dated 9/6/17, identified she received anti-depressant medications. R23's annual CAA, dated 9/6/17, identified she received anti-depressant medication for a history of depression and the medications were reviewed on rounds.

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R23's current physician orders, dated 1/11/18, identified the following medications:
-duloxetine HCL (anti-depressant) 60 mg daily for depression and anxiety
-Trazadone (anti-depressant) 100 mg daily for sleep

R23's current care plan, last revised 1/2/18, identified she received anti-depressant medication related to depression, noting a goal for R23 to be free of adverse effects. The care plan indicated interventions were, "Monitor [R23] condition based on clinical practice guidelines or clinical standards of practice," and, "Consult with pharmacy, health care provider, etc. to consider dosage reduction with clinically appropriate."

R23's medical record lacked side effect monitoring for the anti-depressant medications. R23's medical record lacked evidence she was educated on the risks/benefits of psychotropics.

During observation on 1/10/18, at 8:49 a.m. R23 was transferred into her wheelchair using the sit to stand lift. No side effects were observed.

R1's quarterly MDS dated 9/29/17, identified a severe cognitive impairment and had active diagnoses of Alzheimers dementia, aphasia, depression, and psychotic disorder. The MDS further identified R1 received antipsychotic and antidepressant medications.

R1's current physician orders, printed 1/11/18, contained the following:
-Zoloft (anti-depressant), dated 10/18/17, 75 mg for depression
-Zyprexa (anti-psychotic), dated 8/9/17, 2.5 mg for dementia with behavioral disturbance

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R1's current care plan, last revised 1/2/18, identified R1 was on anti-depressant medication, with the goal to be free of any side effects. The interventions were: Consult with pharmacy, health care provider to consider medication alterations when clinically appropriate, BLACK BOX Warning-depression medications. The careplan also identified R1 had behaviors related to dementia. Interventions included intervene as necessary to protect the rights and safety of others. Hitting, kicking biting, apraxia, and positive manner.

R1's facility progress note, dated 6/15/17, identified R1's daughter was notified that Wellbutrin (anti-depressant) was discontinued on 6/21/7, and was started on Zyprexa 2.5 mg at bedtime.

A facility progress note, dated 9/4/17, identified R1 was difficult to arouse for lunch, barely ate, falling asleep with food in her mouth. Ceased feeding as resident at risk for aspiration.

R1's physician note, dated 11/15/17, identified R1 has some end stage dementia, really is not too communicative, but is aggressive towards others. Some of the psychosis is under fair control with Zyprexa and sertaline [Zoloft], but will need to continue for her safety and for staff.

During observation on 1/09/18, at 10:07 a.m. R1 sitting up in a Broda chair (type of wheelchair) in TV lounge area, other residents were talking, and R1 did not display behaviors.

During observation on 1/09/18, at 12:17 p.m. R1 was eating lunch in dining room with staff

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assistance; R1 did not display behaviors.

During interview on 1/10/18, at 1:53 p.m. trained medication aide (TMA)-A stated R1 was on antipsychotic medication. TMA-A stated, for side effects, she would look for the, "Black box warning", which meant there were big things. like death, associated with the medication. TMA-A also stated R1 was also on Zoloft for depression; she would look at negative mood and crying. TMA-A stated if she observed any behaviors, she would let the nurse know.

During an interview on 1/11/18, at 8:44 a.m. registered nurse (RN)-A stated she didn't see any target behaviors or side effect monitoring listed in R1's medical record.

Although R1's medications were changed to include Zyprexa, an anti-psychotic, R1's medical record lacked documentation of target behavior monitoring. R1's medical record also lacked side effect monitoring and evidence that the risks/benefits of antipsychotic and antidepressant medications were give prior to use.

R5's admission MDS, dated 2/17/17, identified R5 as severely cognitively impaired. R5's admission care area assessment (CAA), dated 2/18/17, indicated the use of sertraline (anti-Depressant) anti-depressant.

R5's quarterly MDS, dated 11/15/17, identified verbal behavioral symptoms towards others. The MDS further indicated R5 received antipsychotic and antidepressant medication.

Physician orders identified the following:
1/18/17- Cymbalta (anti-depressant) 60

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milligrams (mg) daily for depressive episodes.
9/30/17-Seroquel (anti-psychotic) 100 mg daily for major depressive disorder.
1/8/18-Additional anti-depressant sertraline (anti-depressant) 50 mg daily for depression.

R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning." Monitor for behavioral symptoms that present a danger to the resident and others. Updated 1/2/18 resident on antidepressant medication related to depression. "Monitor (R5's) condition based on clinical practice guidelines or clinical standards of practice related to use of antidepressants. Consult with pharmacy, health care provider to consider dose reduction when clinically appropriate.

During observations on 1/10/17, 7:14 a.m. R5 was sitting in a wheelchair in the dining room awaiting breakfast. R5 was pleasant, calm, talking with another resident at the table.

During an interview on 1/11/18, at 12:57 p.m. R5 was sitting in the TV area. R5 stated "I'm kind of blue." R5 was aware he takes medication for "feeling blue" and stated "sometimes" they help. R5 was smiling during the conversation.

R5's point of care history documentation identifies staff monitor and document every shift for the following target behaviors. Trouble falling or staying asleep, feeling bed about self, moving or speaking slowly, fidgeting, states life is not work living, attempts to harm self, being short tempered.

Although staff monitored R5's mood. R5's

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medical record lacked education on the risk/benefits of psychotropic medication. Additionally, the record lacked side effect monitoring of the psychotropic medication.

R13's annual MDS, dated 2/17/17, identified R13 was severely cognitively impaired. R13's CAA, dated 2/18/17, identified R13 used an antidepressant medication.

R13's quarterly MDS, dated 11/15/17, identified R13 receives antipsychotic, antianxiety, and antidepressant medication .

Physician orders revealed the following:
8/9/17- Seroquel (antipsychotic medication) by mouth one time daily for dementia with behaviors.
11/27/17-Zoloft 75 mg one time daily for depression
12/5/17-Ativan 0.5 mg one time daily for anxiety disorder.

R13's care plan included the following:
1/2/18 -on antipsychotic medication. Monitor condition based on clinical standards of practice. Attempt non-pharmacological intervention redirections, offering snacks, blue comfort blanket.
1/2/18- on antidepressant. Monitor condition based on clinical standards of practice. Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate.
1/3/18-antianxiety medication. monitor condition based on clinical standards of practice. interventions for mood also included to keep resident separated from (R18) when agitated. When calling/yelling out, attempt non-pharmacological interventions of offering

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personal items and assist to bathroom. Offer the TV.

During observations on 1/10/18 at 12:37 p.m. R13 in a loud voice repeatedly said "help." Nursing assistant (NA)-E responded and spoke with R13. R13 was quiet. At 12:46 p.m. NA-B approached R13 and assisted R13 to an activity.

R13's point of care history documentation identified staff monitor and document every shift for the target behavior of calling out.

Although staff monitored R13's mood. R13's medical record lacked education on the risk/benefits of psychotropic medication. Additionally, the record lacked side effect monitoring of the psychotropic medication.

During interview on 1/11/18, at 9:19 a.m. RN-A stated the facility was working on implementing target behaviors and side effect monitoring. RN-A reported target behaviors helped to identify the true issue for the resident's behavior. RN-A stated, without target behaviors, a medication could be deemed unnecessary or a medication could be used in an inappropriate way such as for getting residents to sleep. RN-A reported target behaviors alerted staff of what to be aware of. RN-A acknowledged the facility was working on getting target behaviors for everyone, stating they started putting mood symptoms in the chart under "Tasks" in the middle of December. RN-A further reporting the facility was working on side effect monitoring, stating they would like have it so all staff, nursing assistants and nurses, knew what to look for.

During interview on 1/11/18, at 10:07 a.m. social

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services (SS)-A stated behavior monitoring was a work in progress, and they were working on their behaviors screening to target and monitor behaviors. SS-A reported they had started a new format at their last interdisciplinary team meeting (IDT), but hadn't gone into great detail regarding monitoring, such as a looking at the diagnosis and associated behaviors. SS-A stated if consents for psychotropics are done, they would be scanned into the medical record under "Resident Spaces." SS-A further stated the risks/benefits were reviewed at care conferences and with the nurses on admission. SS-A stated there should be progress notes about staff going over them.

During interview on 1/11/18, at 10:31 a.m. the interim director of nursing (IDON) stated the behavior program at the facility was lacking and had identified it as a concern. The IDON stated they had met that Monday to start to address the program. The IDON reported she would like to see the program consist of what medications the resident is on, what specific behaviors the resident is currently having and how often, and have a progress note every quarter. The IDON also reported they were working on non-pharmacological approaches to behaviors, stating she wanted to implement a guide to direct staff on how to intervene for certain behaviors. Lastly, the IDON stated they were working on side effect monitoring and were hoping to have it pop up under the "Tasks" for staff to chart on.

During telephone interview on 1/12/18, at 1:37 p.m. the consulting pharmacist (CP) stated she used to see psychotropic consents, which would list the side effects the facility monitored for like sleepiness or lack of appetite. CP stated the

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F 758	Continued From page 81 family would sign the consent, then the consent was scanned into "Resident Spaces." CP further reported she hadn't seen them in about two years. A policy on psychotropic medication monitoring was requested but was not received.	F 758		
F 838 SS=F	Facility Assessment CFR(s): 483.70(e)(1)-(3) §483.70(e) Facility assessment. The facility must conduct and document a facility-wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include: §483.70(e)(1) The facility's resident population, including, but not limited to, (i) Both the number of residents and the facility's resident capacity; (ii) The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population; (iii) The staff competencies that are necessary to provide the level and types of care needed for the resident population; (iv) The physical environment, equipment, services, and other physical plant considerations	F 838		2/9/18

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 838	Continued From page 82 that are necessary to care for this population; and (v) Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services. §483.70(e)(2) The facility's resources, including but not limited to, (i) All buildings and/or other physical structures and vehicles; (ii) Equipment (medical and non- medical); (iii) Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies; (iv) All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care; (v) Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies; and (vi) Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations. §483.70(e)(3) A facility-based and community-based risk assessment, utilizing an all-hazards approach. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to complete a comprehensive assessment of the facility needs to ensure an effective plan was in place to maintain the highest practicable care for all 36 residents residing at the facility.	F 838	GSS-Sunwood realizes the importance to have a comprehensive facility assessment to ensure the effective plan was in place to maintain the highest practical care for all 36 residents. The facility assessment has been reviewed and updated to include accurate	

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F 838	Continued From page 83 Findings include: Upon entrance to the facility on 1/8/17, at 1:44 p.m. when asked to provide a copy of the current facility assessment, the administrator provided a copy of Imported Demographics and Census Data, undated. During the entrance conference, the administrator stated she had been at the facility for approximately one week, noting the facility assessment had been completed by the previous administrator. During the course of the re-certification survey conducted 1/8/18 to 1/11/18, quality of care and pharmacy concerns were identified regarding the following: -Care of a resident with acute illness (See F684) -Care and implementation of restorative nursing programs (See F688) -Care of residents with pressure ulcers (see F686) -Lack of target behaviors and side effect monitoring for psychotropic medications (See F758) -Filing of advance directives (See F578) The facility's Imported Demographics and Census Data, provided during entrance conference, identified one resident with a stage 3 pressure ulcer, five residents on antipsychotic medications, four residents on antianxiety medications, and sixteen residents on other forms of psychotropic medications. The Data lacked identification of any residents with restorative nursing programs. The facility assessment lacked an accurate identification of the resident population as well as lacked a comprehensive assessment to identify	F 838	documentation of the resident population and assessment to identify staff and contracted staff competencies and education, facility resources including pharmacy and contracted therapy services, structural resources and the management and communication between electronic medical records. To ensure the deficient practice does not reoccur, the facility assessment will be updated annually as per regulation. Ongoing facility assessment results will be reviewed monthly by facility QAPI committee for further recommendation.	

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F 838	Continued From page 84	F 838		

the needs and staff competencies required to care for their residents. The assessment lacked identification of all personnel including contracted pool staff noting their education and competencies needed to provide care. In addition, the facility assessment lacked identification of the facility's resources including pharmacy and contracted therapy services provided, equipment, and structural resources. The assessment lacked information regarding health information technology (HIM) and did not address the management and communication between their electronic medical records i.e. Point Click Care and Resident Spaces.

During interview on 1/11/18, at 10:31 a.m. the interim director of nursing (IDON) stated she had not participated in making the current facility assessment, and could not comment on what it addressed. The IDON stated facility assessments she had worked on in the past were interdisciplinary. The IDON further stated the purpose of a facility assessment was to address a facility's strengths and weakness, achieve the quality standards set forth for ourselves, to be aware of what is potentially out there for concerns, and to be able to function in an emergency situation.

A facility policy entitled Facility Assessment, dated 11/17, identified the purpose of the facility assessment was to determine resources needed to care for residents competently. The policy identified the components of the assessment, including but not limited to, the resident population and care required by disease, condition, physical and cognitive abilities, employee competencies, and services, including therapy and pharmacy services, provided by the

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F 838	Continued From page 85 facility.	F 838		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions	F 880		2/9/18

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F 880	Continued From page 86 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 disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the recommendations for hand hygiene and glove use for 1 of 2 residents (R17) observed for personal cares. Findings include:	F 880	GSS-Sunwood realizes the importance to have proper hand hygiene and glove use for resident's personal care. Policy and procedure on hand hygiene and gloving was reviewed in regards with resident number 17. To prevent further potential deficient practice with hand hygiene and glove use	

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F 880	Continued From page 87 R17's quarterly Minimum Data Set (MDS), dated 11/17/17, indicated R17 was cognitively intact, required staff assistance for all ADLs (activities of daily living), and was always incontinent of bowel. R17's current physician orders, printed 1/11/18, contained the following: Nystatin Cream 100000 unit/GM (units per gram) apply to groin and buttocks two times daily for redness. During observation on 1/10/18, at 8:32 a.m. nurses assistant (NA)-A entered R17's room, used hand sanitizer, and donned clean gloves. NA-A went into the bath room, turned on water, grabbed several washcloths, and wet them at the sink. NA-A walked to R17's bedside table, opened door, and picked up a plastic bag, a package of disposable wipes, and a clean brief. NA-A placed the wet washcloths, plastic bag, and wipes on side of R17's bed. NA-A explained to R17 that he was pulling the covers back. R17 nodded yes. NA-A opened R17's brief and asked R17 to turn over onto his right side. As NA-A pulled open the brief, a large formed BM (bowel movement) was observed between R17 buttocks, in the gluteal fold. NA-A picked up the package of wipes, pulling some out, and wiped BM from R17 gluteal fold using his right gloved hand. NA-A placed soiled wipes into the garbage can at side of bed. NA-A using the soiled gloved right hand to pull out several more wipes, and again wiped BM off R17 gluteal fold. NA-A used the gloved right hand to discard soiled wipes in the garbage can. NA-A pulled the soiled brief out from under R17, rolling it into a ball, and discarded it in the trash can. NA-A then used his soiled gloved right hand to pick up a wet washcloth and washed off R17's buttocks. NA-A placed the soiled washcloth in plastic bag. NA-A then opened the bedside	F 880	that may affect other residents during personal resident care. Staff was reeducated on hand hygiene at an All Staff meeting on 1/16/18. Learning center online education on hand hygiene was completed by January by 1/31/18. Random audits will be completed on observations of staff on hand hygiene during personal care of residents. Audits will be done by the DNS or designee 1 times a week for 2 months then every other week for 1 month. Audit results will be reviewed monthly be facility QAPI committee for further recommendation.	

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F 880	Continued From page 88	F 880		

drawer, picked up container of cream, and applied the cream to R17's coccyx using his soiled gloved right hand. NA-A, using the soiled gloved hand, placed a clean brief under R17 bottom, picked up a clean wet wash cloth, and washed off R17's groin. NA-A continued to use soiled gloved right hand to apply cream to R17's groin. NA-A used the soiled gloved right hand to open the bedside drawer, picked up a bottle of body lotion, and applied lotion to R17's back and legs.

NA-A then went into bathroom and removed soiled gloves; however, NA-A did not wash his hands. NA-A donned clean gloves, picked out shirt and pants from R17's closet, and assisted R17 to put on pants and shoes. NA-A used his gloved hands to assist R17 to a sitting position on the bed. NA-A then assisted R17 to put shirt on, put a transfer belt around R17 waist, and assisted R17 to stand up. While standing up, NA-A pulled up R17 pants. NA-A picked up the soiled laundry bag, tied it, and put it on the floor by garbage can. NA-A then doffed the gloves and placed them in the garbage can. NA-A again did not wash his hands. NA-A made R17's bed using both hands, then picked up garbage bag and soiled linen bag. NA-A carried the soiled linen and trash bags down the hallway to the soiled linen room. NA-A reached into his pocket and used hand sanitizer as he walked out of the soiled linen room.

During interview on 1/10/18, at 9:05 a.m. NA-A stated, "Yeah, I messed up." NA-A stated he didn't change gloves until after the cream and lotion were applied.. NA-A stated he forgot to change gloves and wash his hands after cleaning up R17's BM. NA-A further stated, "Sadly, that's my usual routine."

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F 880	Continued From page 89 During interview on 1/10/17 at 9:30 a.m. interim director of nursing (IDON) stated the expectation was for staff to follow the hand hygiene procedures, meaning changing gloves and washing hands as often as necessary. During interview on 1/11/18, at 4:28 p.m. registered nurse (RN)-B, who was in charge of infection control, stated he was new to the role and was in the process of forming hand hygiene education for staff regarding "foaming in and out," with the hand sanitizer and when they need to change gloves. RN-B stated he hoped to present the information at the next nurses meeting. RN-B further stated he planned on doing audits to make hand hygiene is being done. Hand hygiene policy was requested but not received.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to establish a process for antibiotic review in order to determine appropriate indications, dosage, duration, and trends of antibiotic use and	F 881	GSS-Sunwood realizes the importance to have a process in place for antibiotic review in order to determine appropriate indications, dosage, duration, and trends	2/9/18

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F 881	Continued From page 90 resistance. This had the potential to affect all 36 residents who resided in the facility. Findings include: During review of the facility's infection control program on 1/10/18, at 1:15 p.m. with the registered nurse (RN)-B, the facility lacked documentation that an antibiotic stewardship program was identified. The infection control program lacked protocols for prescribing antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. Monthly Infection Control Report and corresponding Monthly Report of Resident Infections, reviewed from 4/17 to 12/17, indicated the following: -April: one urinary tract infection (UTI) was identified and treated with antibiotic. No culture was taken prior to initiating antibiotic and no symptoms were listed. -May: five UTI's were identified. All were cultured and treated with antibiotics, with two residents growing the same organism and two residents had antibiotic changes during the course of treatment. -July: five UTI's were identified. All were cultured and treated with antibiotics; however, two culture results were not listed. There was no indication the antibiotics had been reviewed. -August: three UTI's were identified. All were cultured and treated with antibiotics; however, one culture result was not listed and two had no symptoms listed. There was no indication the	F 881	of antibiotic use and resistance. Policy and procedure was reviewed in relation to all current residents. To prevent further potential deficient practice that may affect other residents regarding antibiotic process and procedure, the facility is reviewing all , antibiotic orders for corresponding sensitivities and accompanying symptoms the resident is having. .Staff has been reeducated on 2/1/18 concerning facility's antibiotic procedures and process. Audits will be done on the antibiotic usage process for the indication, dose, duration, and trends of antibiotic use and resistance will be done by the DNS or designee 1 time a week for 2 months then every other week for 1 month. Audit results will be reviewed monthly by facility QAPI committee for further recommendation.	

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F 881	Continued From page 91	F 881		

antibiotics had been reviewed.
-September: one UTI was identified and treated with antibiotic. There was no indication the antibiotic had been reviewed.
-October: three UTI's were identified. All were treated with antibiotics. One was admitted to the hospital and one was sent to the emergency room; there was no indication cultures were obtained. The third UTI was cultured and treated with antibiotics; however, no symptoms were listed. There was no indication the antibiotics had been reviewed.
-November: one UTI was identified, cultured, and treated with antibiotics. No symptoms were listed and there was no indication the antibiotic had been reviewed.
-December: two UTI's were identified. Both were treated with antibiotics; however, only one had a culture. Neither UTI listed symptoms and there was no indication the antibiotics had been reviewed.
During interview on 1/11/18, at 4:28 p.m. RN-B and the interim director of nursing (IDON) acknowledged they were aware of the concern with antibiotic stewardship. RN-B stated he was new to the infection control role and was in the process of learning the requirements for the antibiotic stewardship program. RN-B further stated the facility's medical director was coming to the facility the next week to discuss antibiotic stewardship, and so he could bring the program back to fellow physicians and providers. RN-B reported they were in the process of educating staff and providers to obtain and wait for a culture result prior to initiating antibiotics for UTI's, and to document a reason if antibiotics were initiated prior.
A facility policy entitled Antibiotic Stewardship, revised 10/17, directed the purpose of an

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F 881	Continued From page 92 Antibiotic Stewardship Plan was to, "Optimize the treatment of infections while reducing the adverse events associated with antibiotic use." The policy instructed each center would have a plan by November 2017.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-	F 883		2/9/18

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F 883	Continued From page 93 (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure residents were offered and received pneumococcal (PPSV23 and PCV13) vaccinations for 2 of 5 residents (R23, R2) who resided in the facility. Findings include: R23's most recent quarterly MDS, dated 12/7/17, identified she was 89 years old. Review of R23's Clinical-Immunizations, printed 1/9/18, indicated she received PPSV23 pneumococcal vaccine on 9/12/11. R23's medical record lacked documentation as to whether the	F 883	GSS-Sunwood realizes the importance to offer and receive pneumococcal (PPSV23 and PCV13) vaccination for residents. Policy and procedure were reviewed for R2. He was offered PCV13 and PPSV23 and refused both. Resident number 23 has since expired on 1/25/18. To prevent further potential deficient practice that may affect other residents regarding pneumococcal vaccinations facility reviewed records to determine their eligibility for pneumococcal immunization those eligible will have consent obtained and offered the vaccine if desired. Newly admitted residents records will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245237	A. BUILDING _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

(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 883	Continued From page 94 PCV13 pneumococcal vaccine was offered. R2's most recent quarterly MDS, dated 10/4/17, identified he was 74 years old. Review of R2's Clinical-Immunizations, printed 1/9/18, indicated he received PCV13 pneumococcal vaccine on 1/4/17. R23's medical record lacked indication as to whether the PPSV23 pneumococcal vaccine was offered. During interview on 1/10/18, at 1:15 p.m. registered nurse (RN)-B stated he was new in the infection control role and had made a report of the residents who still needed the series of pneumococcal vaccinations. During interview on 1/11/18, at 10:31 a.m. the interim director of nursing (IDON) stated she was aware pneumococcal vaccinations were a concern, further stating the interim nursing director who had been there prior to her had begun to work on updating the vaccinations. The IDON reported the facility had faxed the clinics looking for vaccinations in order to fill in some gaps in their vaccination histories. The IDON stated she had updated some, but there were still residents who were missed. The IDON further stated they were in the process of getting physician approval to administer the second dose of pneumococcal vaccinations, whether that be PCV13 or PPSV23, and had a nurse who would be entering them into the medical records that weekend. During interview on 1/11/18, at 4:28 p.m. registered nurse (RN)-B was aware of the vaccination concern and stated they were attempting to get him access to MIIC (Minnesota	F 883	reviewed and if eligible, they will be offered the PPSV 23 and PCV 13 vaccines, orders will be gotten, consents received then the vaccines will be administered as ordered. Audits will be completed on random charts looking for consent and administration or refusal for PPSV23 and PCV13. Audits will be done by the DNS or designee 1 time weekly for 2 months then every other week for 1 month. Audits results will be reviewed monthly by facility QAPI committee for further recommendation.	

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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F 883	Continued From page 95 Immunization Information Connection) so he had statewide access to residents' vaccination history. The facility's policy entitled Immunization for Residents, dated 9/17, identified, "It is recommended that both PCV13 and PPSV23 be administered in series to all adults aged 65 and older for prevention of pneumococcal disease."	F 883		

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	245237	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/16/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET** **REDWOOD FALLS, MN 56283**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Redwood Falls was found not to be 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 Occupancies and the 2012 edition of NFPA 99, Health Care Facilities Code. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		02/03/2018

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

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	245237	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/16/2018**

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET** **REDWOOD FALLS, MN 56283**

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K 000	Continued From page 1 St. Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Redwood Falls is a one-story building with no basement. The facility is fully fire sprinkler protected, and was determined to be of Type II(000) construction. The original building was constructed in 1962, with building additions in 1966 and 1975. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 43 beds and had a census of 34 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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GOOD SAMARITAN SOCIETY - REDWOOD FALLS	**200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283**

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K 372	Continued From page 2	K 372		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1.(1). This deficient practice could affect 25 of 43 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1)	K 372	Gss-Sunwood has ordered the fire cock, maintenance assistant will seal the hole and fire cock around it. Actual proposed completion date 2/9/18. Brad Stephens is in charge of the correction and monitoring to prevent future reoccurrences.	2/9/18

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K 372	Continued From page 3 Describe any mechanical smoke control system in REMARKS. Findings include: On facility tour between 10:00 AM and 1:00 PM on 01/16/2018, a penetration was observed in the wall above the lay-in ceiling at the southwest smoke barrier. NOTE: All smoke barriers in the Facility need to be checked to ensure there are no penetrations in the smoke barriers. These deficient practices were verified by the Facility Maintenance Director.	K 372		
K 926 SS=E	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety	K 926	Gss-Sunwood staff development/RN has contacted northwest respiratory, they will be sending out training material so then our facility has a trained personnel on the medical gases and cylinders. The proposed completion date is May, 1st	2/9/18

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K 926	Continued From page 4 guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This deficient practive could effect 43 of 43 residents. FINDINGS INCLUDE: Based on observation and documentation review,between 10:00 AM and 1:00 PM on 01/16/2018, documentation could not be located to show that all staff that handle gas cylinders have received safety training guidelines and usage requirements of gas cylinders. This deficient practice was verified by the Facility Maintenance Director.	K 926	2018. Dean Wilson is in charge of monitoring to prevent a reoccurrence of the deficiency.	

Electronically delivered

January 26, 2018

Ms. Haley Amundson, Administrator
Good Samaritan Society - Redwood Falls
200 South Dekalb Street
Redwood Falls, MN 56283

Re: State Nursing Home Licensing Orders - Project Number S5237025 and H5237013

Dear Ms. Amundson:

The above facility was surveyed on January 8, 2018 through January 11, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes and to investigate complaint number H5237013. that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Kathleen Lucas at (320) 223-7343 or email: kathleen.lucas@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.

Please feel free to call me with any questions.

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
Telephone: (651) 201-4118
Fax: (651) 215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00063	A. BUILDING: _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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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 dates 1/8/18 to 1/11/18, 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. In addition, a complaint investigation was also completed at the time of the licensing survey. An investigation of complaint H5237013 was completed. The complaint was not substantiated at a licensing order. 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.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on interview and record review, the facility failed to ensure comprehensive care plans which included medical needs were developed for 1 of 5 residents (R22) who were reviewed for unnecessary medications. Findings include: R22's admission Minimum Data Set (MDS), dated 10/18/17, identified a moderate cognitive impairment, a diagnosis of Diabetes Mellitus, and was receiving therapy due to a hip fracture. The	2 560	Corrected	2/9/18

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2 560	Continued From page 3 MDS further identified R22 was continent of bowel with no symptoms of constipation. R22's admission Care Area Assessments (CAA), dated 10/18/17, indicated she had pain after her recent hip surgery, using scheduled and as needed pain medications. R22's current physician orders, dated 1/11/18, identified the following medications: -Lantus SoloStar Solulion (insulin) 30 units in the morning for Diabetes Mellitus. -Prednisone (steroid medication which can increase blood sugar) 7 mg (milligrams) daily to taper down to 1 mg for left femur fracture. -Polyethylene Glycol (Miralax laxative) 17 gram twice a day for constipation. -Tylenol (pain reliever) 325 mg 2 tablets three times a day for pain. -Tramadol (pain reliever) 50 mg 1 tablet for pain rating 1-5 and 2 tablets pain rating 6-10 every 6 hours as needed. In addition, R22's physician orders directed to check her blood sugar before meals and at bedtime, noting blood sugars weekly and if greater than 200, increase Lantus insulin by 5 units. R22's physician communication forms and orders identified her Lantus had been increased twice during her stay, on 10/21/17 and again on 11/15/17, due to high blood sugars. R22's physician notes were reviewed and indicated the following: - On 10/27/17, noted R22 had a decrease in her bowel movements and increased her Miralax, further noting she also had used enemas and suppositories. - On 12/13/17, noted R22's, "Biggest complaint is	2 560		

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GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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2 560	Continued From page 4	2 560		

being constipated," and another laxative medication was ordered.

R22's current care plan, last revised 1/3/18, lacked diagnoses, goals, and interventions for her Diabetes Mellitus with Prednisone use and associated hyperglycemia (high blood sugar), bowel status with symptoms of constipation, and treatment of post operative pain.

During interview on 1/11/18, at 9:19 a.m. registered nurse (RN)-A stated any of the nurses could revise or update the care plan, further stating they had started to review care plans weekly with an interdisciplinary team (IDT) for short stay residents. RN-A stated the care plan usually contained a diagnosis of Diabetes Mellitus and noted if a resident was on insulin; however, she acknowledged R22's care plan was missing the diagnosis and interventions. RN-A reported R22 had not presented with constipation on admission, but had developed symptoms due to the pain medications, further stating R22's family had also mentioned a history of bowel issues after admission. RN-A further reported resident toileting plans and continence status were put on the care plan, noting R22's care plan only mentioned her bladder not her bowel status. When asked if bowel symptoms of constipation were typically care planned, RN-A reported, "It will in the future." RN-A further acknowledged R22's care plan did not address pain; she would expect the care plan to address a goal to be comfortable with the pain level after hip surgery along with the interventions of administering medications as ordered, offering alternatives like an ice pack or repositioning, and monitoring for signs of increased pain and to alert the physician.

During interview on 1/11/18, at 10:31 a.m. the

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2 560	Continued From page 5 interim director of nursing (IDON) was aware of concerns with the care plans and charting, noting not all of the care plans were current, basic charting was not getting done, and skilled residents were not being charted on. The IDON stated she had a nurse working on getting the care plans up to date that weekend. The IDON further stated the facility was not documenting reviews of the care plans prior to her coming to the facility, further noting she had implemented adding quality measure questions into the weekly IDT care plan reviews, a process they had just started the week prior. During interview on 1/11/18, at 12:35 p.m. R22 stated the insulin was a new medication she had been put on after surgery while she was taking the Prednisone, stating the hip surgery had brought on Diabetes. R22 further stated she had been told the Prednisone would help with healing. R22 further stated her bowels were, "Not very good," noting she gets constipated easily and had been constipated the previous day. R22 stated the constipation made her feel uncomfortable. R22 reported she had pain, which could be real bad when she got up; however, further reported the pain killers helped a lot. R22 reported she had tried ice packs but didn't think they helped. A facility policy entitled Care Plan, revised 11/16, directed, "Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs." The policy further directed the comprehensive care would be completed seven days after completing the assessment.	2 560		

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2 560	Continued From page 6 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee (DON) could educate staff to develop a care plan which includes appropriate goals and interventions for all identified care needs. A monitoring program or auditing could be established in order to assure ongoing and effective care planning in response to resident care needs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure oxygen administration was consistently monitored for 1 of	2 830	Corrected	2/9/18

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2 830	Continued From page 7 1 residents (R238) reviewed for oxygen. Findings include: R238's diagnosis report indicated, on 1/4/18, diagnoses of " Influenza due to unidentified influenza virus with other respiratory manifestations." R238's current physicians orders identified an order, dated 1/5/18, for " O2 (oxygen) to keep sats (saturation) greater than 90% (percent)." R238's medication administration record (MAR) and treatment administration record (TAR), for 1/18, lacked documentation of oxygen use or monitoring. R238's care plan, dated 1/6/18, directed to assess for shortness of breath and cyanosis (appearance of a blue or purple discoloration of the skin). The care plan lacked identification of oxygen use and interventions related to oxygen use or non-compliance. On 1/6/18, at 1:39 p.m. vital sign documentation identified R238 was on oxygen (lacked flow rate). Oxygen saturation 96% via nasal cannula. On 1/7/18, at 1:02 p.m. vial sign documentation indicated R238 was on oxygen (lacked flow rate) via nasal cannula. R238's oxygen saturation was 98%. A progress note dated 1/7/18, at 11:30 a.m. indicated oxygen at 2 liters (liters/min) via nasal cannula. Alert. Able to make needs known. A progress note dated 1/8/18, at 12:03 p.m. indicated R238 was alert and able to make needs	2 830		

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2 830	Continued From page 8	2 830		

known. Uses Oxygen at 2 L (liters) via nasal cannula. R 238's medial record lacked documentation of an oxygen saturation level on 1/8/18.

A progress note dated 1/9/18, at 6:47 a.m. indicated R238 had O2 at 2L via nasal cannula. Regular, easy respirations.

During observation on 1/9/18, at 11:15 a.m. R238 was laying in bed. An oxygen concentrator located next to the head of the bed was turned off. The nasal cannula, which was connected to the concentrator was laying on the recliner in the room. The oxygen tubing was not dated. When asked when the oxygen was used, R238 replied, "Oh, when the nurse pokes her head in here." R238 stated he did take the oxygen tubing off at times. R238 was not short of breath. The oxygen tubing was not dated.

A progress note, dated 1/9/18, at 11:47 a.m. indicated R238 was alert, oriented, and pleasant. Will use call light for assistance.

During observation on 1/9/18, at 12:14 p.m. R238 was sitting on the side of his bed independently eating lunch. R238 was not receiving oxygen.

R238's medical record lacked documentation of an oxygen saturation level or monitoring to determine if R238's oxygen was above 90% per physicians order on 1/9/18. The record lacked documentation of the discontinuation of oxygen. The record from admission to 1/9/18 lacked documentation of R238 removing his oxygen tubing.

During observation on 1/10/18, at 7:06 a.m. R238 was sleeping in bed. The oxygen concentrator

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2 830	Continued From page 9 was on and set at 2L, however; R238 was not receiving oxygen. The nasal cannula was laying on the floor next to the bed. R238 did not appear short of breath. On 1/10/18, at 9:06 a.m. vital sign documentation identified an oxygen saturation of 96%. Oxygen via nasal cannula. During observation on 1/10/18, at 11:28 a.m. R238 was sitting in the recliner in his room with his feet elevated. The oxygen concentrator was on, and R238 was receiving oxygen via nasal cannula at 2L/min. When asked if he experienced shortness of breath, R238 replied, "Yeah, especially today." R238 went on to say he was short of breath earlier. When asked about oxygen administration, R238 stated he, "Loses the tubing." "If I could find the darn thing, I would put it on." Oxygen tubing continued to be undated. During interview on 1/10/18, at 11:34 a.m. licensed practical nurse (LPN)-A stated oxygen concentrators are used in resident rooms and portable oxygen tanks are used outside of the resident's room. LPN-A stated R238 used oxygen at 2 liters. R238's oxygen saturations needed to be kept above 90%. When asked how staff monitor R238's oxygen, LPN-A replied that staff obtain daily oxygen saturations readings. LPN-A stated R238 would sometimes take his oxygen tubing off. When that happened, staff put the oxygen cannula back on. LPN-A stated earlier that day, she had put the oxygen cannula back on R238 after finding it off. LPN-A stated the day nurse changes all oxygen tubing weekly on "tubing Tuesday." The tubing is dated when changed. Tubing Tuesday was on 1/9/18. R238's tubing was not changed, as R238 had not resided at the facility for a week on 1/9/19. LPN-A stated	2 830		

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2 830	Continued From page 10 R238's tubing should be dated, but was not. During interview on 1/11/18, at 11:35 a.m. registered nurse (RN)-A stated R238's oxygen order directed to keep oxygen saturations above 90%. Staff were to monitor R238's oxygen saturation levels at least once daily. Oxygen administration was documented on the MAR or TAR. RN-A stated R238's MAR/TAR record did not contain documentation of oxygen administration. The record was inconsistent with monitoring of oxygen saturations levels, missing monitoring on 1/8/18 and 1/9/18. R238's oxygen use, as well as interventions, should be on the care plan. RN-A stated R238's care plan did not include oxygen therapy or interventions related to non-compliance. During interview on 1/11/18, at 12:34 p.m. the interim director of nursing (IDON) stated when a resident had an order for continuous oxygen, staff were to monitor the oxygen saturations levels each shift and as needed. Additionally, staff were to obtain an oxygen saturation reading when a resident was found to have removed the oxygen tubing. Oxygen use was to be addressed on the care plan. All oxygen tubing should be dated and replaced weekly. The facility's policy Oxygen Administration with Nasal Cannula, Face Mask or Face Tent, dated 10/17, identified the procedure for oxygen administration. The process included: verify physicians order. Observe for signs of tachycardia, hypoxia, dyspnea, confusion, anxiety, cyanosis, and restlessness. For resident on continuous oxygen therapy, give oral. nasal care every eight hours. Observe resident for tolerance of oxygen therapy and for any adverse symptoms. Disposable equipment should be	2 830		

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2 830	Continued From page 11 changed weekly, or according to manufactures instructions, and marked with date and initials. Document on TAR or eAdmin note when these items are changed. Record when oxygen therapy started, type of administration used, flow rate and time when oxygen tanks are changed. Document resident's reaction and tolerance to therapy. Document as appropriate on the eMAR and TAR and on the progress note in the MAR or TAR. SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review and revise polices and procedures regarding the assessment, monitoring, and documentation of a change of condition. The DON or designee could educate staff on the policies and procedures, and audit resident charts to ensure complaince. The DON or designee could review and revise policies and procedure regarding oxygen use, edcuate staff on monitoring oxygen levels, and audit for compliance with oxgyen order. TIME FRAME FOR CORRECTION: Twenty One (21) Days	2 830		
2 895	MN Rule 4658.0525 Subp. 2.B Rehab - Range of Motion Subp. 2. Range of motion. A supportive program that is directed toward prevention of deformities through positioning and range of motion must be implemented and maintained. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which	2 895		2/9/18

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2 895	Continued From page 12 provides that: B. a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and to prevent further decrease in range of motion. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide restorative nursing for 4 of 4 residents (R17, R19, R7, R1) reviewed for mobility. This had the potential to affect 17 of 36 residents who had therapy recommended programs. Findings Include: R17's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of pain in left hip, displaced intertrochanteric fracture left femur, subsequent encounter for closed fracture with routine healing, muscle weakness, and difficulty in walking. R17's quarterly Minimum Data Set (MDS), dated 11/17/17, identified no cognitive impairment and required staff assistance for ambulation. R17's Functional Maintenance Restorative Program dated 4/14/17, identified exercise and walking program 5 x/wk [five times a week]. R17's care plan, last reviewed 12/27/17, identified R17 needed restorative intervention due to weakness. R17 will improve current level of standing tolerance by next review date. Identified interventions included: "Nursing rehab: Ambulate with resident 3 x[times]/day with FWW [four	2 895	Corrected	

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wheeled walker], CGA [care giver assist] and W/C [wheelchair] to follow PRN [as needed], Scifit [a type of exercise bike] level 3 PRN, Seated bilateral leg kick, green band knees apart, green band pull back, 2 x 10 REPS [repetitions]each."

R17 physician progress note, dated 12/20/17, identified has pain in hip and radiates down his leg, stated he really does not walk.

R17's medical record lacked evidence that the restorative nursing program was being offered, implemented, and evaluated.

During observation on 1/09/18, at 10:03 a.m. R17 was sitting in his wheelchair in the hallway outside his room. No offers of ambulation by staff were observed.

During observation on 1/09/18, at 2:00 p.m. R17 self propelled in his wheelchair down the hallway towards the dining room.

During interview on 1/09/18, at 3:27 p.m. physical therapist (PT)-A stated R17 had been on a restorative walking program since 4/17. PT-A stated since then he has had a decline in ambulation due to increased pain in his legs and hip. PT-A stated R17 had increased apprehension with pain and often refused ambulation. PT-A stated with residents refusal, nursing may change the frequency of the walking program as needed. Nursing wouldn't necessarily let physical therapy know that. PT-A stated would expect that ambulating be offered and documented if refused.

During interview on 1/09/18, at 3:41 p.m. R17 stated he hadn't walked in about two weeks. R17

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2 895	Continued From page 14 further stated staff had not offered ambulation. During interview on 1/10/18, at 11:38 a.m. licensed practical nurse (LPN)-C stated R17 had a restorative walking program, but today was observed mainly in the wheelchair. LPN-C stated she would expect staff at least offer to walk everyday and document resident's refusal. LPC-C stated if walking isn't occurring would be reported to charge nurse who would report to physician, so it could be followed up on, so no decline in his ability to walk. LPN-C stated she reviewed notes back to 12/20/17 and found no documentation R17 had been offered restorative rehabilitation. During interview on 1/11/18, at 8:33 a.m. registered nurse (RN)-A stated when the restorative aides are not working, R17 probably would not receive restorative interventions. RN-A reviewed R17's medical record and did not find any assessments or goals in his medical record regarding his restorative program. R19's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of Unspecified sequelae of unspecified cerebrovascular disease. R19's quarterly MDS, dated 11/20/17, identified no cognitive impairment. The MDS further identified R19 had an active diagnosis of hypertension and left sided hemiparesis (paralysis). R19's care plan, last review 12/28/17, indicated R19 had limited physical mobility related to a history of stroke and would maintain current level of mobility. Interventions identified: "Ambulation able to ambulate 75'[feet] with CGA, gait belt and	2 895		

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2 895	Continued From page 15	2 895		

single point cane daily and PRN. Likes to ambulate to meals to tolerance, SBA [stand by assist] of one and bring the w/c [wheelchair] behind." Also identified, R19 needed restorative intervention due to limited physical mobility related to CVA [cerebrovascular accident] left side weakness. Identified interventions included: R19 should perform Scifit[exercise bicycle] at level 5 up to 10 minutes 2-3 times per week. Leg press resistance 150 lbs[pounds]2 x 10 3 x/ [times]week.

A physician progress note, dated 8/17/17, identified R19 was getting around fairly well, used a cane to walk around despite left sided hemiparesis. R19's goal was to look into handicapped apartment. This will be very reasonable.

R19's progress note, dated 8/23/17, indicated continued weight gain is a concern, his activity level has decreased as he does not walk to diner as he did in the past.

R19's progress note, dated 12/30/17, physical therapy order clarification to discharge form physical therapy to SNF[skilled nursing facility].

R19's medical record lacked documentation that ambulation and restorative nursing programs were being offered, implemented, and evaluated.

During interview on 1/9/18, at 3:27 p.m. R19 stated he hadn't been walking the past couple of weeks. R19 further stated he had not seen the restorative aide staff for a couple of weeks and no one else had offered to walk him.

During interview on 1/9/18, at 3:30 p.m. PT-A stated R19 was in a restorative nursing program

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2 895	Continued From page 16	2 895		

and should be walking everyday to breakfast as he could tolerate. R19 had limited mobility due to a stroke and if he was not ambulating, the RN care manager should have been notified.

During interview on 1/10/18, at 11:31 a.m. LPN-C stated R19 ambulated with assist of one staff. LPN-C also stated R19 had a restorative walking program, but whoever got him up can walk him to breakfast. LPN-C further stated R19 was pushed in his wheelchair to breakfast that morning.

During interview on 1/11/18, at 8:35 a.m. RN-A stated when the restorative aides were not working, R19 probably would not have received restorative interventions. RN-A reviewed R19's electronic medical record and stated there was no documentation on restorative programs being offered or assessed.

R7's admission Minimum Data Set (MDS), dated 4/9/17, identified no cognitive impairment, required extensive assistance of one staff to walk in her room, and did not identify any upper or lower body range of motion (ROM) limitations. The MDS also identified R1 was receiving occupational therapy (OT) and physical therapy (PT).

R7's quarterly MDS, dated 10/18/17, indicated she continued to require extensive assistance of one staff with mobility, but had not ambulated in her room or outside her room during the assessment period, nor had she received OT or PT services during the assessment period.

R7's most recent Physical Therapy Discharge Summary, dated 10/5/17, indicated R7 had been working with therapy on increasing bilateral lower

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GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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2 895	Continued From page 17 extremity strength and transfer ability. The discharge summary noted R7 did not meet the goals of therapy and, "Patient is discharged from skilled therapy intervention at this time due to patient's overall decline in health status and therefore slowed progress towards functional therapy goals. Patient referred to neurologist and will be appropriate for further skilled therapy intervention once the patient is more medically stable. Ath [sic] this time the patient is appropriate to DC [discharge] to RNP [restorative nursing program] to be performed on a daily basis to maintain therapy gains." Functional Maintenance Restorative Programs were reviewed for R7, and identified the following: -On 10/3/17, a new restorative program was recommended, which replaced R7's previous walking program. The overall goal was to, "maintain current LE [lower extremity] strength." R7's program included using the Scifit bike (type of exercise bike) 10 minutes five times a week. A physician progress note, dated 11/14/17, identified R7 could no longer transfer and walk on her own, noting she was requiring a lift to transfer and had noticed gradually declining strength in her hands and feet. At that time, R7 had been diagnosed with "progressive neurological dysfunction of her extremities," and was to see a neurologist. R7's current care plan, last revised 1/3/18, identified an ADL (activities of daily living) deficit requiring the sit to stand lift and staff assistance for transfers. The care plan also identified R7 had a musculoskeletal alteration related to left food drop and wore a brace. The care plan did not address R1 impaired mobility, new neurological decline, or restorative nursing program.	2 895		

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2 895	Continued From page 18 R7's medical record lacked evidence a restorative nursing program was being offered, implemented, and evaluated. During observations on 1/9/18, from 10:35 a.m. to 3:45 p.m. R7 was consistently in her room and no restorative nursing program was provided. During observations on 1/10/18, from 7:30 a.m. to 11:30 a.m. R7 was consistently in her room and no restorative nursing program was provided. During observations on 1/11/18, from 7:36 a.m. to 12:02 p.m. R7 was consistently in her room and no restorative nursing program was provided. During interview on 1/9/18, at 10:41 a.m. R7 stated she felt weaker especially in her hands and legs, noting staff used to walk with her, but didn't do that anymore and now used the sit to stand lift to transfer her. R7 stated she was seeing a neurologist for her weakness and foot drop. During interview on 1/9/18, at 3:02 p.m. physical therapist (PT)-A stated she had seen R7 in October due to new onset right foot drop. PT-A stated R7 had had a very significant functional decline very quickly while in therapy, and she had discharged her from therapy thinking there was something more serious going on and referred R7 to a neurologist. PT-A stated, when R7 was discharged from therapy, she was no longer able to walk, and staff used the sit to stand lift for safety. PT-A reported she had discharged R7 with home ROM exercises that R7 could do herself and with a restorative bike program. PT-A further reported recommended restorative programs were given to the nurse case manager (registered	2 895		

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2 895	Continued From page 19	2 895		

nurse (RN)-A) who put them in the electronic chart. PT-A observed R7 in her room, stating she would've expected a decline in mobility, considering R7 had a rapid decline while in therapy. PT-A stated, if R7's transfer ability changed to needing the full body lift, then she would have declined. PT-A reported she had trained in several nursing aides on the restorative bikes, further reporting R7 needed a restorative aide with her while on the Scifit bike. PT-A was not sure if the restorative aides were completing the programs.

During interview on 1/10/18, at 9:30 a.m. nursing assistant (NA)-G was unaware of R7's restorative program, stating she was on a walking program at one time, but doesn't walk anymore.

During interview on 1/11/18, at 8:21 a.m. registered nurse (RN)-A reviewed R7's medical record and acknowledged she did not have a restorative nursing program listed.

R1's quarterly MDS, dated 9/29/17, identified a severe cognitive impairment with a diagnosis of Alzheimer's dementia. The MDS also identified R1 required extensive assistance to total dependence of two staff with mobility, but did not identify any upper or lower body ROM limitations.

R1's most recent Occupational Therapy Discharge Summary, dated 8/11/17, indicated R1 had been assessed for a left hand splint due to left hand tightness. The goal of therapy at the time was, "Patient will have increased tolerance of left resting hand splint to 8 hours during day or overnight in order to prevent contractures." The therapy discharge indicated R1 had behaviors of biting and hitting; however, the discharge plan/instructions included, "Discharged to to

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2 895	Continued From page 20 nursing splinting program at SNF [skilled nursing facility] where pt [patient] will reside long term...ROM [range of motion] program in place with added focus on hand ROM." Functional Maintenance Restorative Programs were reviewed for R1, and identified the following: -On 1/25/17, a new restorative program was recommended. The overall goal was to, "Prevent joint contractures and support midline posture in wheelchair." R1 program included daily passive ROM to both arms and both legs. -On 8/4/17, a change to the restorative program was recommended. The overall goal was to, "decrease risk of contractures." R1's program was changed to include wearing the left hand splint at night. R1's current care plan, last revised 1/2/18, identified an ADL deficit requiring staff assistance and identified the need for, "restorative intervention to support midline posture in wheelchair," however; the nursing rehab addressed interventions with pocketing food. The care plan did not address R1 impaired mobility, risk for contractures, or ROM program. R1's medical record lacked evidence a ROM program was being offered, implemented, and evaluated. During observation on 1/10/18, at 9:09 nursing assistant (NA)-F and NA-G brought R1 back to her room and transferred her from her Broda chair (type of wheelchair) into bed. No behaviors were observed during transfer. R1's hands were observed to be clenched in fists. No ROM was provided by NA-F or NA-G. When interviewed directly after observation, NA-F stated she was unaware of a restorative program for R1 stating,	2 895		

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2 895	Continued From page 21 "Not since I've been here," and NA-G stated R1 was currently on a ROM program; however, only the restorative aides completed ROM. During interview on 1/10/18, at 11:38 occupational therapist (OT)-A stated she had seen R1 in August for a decline in ROM in R1 left hand. OT-A stated she had discharged R1 to a ROM program for contractures prevention. OT-A stated the restorative recommendations were written up and given to the director of nursing (DON), stating therapy also kept a copy in their restorative binder. OT-A looked in the restorative binder for R1's ROM program, couldn't find one for August stating the binder, "Isn't all comprehensive." OT-A looked at R1's ROM program from January and stating it would still be current. OT-A observed R1's hands, which were in fists, while R1 was lying in bed. OT-A was able to open R1's hands, stating there was no decline in ROM. OT-A reported NA-I was a trained restorative aide, who consistently completed ROM programs; however, OT-A further reported she had not seen NA-I, "For a while." During interview on 1/11/18, at 8:21 a.m. registered nurse (RN)-A reviewed R1's medical record and acknowledged she did not have a restorative ROM program listed. During interview on 1/19/18, at 2:42 p.m. the interim director of nursing (IDON), when asked for documentation on restorative nursing programs, stated," You won't find any." The IDON further stated restorative programs were in their plan to implement, but they currently did not have any formal restorative programs in place. The IDON reported a while ago the restorative aides had been pulled out of their restorative roles due to staffing issues. The IDON further reported the	2 895		

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2 895	Continued From page 22 facility was in the process of training nursing assistants to complete the restorative programs. During interview on 1/10/18, at 8:14 a.m. licensed practical nurse (LPN)-A stated therapy had a binder with residents' restorative programs and the facility had two restorative aides, NA-I and NA-H. LPN-A stated usually one of them was working; however, that was NA-H's day off and NA-I was on vacation. When asked who completed restorative programs when NA-I and NA-H were gone, LPN-A reported they were the only two who had been trained on the restorative equipment. During interview on 1/10/18, at 9:30 a.m. NA-G stated there were two restorative aides, NA-I and NA-H. NA-G stated they were the only two who went through the restorative training. NA-G stated the restorative aides also helped out on the floor and would get pulled to work on the floor. NA-G stated they weren't pulled everyday, just depended on how busy they were. NA-G stated NA-I was on vacation. When asked who completed restorative programs when NA-I and NA-H were gone or pulled to the floor, NA-G re-iterated that they were the only ones trained to do the restorative programs. Neither NA-H and NA-I were available during the survey for comment. The facility's staffing schedule, reviewed for the week of 1/7/18 to 1/13/18, identified neither NA-I or NA-H worked on 1/7/18, 1/10/18, and 1/11/18. During interview on 1/11/18, at 8:21 a.m. RN-A, who had been at the facility since August, stated the facility had no formal restorative programs which included documenting on the program, the	2 895		

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2 895	Continued From page 23	2 895		

minutes or reps performed, and did not have formal programs in which resident's progress was evaluated. RN-A stated NA-I and NA-H were the only two aides trained to use the restorative equipment, while the rest of the staff, "We do some of the walking, but not the machines." RN-A stated, when therapy wrote restorative recommendations, some of the recommendations ended up on her desk and some on the DON's desk to put into the electronic medical record. RN-A went on to state there had been four DON's in the time she had been there, so was not sure if all recommendations were entered. RN-A reported the restorative aides were still being pulled to the floor, but it was getting better with them being pulled one to two days less. RN-A reported the facility was working on the process for completing and evaluating the restorative programs, further reporting ideally they would like all staff doing the programs. RN-A acknowledged, on specific days, yes restorative programs weren't getting done.

A facility policy entitled Restorative Nursing Care, dated 6/12, directed, "Each resident will receive restorative nursing care to the extent possible, based on individual strengths, needs and problems as defined in nursing assessments. The restorative care will be outlined in the residents nursing care plan." The policy further directed the goal of restorative nursing would be to maintain independence and prevent decline.

SUGGESTED METHOD OF CORRECTION:
The Director of Nursing (DON) or designee could ensure residents with restorative needs are identified and provided with a program to prevent further limitation and/or maintain the resident's abilities. The DON or designee could give

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2 895	Continued From page 24 education and perform audits to ensure compliance with restorative programs. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 895		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide consistent assessment and monitoring of a pressure ulcer for 1 of 2 residents (R28) reviewed for pressure ulcers. Findings include: R28's 12/19/17 admission minimum data set (MDS) indicated R28 required extensive	2 900	Corrected	2/9/18

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2 900	Continued From page 25 assistance of 2 staff for bed mobility. R28 did not have a pressure ulcer, but was at risk for pressure ulcer development. A Brief Interview for Mental Status indicated a score of 6, severe cognitive impairment. R28's Care Plan for pressure ulcers, initiated 12/12/17, indicated interventions of a pressure relieving device in the chair and pressure reducing mattress. The care plan directed staff to turn and reposition the resident every 2 hours. A 12/20/17 Wound RN Assessment identified R28 developed a stage 2 (partial-thickness skin loss with exposed dermis) pressure ulcer to the coccyx. Physician notified of pressure ulcer and care plan updated. The assessment lacked documentation of measurements and pressure ulcer characteristics On 12/20/17 the residents care plan updated to "actual stage 2 pressure ulcer." An intervention of medication and treatments as ordered was added to the care plan. R28's physician orders revealed a 12/21/17 order for Arginaid (nutritional supplement to promote healing) two times daily. A wound treatment dressing order, dated 12/23/17, directed to apply a Mepilex border dressing one time every 3 days. A 12/23/17 Wound Data Collection form indicated the coccyx Mepilex dressing was intact. Drainage present. Area surrounding dressing pink. The form indicated "Measurements-Required at least once every 7 days" however, the section for measurements and wound characteristics was blank. R28's medical record lacked a comprehensive	2 900		

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2 900	Continued From page 26 assessment of the pressure ulcers measurements and characteristics of the pressure ulcer, until 12/26/17, 6 days after development. A 12/26/17 Wound Data Collection form identified a coccyx stage "2-3" pressure ulcer. Length 3 cm (centimeters). Width 1 cm. Open area measurements above with a pink red circular area around o/a (open area) witch measures 4 x 5 cm has a sm (small) white area of skin to rt (right) side of open area. 90% epithelialized (superficial tissue, new pink or shiny). 1/1/17, 1/3/17, and 1/4/17 Wound Data Collection forms revealed measurements of the pressure ulcer were unchanged. The record lacked a comprehensive assessment of the wound bed until 1/5/17, 10 days after the 12/26/17 assessment. A 1/5/17, Wound Data Collection form identified the pressure ulcers length of 2.5 cm, 0.5 cm smaller than previous. The width remained unchanged at 1 cm. Wound bed characteristics changed to 90% slough (tissue yellow/white in appearance and adheres to the ulcer bed in strings or thick clumps) and 10% epithelialized tissue. Although slough was present, the pressure ulcer continued to be staged at a 2. A review of R28's January 2018 electronic treatment record (ETAR) indicated the physicians order to change the Mepilex border dressing every 3 days. Documentation on the ETAR identified a Mepilex dressing change on 1/4/17. The ETAR and medical record lacked any further dressing changes until 1/10/17, 6 days later. During observations on 1/10/17, at 8:43 a.m.,	2 900		

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2 900	Continued From page 27 registered nurse (RN)-A and RN-B entered R28's room to re-assess the pressure ulcer. R28's pressure ulcer lacked a dressing. RN-A stated the dressing "must have peeled off." No dressing was viewable in the bed. The pressure ulcer measurements remained unchanged from 1/5/17 at 2.5 cm x 0.5 cm. RN-B stated the pressure ulcer "looks very similar to last week" 90% slough with red granulation around the edges. RN-B cleansed the pressure ulcer with a wound cleaner and RN-A placed a Mepilex dressing over the pressure ulcer as ordered. Nursing assistant (NA)-J entered the room to assist getting R28 up for the day. During an interview on 1/10/17, at 1:29 p.m., NA-J stated she did not find a wound dressing in R28's bed. During an interview on 1/11/17, at 9:04 a.m. RN-A stated the previous director of nursing was supposed to be completing weekly wound rounds. It was recently discovered this was not being done. RN-A stated last Thursday, a weekly wound round schedule was initiated. RN-A stated pressure ulcer assessments were not being completed as they "should have" for R28. RN-A stated a clinical wound specialist (CWS)-G does come to the facility to advise on pressure ulcers. RN-A stated she sent an email to CWS-G on 1/3/17 for advise on treatment. During a phone interview on 1/10/18, at 11:08 a.m., CWS-G stated she was coming to the facility today or tomorrow to assess R28's pressure ulcer. When informed the wound bed was 90% slough and 10% epithelial tissue, CWS-G stated it sounds like the pressure ulcer would be a stage 3 (Full-thickness skin loss). CWS-S stated the pressure ulcer was relatively	2 900		

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2 900	Continued From page 28 new and likes to stay with the initial treatment of Mepilex for a least 2 weeks, to give it a chance to respond to treatment. With the recent development of slough, will now need to evaluate for treatment changes for debridement; however, would not have made any changes in the treatment prior to her evaluation today or tomorrow. During an interview on 1/11/17, at 12:34 p.m. when asked about the process for assessing and monitoring pressure ulcers the interim director of nurses (IDON) stated "I don't think there was one." Staff are to comprehensively assess pressure ulcers at a minimum of weekly. The staff were not doing weekly wound round assessments until last week. We do have a wound nurse who will be coming out do some teaching. The IDON stated the staging and assessments of R28's pressure ulcer were inconsistent. The facility's Pressure Ulcer Practice Guidelines policy, dated 9/16 indicated. "It is recommended that the Wound Data Collection UDA reflects the nurse's observation and management of wounds from a shift-to shift perspective and with each dressing change. At a minimum, weekly documentation is recommended to provide a review of the pressure ulcer/wound. Once a resident experiences a pressure ulcer, an assessment should take place immediately.	2 900		

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2 900	Continued From page 29 SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee, could conduct random audits of the delivery of care; to ensure appropriate care and services are implemented; to reduce the risk for pressure ulcer development. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to follow the recommendations for hand hygiene and glove use for 1 of 2 residents (R17) observed for personal cares and failed to establish a process for antibiotic review in order to determine appropriate indications, dosage, duration, and trends of antibiotic use and resistance. This had the potential to affect all 36 residents who resided in the facility. Findings include:	21375	Corrected	2/9/18

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Hand Hygiene
R17's quarterly Minimum Data Set (MDS), dated 11/17/17, indicated R17 was cognitively intact, required staff assistance for all ADLs (activities of daily living), and was always incontinent of bowel.

R17's current physician orders, printed 1/11/18, contained the following: Nystatin Cream 100000 unit/GM (units per gram) apply to groin and buttocks two times daily for redness.

During observation on 1/10/18, at 8:32 a.m. nurses assistant (NA)-A entered R17's room, used hand sanitizer, and donned clean gloves. NA-A went into the bath room, turned on water, grabbed several washcloths, and wet them at the sink. NA-A walked to R17's bedside table, opened door, and picked up a plastic bag, a package of disposable wipes, and a clean brief. NA-A placed the wet washcloths, plastic bag, and wipes on side of R17's bed. NA-A explained to R17 that he was pulling the covers back. R17 nodded yes. NA-A opened R17's brief and asked R17 to turn over onto his right side. As NA-A pulled open the brief, a large formed BM (bowel movement) was observed between R17 buttocks, in the gluteal fold. NA-A picked up the package of wipes, pulling some out, and wiped BM from R17 gluteal fold using his right gloved hand. NA-A placed soiled wipes into the garbage can at side of bed. NA-A using the soiled gloved right hand to pull out several more wipes, and again wiped BM off R17 gluteal fold. NA-A used the gloved right hand to discard soiled wipes in the garbage can. NA-A pulled the soiled brief out from under R17, rolling it into a ball, and discarded it in the trash can. NA-A then used his soiled gloved right hand to pick up a wet washcloth and washed off R17's buttocks. NA-A placed the soiled washcloth in

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plastic bag. NA-A then opened the bedside drawer, picked up container of cream, and applied the cream to R17's coccyx using his soiled gloved right hand. NA-A, using the soiled gloved hand, placed a clean brief under R17 bottom, picked up a clean wet wash cloth, and washed off R17's groin. NA-A continued to use soiled gloved right hand to apply cream to R17's groin. NA-A used the soiled gloved right hand to open the bedside drawer, picked up a bottle of body lotion, and applied lotion to R17's back and legs.

NA-A then went into bathroom and removed soiled gloves; however, NA-A did not wash his hands. NA-A donned clean gloves, picked out shirt and pants from R17's closet, and assisted R17 to put on pants and shoes. NA-A used his gloved hands to assist R17 to a sitting position on the bed. NA-A then assisted R17 to put shirt on, put a transfer belt around R17 waist, and assisted R17 to stand up. While standing up, NA-A pulled up R17 pants. NA-A picked up the soiled laundry bag, tied it, and put it on the floor by garbage can. NA-A then doffed the gloves and placed them in the garbage can. NA-A again did not wash his hands. NA-A made R17's bed using both hands, then picked up garbage bag and soiled linen bag. NA-A carried the soiled linen and trash bags down the hallway to the soiled linen room. NA-A reached into his pocket and used hand sanitizer as he walked out of the soiled linen room.

During interview on 1/10/18, at 9:05 a.m. NA-A stated, "Yeah, I messed up." NA-A stated he didn't change gloves until after the cream and lotion were applied.. NA-A stated he forgot to change gloves and wash his hands after cleaning up R17's BM. NA-A further stated, "Sadly, that's my usual routine."

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21375	Continued From page 32 During interview on 1/10/17 at 9:30 a.m. interim director of nursing (IDON) stated the expectation was for staff to follow the hand hygiene procedures, meaning changing gloves and washing hands as often as necessary. During interview on 1/11/18, at 4:28 p.m. registered nurse (RN)-B, who was in charge of infection control, stated he was new to the role and was in the process of forming hand hygiene education for staff regarding "foaming in and out," with the hand sanitizer and when they need to change gloves. RN-B stated he hoped to present the information at the next nurses meeting. RN-B further stated he planned on doing audits to make hand hygiene is being done. Hand hygiene policy was requested but not received. Antibiotic Stewardship During review of the facility's infection control program on 1/10/18, at 1:15 p.m. with the registered nurse (RN)-B, the facility lacked documentation that an antibiotic stewardship program was identified. The infection control program lacked protocols for prescribing antibiotics, criteria before antibiotic use and periodic review of antibiotic use by physicians. The program also lacked protocols for review of signs and symptoms, labs, determination of appropriate antibiotic use and reporting of any patterns identified. Monthly Infection Control Report and corresponding Monthly Report of Resident Infections, reviewed from 4/17 to 12/17, indicated the following: -April: one urinary tract infection (UTI) was	21375		

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identified and treated with antibiotic. No culture was taken prior to initiating antibiotic and no symptoms were listed.
-May: five UTI's were identified. All were cultured and treated with antibiotics, with two residents growing the same organism and two residents had antibiotic changes during the course of treatment.
-July: five UTI's were identified. All were cultured and treated with antibiotics; however, two culture results were not listed. There was no indication the antibiotics had been reviewed.
-August: three UTI's were identified. All were cultured and treated with antibiotics; however, one culture result was not listed and two had no symptoms listed. There was no indication the antibiotics had been reviewed.
-September: one UTI was identified and treated with antibiotic. There was no indication the antibiotic had been reviewed.
-October: three UTI's were identified. All were treated with antibiotics. One was admitted to the hospital and one was sent to the emergency room; there was no indication cultures were obtained. The third UTI was cultured and treated with antibiotics; however, no symptoms were listed. There was no indication the antibiotics had been reviewed.
-November: one UTI was identified, cultured, and treated with antibiotics. No symptoms were listed and there was no indication the antibiotic had been reviewed.
-December: two UTI's were identified. Both were treated with antibiotics; however, only one had a culture. Neither UTI listed symptoms and there was no indication the antibiotics had been reviewed.

During interview on 1/11/18, at 4:28 p.m. RN-B and the interim director of nursing (IDON)

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21375	Continued From page 34 acknowledged they were aware of the concern with antibiotic stewardship. RN-B stated he was new to the infection control role and was in the process of learning the requirements for the antibiotic stewardship program. RN-B further stated the facility's medical director was coming to the facility the next week to discuss antibiotic stewardship, and so he could bring the program back to fellow physicians and providers. RN-B reported they were in the process of educating staff and providers to obtain and wait for a culture result prior to initiating antibiotics for UTI's, and to document a reason if antibiotics were initiated prior. A facility policy entitled Antibiotic Stewardship, revised 10/17, directed the purpose of an Antibiotic Stewardship Plan was to, "Optimize the treatment of infections while reducing the adverse events associated with antibiotic use." The policy instructed each center would have a plan by November 2017. Suggested Method of Correction: The director of nursing (DON) or designee could review and re-inforce policy and procedures regarding hand hygiene and glove use. The DON or designee could audit for compliance with cares. The DON or designee could develop a system for reviewing antibiotics to ensure appropriate cultures are performed prior to intiation. Time Period for Correction: Twenty one (21) days.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be	21530		2/9/18

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reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change.

B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician.

C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee.

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21530	Continued From page 36 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consulting pharmacist identified and reported medication irregularities related to the lack of resident specific target behaviors for anti-psychotic and anti-anxiety medications for 2 of 5 residents (R22, R1) and side effect monitoring for psychotropic medications to the attending physician and the director of nursing for 5 of 5 residents (R22, R23, R1, R5 R13) reviewed for unnecessary medications. Findings include: R22's admission Minimum Data Set (MDS), dated 10/18/17, identified a moderate cognitive impairment and had been admitted to the facility due to a hip fracture. The MDS further identified R22 received anti-anxiety and anti-depressant medications. R22's admission Care Area Assessment(CAA), dated 10/18/17, indicated she used a daily anti-depressant and as needed anti-anxiety medications which would be reviewed during rounds. R22's current physician orders, dated 1/11/18, identified the following medications: -Xanax (anti-anxiety) 0.25 mg (milligram) three times a day for anxiety disorder -Wellbutrin SR (anti-depressant) 150 mg every morning and at bedtime for anxiety disorder -Remeron (anti-depressant) 7.5 mg daily for depression R22's current care plan, last revised 1/3/18, identified she received anti-anxiety medication related to anxiety and anti-depressant medication related to depression, noting a goal for R22 to be	21530	Corrected	

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free of adverse effects. The care plan indicated interventions were, "Monitor [R22] condition based on clinical practice guidelines or clinical standards of practice," and, "Consult with pharmacy, health care provider, etc. to consider dosage reduction with clinically appropriate."

R22's Monthly Pharmacy Reviews, reviewed from 10/17 to 12/17, identified the following:
-on 10/16/17 denoted R22 was a, "New resident." No other entry was made indicating no irregularity.
-on 11/28/17 and 12/22/17 entries were blank, indicating no irregularities.

R22's medical record lacked target behaviors for anxiety and side effect monitoring.

During interview on 1/11/18, at 9:19 a.m. registered nurse (RN)-A stated the facility was working on implementing target behaviors and side effect monitoring. RN-A reviewed R22's medical record and acknowledged it lacked target behaviors and side effect monitoring.

R1's quarterly MDS, dated 9/29/17, identified a severe cognitive impairment and had active diagnoses of Alzheimers dementia, aphasia, depression, and psychotic disorder. The MDS further identified R1 received antipsychotic and antidepressant medications.

R1's current physician orders, printed 1/11/18, contained the following:
-Zoloft dated 10/18/17, 75 mg, for depression
-Zyprexa dated 8/9/17, 2.5 mg for dementia with behavioral disturbance

R1's current care plan, last revised 1/2/18, identified R1 was on an anti-depressant with a

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goal to be free side effects, free of discomfort or adverse side effects from antipsychotic medication use. Non pharmacological interventions included redirect, offer a drink or snack, approach in a positive smiling manner, offer her personal items, (bunny, baby or dog).

R1's Monthly Pharmacy Reviews, from 12/16 to 12/22/17, contained the following:
-On 9/27/17, was started on low dose Zyprexa a few months back.

R23's annual MDS, dated 9/6/17, identified she received anti-depressant medications. R23's annual CAA, dated 9/6/17, identified she received anti-depressant medication for a history of depression and the medications were reviewed on rounds. The CAA indicated R23 had minimal depression, identifying she felt tired and had little energy for one day.

R23's current physician orders, dated 1/11/18, identified the following medications:
-duloxetine HCL (anti-depressant) 60 mg daily for depression and anxiety
-Trazadone (anti-depressant) 100 mg daily for sleep

R23's current care plan, last revised 1/2/18, identified she received anti-depressant medication related to depression, noting a goal for R23 to be free of adverse effects. The care plan indicated interventions were, "Monitor [R23] condition based on clinical practice guidelines or clinical standards of practice," and, "Consult with pharmacy, health care provider, etc. to consider dosage reduction with clinically appropriate."

R23's Consulting Pharmacist Reviews, reviewed from 2/17 to 12/17, identified on 2/20/17, the

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pharmacist requested to taper R23's fluoxetine medication. There was no indication the consulting pharmacist had identified the lack of side effect monitoring.

R23's medical record lacked side effect monitoring for the anti-depressant medications.

During interview on 1/10/18, at 1:53 p.m. trained medication aide (TMA)-A stated R1 was on antipsychotic medication, and she would look for the, "Black box warning, that means the big things to look for Zyprexa, mortality rate." TMA-A also stated they tried non pharmacological interventions like one on one, if grabbing, biting, or combative to give her a stuffed animal, which helped to soothe her, and if she continued, encouraged staff to take a step back and re-approach and maintain calm environment.

During interview on 1/11/18, at 8:44 a.m. RN-A stated she didn't see any target behaviors documented in R1's medical record.

R1's medical record lacked documentation of target behavior and side effect monitoring.

During telephone interview on 1/12/18, at 1:37 p.m. the consulting pharmacist (CP) stated she focused on a different topic each month for the medication reviews, but looked at anti-psychotics and anti-depressants more frequently, at least every six months. When asked about target behaviors, CP stated, "Ya know they say behaviors, like in the notes will say resident is withdrawn and not coming out to dining room etc," however; CP stated the behaviors were not targeted toward the medications the resident was taking. CP reported in some of her facilities, she had targeted behaviors, but not at this facility. CP

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21530	Continued From page 40 stated she hadn't had any concerns with the behaviors or medications. When asked about side effect monitoring, CP reported she used to see psychotropic consents, which would list the side effects the facility monitored for like sleepiness or lack of appetite, but further reported she hadn't seen them in about two years. CP admitted it had slipped her mind to look for them, and she would write herself a note to look the next time she was at the facility. R5's admission MDS, dated 2/17/17, identified R5 as severely cognitively impaired. R5's admission CAA, dated 2/18/17, indicated the use of Sertraline (anti-depressant). R5's quarterly MDS, dated 11/15/17, identified verbal behavioral symptoms towards others. The MDS further indicated R5 received antipsychotic and antidepressant medication. Physician orders identified the following: 1/18/17- Cymbalta (anti-depressant) 60 milligrams (mg) daily for depressive episodes. 9/30/17-Seroquel (anti-psychotic) 100 mg daily for major depressive disorder. 1/8/18-Additional anti-depressant Sertraline (anti-depressant) 50 mg daily for depression. R5's care plan, last reviewed 5/18/17 identified R5 received antipsychotic medication related to depressive disorder. "Black Box Warning." Monitor for behavioral symptoms that present a danger to the resident and others. Updated 1/2/18 resident on antidepressant medication related to depression. "Monitor (R5's) condition based on clinical practice guidelines or clinical standards of practice related to use of antidepressants. Consult with pharmacy, health care provider to consider dose reduction when	21530		

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21530	Continued From page 41 clinically appropriate. R5's point of care history documentation identifies staff monitor and document every shift for the following target behaviors. Trouble falling or staying asleep, feeling bed about self, moving or speaking slowly, fidgeting, states life is not worth living, attempts to harm self, being short tempered. R5's medical record lacked side effect monitoring of the psychotropic medication R5's Monthly pharmacy reviews between 2/17 and 12/17 were reviewed. The reviews lacked recommendation for side effect monitoring. R13's annual MDS, dated 2/17/17, identified R13 was severely cognitively impaired. R13's CAA, dated 2/18/17, identified R13 used an antidepressant medication. R13's quarterly MDS, dated 11/15/17, identified R13 receives antipsychotic, antianxiety, and antidepressant medication . Physician orders revealed the following: 8/9/17- Seroquel (antipsychotic medication) by mouth one time daily for dementia with behaviors. 11/27/17-Zoloft 75 mg one time daily for depression 12/5/17-Ativan 0.5 mg one time daily for anxiety disorder. R13's care plan included the following: 1/2/18 -on antipsychotic medication. Monitor condition based on clinical standards of practice. Attempt non-pharmacological intervention redirections, offering snacks, blue comfort	21530		

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blanket.
1/2/18- on antidepressant. Monitor condition based on clinical standards of practice. Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate.
1/3/18-antianxiety medication. monitor condition based on clinical standards of practice. interventions for mood also included to keep resident separated from (R18) when agitated. When calling/yelling out, attempt non-pharmacological interventions of offering personal items and assist to bathroom. Offer the TV.

R13's point of care history documentation identified staff monitor and document every shift for the target behavior of calling out. R13's record lacked side effect monitoring for psychotropic medication.

R13's Monthly pharmacy reviews between 1/17 and 12/17 were reviewed. The reviews lacked recommendation for side effect monitoring.

During an interview on 1/11/18, at 11:35 a.m., registered nurse (RN)-A stated "we don't have any official documentation on that" when asked about side effect monitoring for R5 and R13.

A policy on psychotropic medication monitoring was requested but was not received.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the consultant pharmacist identifies drug irregularities including target

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	00063	A. BUILDING: _____ B. WING _____	C 01/11/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - REDWOOD FAL	200 SOUTH DEKALB STREET REDWOOD FALLS, MN 56283

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21530	Continued From page 43 behaviors for anti-psyschotic/anti-anxiety medications and appropriate side effect monitoring of psychotropic medications. 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.	21530		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced	21540		2/9/18

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21540	Continued From page 44 by: Based on observation, interview, and document review, the facility failed to monitor bruising and notify the coumadin clinic of possible side effect of anticoagulant therapy for 1 of 2 residents (R19) reviewed for unnecessary medications. Findings include: R19's Diagnosis Report, printed 1/11/18, identified a primary admitting diagnosis of Unspecified sequelae of unspecified cerebrovascular disease, R19's quarterly Minimum Data Set (MDS), dated 11/20/17, identified no cognitive impairment. The MDS further identified R19 had an active diagnosis of hypertension, hemiparesis, seizure disorder or epilepsy. R19's current physician orders, printed 1/11/18, contained the following: -Recheck INR 1/16/2018, dated 1/9/18. -Coumadin tablet 2.5 mg (milligrams) every Monday, dated 12/4/17, for cerebrovascular disease, -Coumadin 2 mg every Sunday, Tuesday, Wednesday, Thursday, Friday and Saturday, dated 12/5/17, for cerebrovascular disease. -Aspirin 81 mg one tablet daily, dated 3/9/15, related to cerebrovascular disease. R19's Monthly Pharmacy Reviews, reviewed from 11/14 through 12/17, contained a note on 6/23/14 INR 2.4, a note on 5/22/15 INR 2.2, and a note on 9/22/17 on coumadin. R19's current care plan, revised 12/28/17, identified anticoagulant therapy related to heart disease and directed staff to, "Report	21540	Corrected	

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21540	Continued From page 45 observations of blood tinged or frank blood in urine, black tarry stools, darker bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, SOB,[shortness of breath] loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs." R19's Skin Observations, reviewed from 12/17 to 1/19, identified the following: -On 12/11/17, no bruising observed, a skin tear was noted on R19's left hand. -On 1/1/18, no bruising observed and no skin conditions observed. -On 1/9/18, at 9:51 a.m. a right elbow-bruise measured 4 cm (centimeters) around was observed and was related to bumping stuff in his room. The back of right hand bruising in different stages of healing. R19 reported the bruising was related to the medicine. The back left hand bruising in different stages of healing. Treatment included wearing geri sleeves on both forearms. During observation on 1/8/18, at 3:45 p.m. large bruising was noted above the elbow and on the back of both upper arms. The bruising was approximately 3-4 inches in diameter, in various shades of dark purple in color. R19 had sleeve protectors on both forearms covering to the elbow bend, but did not cover the upper arms where the bruised areas were located. During interview on 1/10/18, at 8:08 a.m. R19 stated he got bruises on his arms from the coumadin, stating any little bump caused a bruise. He further stated the nurses told him about side effects and what to watch for; he let them know if there was bruising. R19 stated he wore sleeve protectors and tried to be careful.	21540		

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21540	Continued From page 46 R19 stated, "Yeah, these bruise are from bumping my dresser." R19 thought the nurse looked at them. A facility progress note, dated 1/9/18, at 12:18 p.m. indicated communication to physican, "resident had INR 1.9, no Coumadin changes at this time will recheck INR 1/16/18." Although R19 was identified on 1/9/18 as having bruising on arms and elbow there is is no indication the physican was notified of the bruising. During interview on 1/10/18, at 8:28 a.m. trained medication aide (TMA)-A stated R19 was on Coumadin, and they checked for any bruising or scabs. TMA-A reported, on the medication administration record (MAR), there was a list of side effects to look for. TMA-A further reported if R19 reported or noticed any bruising, she would go to the charge nurse, and would document it in the progress notes. TMA-A stated she wasn't aware of any bruising for R19. TMA-A further stated R19 had a bath on Monday and the nurse would have checked for any bruising then. During an interview on 1/10/18, at 11:37 a.m. licensed practical nurse (LPN)-C stated she would expect the nursing assistants to report any open areas, any bleeding, or any major bruising. LPN-C stated she would get it reported to the doctor. LPN-C stated would also document the bruising. LPN-C further stated R19 wears the sleeves, to protect his arms. During interview on 1/11/18, at 9:18 a.m. registered nurse (RN)-A stated the expectation was a weekly skin assessment for anticoagulant side effect monitoring. Nursing would address	21540		

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21540	Continued From page 47 any bruising or any skin tears documented on the skin observation sheet. Serious bruising would be reported to the physican. RN-A observed R19's medical record, acknowledging his weekly skin assessments lacked documentation and monitoring of the bruising. A facility policy entitled Pro Time: Measuring Anticoagulation Values, dated 9/12, identified the purpose was to increase recognition of potential adverse effects and proper dosing of anticoagulation therapy, to decrease reporting time to the attending physican or health care practitioner. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) and/or designee could review policies and procedures related to monitoring side effects for anticoagulants. The DON or designee could educate staff and develop a system of compliance with anticoagulation therapy side effecting monitoring. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21540		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or	21830		2/9/18

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both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance

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21830	Continued From page 49 directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on observation, interview, and document	21830	Corrected	

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review, the facility failed to identify a resident's preference for frequency of shaving for 1 of 2 residents (R30) reviewed for activities of daily living.

Findings include:

R30's significant change Minimum Data Set (MDS), dated 11/28/17, indicated R30 required physical assist of one staff for personal hygiene, including shaving. R30's Brief Interview for Mental Status (BIMS) indicated a score of 14, indicating he was cognitively intact.

R30's Care Area Assessment, dated 12/12/17, identified R30 required limited assist with ADL's (activities of daily living.) The assessment did not identify R30's shaving frequency preference.

R30's care plan, dated 12/19/17, indicated R30 required staff to comb hair, identifying can wash face, arms and hands after set up. The care plan did not identify R30's preference for frequency of shaving.

During observation on 1/8/18, at 2:50 p.m. R30 was observed to have long gray facial hairs. R30 stated he needed help from staff to shave and used an electric razor. An electric razor was plugged into the wall and laying on top of the dresser in R30's room. R30 stated he liked to be clean shaven. R30 stated the last time he was assisted with shaving was "a couple three days ago".

During observation on 1/9/18, at 11:09 a.m., R30's continued to have gray facial hair. R30 stated staff had never asked him how often he would like to be shaved, that he had not been shaved today and that he would like to be shaved

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21830	Continued From page 51 daily. During observation on 1/9/18, at 2:12 p.m. nursing assistant (NA)-B assisted R30 with a shower. After the shower, NA-B assisted R30 back to his room. NA-B stated, "Let's get you shaved up." NA-B shaved R30, using the electric razor that was located on R30's dresser. During interview on 1/9/18, at 2:49 p.m. NA-B stated R30 receives weekly baths. NA-B stated she had assisted R30 with his bath the previous week as well. When asked about shaving, NA-B believed R30 was only shaved on his bath day. NA-B stated she did not know what R30's preference for frequency of shaving was. NA-B stated she followed the group sheet and the group sheet did not direct to shave R30 daily. NA-B stated if the group sheet did not indicate to shave daily, residents are shaved one time weekly on their shower day. NA-B stated when she assisted R30 with his shower the previous week, he had facial stubble as well. During interview on 1/11/18, at 11:35 p.m. registered nurse (RN)-A stated she believed residents are asked upon admission about their shaving preferences, but couldn't say for sure. RN-A stated staff should be asking resident's, including R30, everyday if they wanted to be shaved. If resident's needed assistance with shaving, shaving needed to be addressed on the care plan. RN-A stated R30's care plan did not address the frequency of shaving. During an interview on 1/11/18, at 12:34 p.m. the interim director of nursing (IDON) stated staff should ask residents about their shaving frequency preference when admitted and at each quarterly care conference. The shaving	21830		

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21830	Continued From page 52 preference needed to be addressed on the care plan. The facility's policy Activities of Daily Living, dated 6/14, directed "Any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming, and personal and oral hygiene." "General Personal, Daily Hygiene/Grooming: care of hair, hands, face, shaving, applying makeup, skin, nails and oral care." SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could educate on policies and procedures regarding resident choices and conduct audits to ensure resident likes, dislikes and routines are followed by staff. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	21830		