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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L4XR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

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 **04/16/2015** (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 **96** (L18)

13.Total Certified Beds **96** (L17)

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

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susanne Reuss, Supervisor 04/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/24/2015 (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
04/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
04/09/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5221

Electronically Delivered: April 24, 2015

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

Dear Ms. Jensen:

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 April 6, 2015 the above facility is certified for:

96 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

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

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

Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: April 24, 2015

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

RE: Project Number S5221026

Dear Ms. Jensen:

On March 9, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 26, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required.

On April 16, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on April 24, 2015 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 26, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 6, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 26, 2015, effective April 6, 2015 and therefore remedies outlined in our letter to you dated March 9, 2015, will not be imposed.

Please note, it is your responsibility to share the information contained in this letter and the results of this visit with the President of your facility's Governing Body. Please contact me if you have any questions about this electronic notice.

Sincerely,

Anne K. Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245221	A. Building B. Wing	4/16/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0327** Reg. # **483.25(i)** LSC	Correction Completed **04/06/2015**
ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **04/06/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **04/06/2015**
ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **04/06/2015**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	04/24/2015	16022	04/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/26/2015	

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245221	A. Building 01 - MAIN BUILDING 01 B. Wing	4/24/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0020	04/06/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	PS/AK	04/24/2015	12424	04/24/2015
CMS RO				

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
2/25/2015	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L4XR

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

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(L1) **245221**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

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(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/26/2015** (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 **96** (L18)

13.Total Certified Beds **96** (L17)

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Sue Miller, HFE NE II 03/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 04/08/2015 (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
04/01/1978
(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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 9, 2015

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

RE: Project Number S5221026

Dear Ms. Jensen:

On February 26, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Email: susanne.reuss@state.mn.us
Telephone: (651) 201-3793
Fax: (651) 201-3790

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 April 7, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are

sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

in your plan of correction.

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 26, 2015 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 26, 2015 (six months after the

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

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division

Email: pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/6/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/19/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

(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 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop an individualized plan of care for 1 of 1 residents (R147) reviewed for dehydration. Findings include: R147 was at risk for dehydration related to chronic diarrhea, medications with anticholinergic properties and abnormal laboratory (lab) values indicative of dehydration. However, the facility lacked monitoring to ensure R147 received the recommended amount of fluids per day to prevent dehydration. R147 was observed to drink 360 cc's [cubic centimeter] of fluids with the evening meal tray on 2/23/15, at 6:00 p.m. During an interview with R147 on 2/25/15, at 2:30 p.m. observation of mouth, lips, tongue and teeth appeared dry. R147 stated, "Yes I need to drink more fluids, I get so dry at night and when I wake in the morning my mouth is bone dry." R147 had a significant change minimum data assessment (MDS) completed 12/2/14, and indicated an alteration in cognition to severely impaired. The care area assessment (CAA) further read, "Resident is able to make some day to day decisions but does present with forgetfulness and confusion at times." The CAA indicated Alzheimer's Disease of other dementia's. According to the nutritional assessment dated	F 279	Plan of Correction General Disclaimer 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 facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F279 483.20 (d), 483.20(k)(1)Develop Comprehensive Care Plans Corrective Action for resident R147 R147 has had a thorough review and re-development of individualized plan of care to address fluid intake and possible risks for dehydration. R147 has been placed on a fluid intake monitoring record. How to identify other residents with the same issue The facility will assess residents to identify others having the potential to be affected upon admission, quarterly, and with change of condition. All residents will	

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F 279	Continued From page 2 12/1/14, the dietitian recommended R147 receive 2100-2500 cc/day (centimeter per) of fluid according to individual body weight. This information was not on the plan of care and there were no quantifying records to support R147 received the recommended cc's of fluid intake per day. Document review for R147's plan of care dated 12/9/14, read, "The resident has bowel incontinence potential R/T [related to] chronic diarrhea E/B [episodes/bouts] occasional to frequent bowel incontinence." The plan of care did not address the stool sample tested for the toxigenic clostridium difficile [bacterium that causes diarrhea] on 4/27/13 which was negative for clostridium difficile to rule out a possible cause for chronic diarrhea. R147 received chemotherapy for malignant neoplasm of the bladder. One of the side effects for the chemotherapy and addressed on the plan of care lists but was not limited to diarrhea, nausea, lips dry and or cracked lips. An intervention read, "Drink plenty of fluids." Medications R147 received, included Prozac for depression, which had a warning for adverse effects which included but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral neuropathy and the side effects included but were not limited to dry mouth, dry throat and nausea. R147 had taken Aricept for cognitive function and the side effects were not limited to but did include nausea, diarrhea and dehydration. R147 had abnormal laboratory values for creatinine (chemical waste molecule that is	F 279	receive a comprehensive care plan to address fluid intake and possible risks for dehydration, as indicated through assessment, upon admission, quarterly, and with change of condition. Residents assessed with increased risk for dehydration will have monitoring of their fluid intake per care plan. Recurrence will be prevented by Following and using facility policy and procedure, systematic changes will be in place to identify residents for fluid intake risks such as potential for dehydration, diuretic use, renal disease, diarrhea, etc. A care plan will be developed for residents found to be at risk and will be monitored for fluid intake per care plan. Re-education will be given to all nursing staff and dietician. Audits will be completed to ensure care plans are developed for residents at risk and fluid intake is monitored as assessed per policy for compliance as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers, and Dietician will audit care plans for residents at risk for dehydration and development of comprehensive care plan completion weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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F 279	Continued From page 3 generated from muscle metabolism) and blood urea nitrogen (indicator of kidney disease and/or dehydration) The abnormal lab values were not addressed on the individual plan of care for R147 which could be an indicator for dehydration. A review of the facility policy dated 11/13, and titled, Intake and Output, indicated a nurse could choose to initiate intake and output on a resident at risk for imbalances such as potential for dehydration, diuretic use, renal disease and diarrhea. When interviewed on 2/25/15, at 2:00 p.m. registered nurse (RN)-C, nursing assistant NA-B and NA-C did not know what the minimum fluid requirements were per day for R147 or the number of cc's they should strive for when encouraging fluids. All three staff verified R147 had bouts of diarrhea.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the plan of care for antiarrhythmic and psychoactive medication adverse side effects were monitored for 1 of 5 (R137) residents in the sample.	F 282	F282 483.20 (k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN Corrective Action for residents R137 Adverse side effect monitoring has been put in place for R137 per the care plan for	4/6/15

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F 282	Continued From page 4 Findings include: On 02/25/15 R137's medical record was reviewed; the care plan dated, 05/09/14 reflected that R137 was on antiarrhythmic therapy and the goal indicated R137 would be free from adverse reactions related to digoxin and Amiodarone use. The care plan interventions directed staff to monitor for adverse reactions of these two medications which included hypothyroidism, dizziness, nausea, and vomiting and the black box warning signs and report to the physician or nurse practitioner. On 02/26/15, at 8:51 a.m., when asked if R137 felt dizzy, R137 stated, "oh, yes, I feel dizzy all of the time and the dizziness increases when I tilt my head to the right side." R137 added the wheelchair she used kept her from falling down due to being dizzy. When asked if she felt nauseated, R137 stated, "I wake up during the night from nausea and they bring me my plastic pan to throw up in." R137 explained that it happened quite often during the night and that she informed her nurse practitioner(R137 identified the nurse practitioner by name.)R137 further stated that she experienced stomach problems and had loose stools at least twice a day; R137 voiced frustrations of not feeling well and stated she had told the nurses who give her medications that she did not feel well. On 02/26/15, at 9:30 a.m. registered nurse (RN)-A stated after reviewing R137's electronic medical record that she was unable to find any other documentation, other than daily monitoring of heart rate and blood pressure, to show whether the nurses documented on potential medication adverse effects. RN-A indicated the nurses were	F 282	antiarrhythmic medication Digoxin. Antiarrhythmic medication Amiodarone was decreased from 200mg to 100mg on 1- 27-15, with a plan to discontinue this medication once the resident adjusted to the decrease. This medication was discontinued on 2-26-15. R137 does not take psychoactive medication. How to identify other residents with the same issue All residents who receive antiarrhythmic and psychoactive medications will have a care plan initiated and side effect monitoring in place upon admission or when beginning these medications. Care plans will be reviewed and updated as needed quarterly and with changes of condition or changes in medication use. Recurrence will be prevented by Re-education will be given to all nurses regarding the side effect monitoring system and following care plans related to antiarrhythmic and psychoactive medications. Audits will be completed to assure monitoring of side effects and care plans in place as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers will audit resident records for side effect monitoring as per the care plan weekly for one month, then monthly for one quarter and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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F 282	Continued From page 5	F 282		

trained to follow the care plan, monitor and document on any medication side effects and inform the physician promptly. After reviewing of in depth electronic progress notes, RN-A provided copy of NP's documentation, dated 1/27/15, in which, licensed practical nurse (LPN)-B reported to NP of R137 complaining of feeling nauseated and vomited in the past week. RN-A provided additional nursing progress notes, dated 10/09/14 through 11/19/14, in which R137 repeatedly complained of feeling nauseated, not feeling well, refusing to eat due to upset stomach, feeling lightheadedness and dizzy. RN-A stated these were the only documentation in R137's record related to potential medication side effects. RN-A further added, the nurses needed to read the Black Box warnings listed on R137's care plan, document and report anything unusual to the physician.

On 02/26/15, at 10:00 a.m. LPN-C indicated R137 was alert and capable of informing the nurses if she was not feeling well; however, R137, " is one of those residents who didn't want to bother anyone with her complaints," LPN-C indicated typically she would ask residents on her unit how they were feeling and documented in the nursing progress notes if there was anything unusual. She stated for R137 prior to administering her medications they obtained blood pressure and heart rate because the physician ordered it and documented in the medication administration record. LPN-C stated they would hold R137's heart medications if the pulse and/or blood pressure were out of range and notify the physician. After reviewing the current plan of care related to antiarrhythmic therapy for R137, LPN-C stated, the dizziness, nausea/vomiting and diarrhea could potentially be

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F 282	Continued From page 6 the adverse reactions of digoxin and amiodarone use and needed monitoring each shift. She added these findings needed to be documented in the nursing progress notes and the physician needed to be notified. LPN-C stated she was not aware R137 had been experiencing any dizziness, nausea or loose stools. The facility policy/procedures, titled,"Administration of Medication," revised 11/14, directed staff to be familiar with action and adverse reactions of medications and to use a Drug Handbook as needed. Another policy/procedures, titled, "Notification of Condition Change And Observation," dated 9/2012, directed staff to notify physician of any change in resident's status.	F 282		
F 327 SS=D	483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor and/or provide recommended fluid intake for 1 of 1 resident(R147) identified as at risk for dehydration. Findings include: R147 was at risk for dehydration related to chronic diarrhea, medications with anticholinergic properties and abnormal laboratory (lab) values	F 327	F327 483.25(j) SUFFICIENT FLUID TO MAINTAIN HYDRATION: Corrective Action for resident R147 R147 has been placed on a fluid intake monitoring record, facility is providing adequate fluids and R147 is taking fluids. R147 has had a thorough review and re-development of individualized plan of care to address fluid intake and possible risks for dehydration and is being monitored for fluid intake. R147□s	4/6/15

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F 327	Continued From page 7 indicative of dehydration. However, the facility lacked monitoring to ensure R147 received the recommended amount of fluids per day to prevent dehydration. During an interview with R147 on 2/25/15, at 2:30 p.m. observation of mouth, lips, tongue and teeth appeared dry. R147 stated, "Yes I need to drink more fluids, I get so dry at night and when I wake in the morning my mouth is bone dry." R147 had a significant change minimum data assessment (MDS) completed 12/2/14, and indicated an alteration in cognition to severely impaired. The care area assessment (CAA) further read, "Resident is able to make some day to day decisions but does present with forgetfulness and confusion at times." The CAA indicated Alzheimer's Disease of other dementia's. R147 did not receive adequate fluid intake monitoring according to the nutritional assessment dated 12/1/14, which recommended R147 receive 2100-2500 cc/day [cubic centimeter per] of fluid according to individual body weight. There was no accurate quantifying data for fluid intake numbers to support R147 received the recommended cc's of fluid intake per day. R147 averaged 5 episodes of diarrhea each month in the months of November and December of 2014 and in January of 2015. The month of February 2015 there were 6 recorded episodes of diarrhea. The medication Imodium was given following the bouts of diarrhea, and the adverse reactions for Imodium were not limited to but did include, dry mouth and nausea.	F 327	physician will review resident□s health status by 3-19-15. How to identify other residents with the same issue The facility will assess residents to identify others having the potential to be affected per policy upon admission, quarterly, and with change of condition. Residents will receive a comprehensive care plan to address fluid intake and possible risks for dehydration, as indicated through assessment, upon admission, quarterly, and with change of condition. Residents assessed with increased risk for dehydration will have monitoring of their fluid intake per care plan. Recurrence will be prevented by Following and using facility policy and procedure, systematic changes will be in place to assess residents for fluid intake risks such as potential for dehydration, diuretic use, renal disease, diarrhea, etc. Residents found to be at risk will be monitored for fluid intake per care plan. Re-education will be given to all nursing staff and dietician. Audits will be completed to ensure care plans are developed for residents at risk; fluid intake is monitored and provided as assessed per policy for compliance as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers, and Dietician will audit residents at risk for dehydration for development of comprehensive care plan, intake monitoring completion and adequate	

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F 327	Continued From page 8 Imodium was given for diarrhea February 4, 9, 11, 16, 17, and 20/2015. The number of fluid intake cc's recorded on the Food and Fluid Intake form all fell below the assessed requirement for R147 of 2100-2500 cc's of fluid per day. Fluid intake cc's for R147 on the days diarrhea was documented were; 2/4/15, 400 cc's, 2/9/15, 1010cc's, 2/11/14, 1260 cc's, 2/16/15, 1070 cc's, 2/17/15, 1320 cc's and 2/20/15, 650 cc's. During an interview on 2/26/15, at 9:45 a.m. RN-B verified she could not prove with quantifying data R147 took in orally 2100-2500 cc's of fluid in a twenty-four hour period but the staff visually could see R147 consumed pop and fluids throughout the day. There was observation of the water pitcher at R147's bedside each day of the survey. R147 received chemotherapy for malignant neoplasm of the bladder. One of the side effects for the chemotherapy, and addressed on the plan of care, listed but was not limited to diarrhea, nausea, lips dry and or cracked lips. An intervention read, "Drink plenty of fluids." On 1/10/15, R147 received an order for Biotene Dry Mouth Gel after the family requested due to complaints of dry mouth. R147 was receiving Artificial Tears Solution 1.4% 2 drops in both eyes at bedtime for dry eyes since 1/10/14. Medications R147 had taken included Prosac for depression which had a warning for adverse effects which include but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral neuropathy and the adverse effects include but are not limited to dry mouth, dry throat and nausea. R147 had taken	F 327	hydration weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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F 327	Continued From page 9	F 327		

Aricept for cognitive function and the adverse effects are not limited to but do include nausea, diarrhea and dehydration.

The blood creatinine blood level (chemical waste molecule that is generated from muscle metabolism) had been above normal since admission at 1.21 mg.dLwith the expected value range of 0.60 to 1.10. The 2/3/15, creatinine continues to rise currently at 1.97 mg/dL.

The blood urea nitrogen (BUN) (indicator of kidney disease and/or dehydration) on 9/12/13, was 25 with a expected value range of 8 to 28 mg/dL. The BUN on 12/5/14, remained within range at 27 mg/dL. The most recent BUN on 2/3/15, exceeded the expected value range at 40 mg/dL.

R147 was seen at the Medical Oncology clinic 0n 2/3/15, by a certified nurse practitioner (CNP-A) who reviewed the labs and wrote on the referral, "Worsening kidney function." Under the Plan #4. "Encourage her to drink more fluids. Her BUN is also elevated suggesting at least partly dehydrated." Furthermore, the CNP addressed an increase in the diarrhea, and complaints of urinary frequency, urgency, and not being able to fully empty her bladder. The returned form titled Clinic Referral dated 2/3/15, signed by CNP-A read, "Hemoglobin 10.7 Kidney function creatinine 1.97-likely dehydrated." Under the order section of the referral was written no new orders, but on page 2, the plan read, "Encourage her to drink more fluids. Her BUN is also elevated suggesting at least partly dehydration."

When interviewed on 2/25/15, at 2:00 p.m. RN-C, nursing assistant NA-B and NA-C did not know

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F 327	Continued From page 10	F 327		

what the minimum fluid requirements were per day for R147 or the number of cc's they should strive for when encouraging fluids. All three staff verified R147 had bouts of diarrhea and had bladder cancer.

When interviewed on 2/26/15, at 9:45 a.m. Registered Nurse (RN-B) produced a form titled, Food and Fluid Intake, and designated on 2/25/15, R147 was added into the computer task section so that the staff would record the number of fluid cc's R147 consumed in a twenty four hour period. The number recorded was 1380 cc's which was 720 cc's less than the minimum recommended fluid intake for R147.

When interviewed about R147's fluid intake on 2/26/15, at 9:45 a.m. RN-B expressed, because the plan of care said to encourage fluids, there did not need to be any further direction for staff. RN-B acknowledged there was not accurate quantifying data for R147's fluid intake per day and stated, "We see her taking fluids all the time." Furthermore, RN-B discredited CNP-A's progress notes and plan by saying the nurse practitioner did not know R147 because this was the first time CNP-A had seen R147 in the clinic.

A review of the facility policy dated 11/13, and titled, Intake and Output, indicated a nurse could choose to initiate intake and output on a resident at risk for imbalances such as potential for dehydration, diuretic use, renal disease and diarrhea.

The policy titled, Hydration of Residents, dated September 2012, addressed maintaining the hydration status by the registered dietitian (RD) who will estimate the individual fluid requirements

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F 327	Continued From page 11 by taking the resident weight in kilograms times 30 millimeters gives the estimated resident requirements. When interviewed on 2/25/15, at 2:00 p.m. the RD verified R147's assessment recommending 2100 to 2500 cc's of fluid per day to maintain hydration was accurate.	F 327		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 329	F329 483.25(l) DRUG REGIMEN	4/6/15

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F 329	Continued From page 12 facility failed to adequately identify and monitor clinical indications for continued use of antiarrhythmic medications and adverse effects for 1 of 5 (R137) residents in the sample. Findings include: R137's physician (MD)'s documentation dated, 4/9/13 indicated R137 had been taking digoxin and amiodarone for atrial fibrillation (to control heart rate); however, the facility lacked indication for continued use and potential adverse effects monitoring of these medications. On 02/26/15, at 8:51 a.m., alert resident, R137 stated, "Oh, yes, I feel dizzy all of the time and the dizziness increases when I tilt my head to the right side." R137 added the wheelchair she used kept her from falling down due to being dizzy. Regarding feeling nauseated, she stated, "I wake up during the night from nausea and they bring me my plastic pan to throw up in." R137 indicated it happened quite often during the night and had informed the NP. R137 further stated she experienced stomach problems and had loose stools at least twice a day; R137 voiced frustrations of not feeling well and stated she had told the nurses who gave her medications that she did not feel well. R137 was admitted to the facility on 4/29/13 the admission history and physical dated, 05/02/13 had diagnoses that included hypothyroidism, congestive heart failure (CHF), diabetes mellitus, chronic kidney disease stage II, aortic valve replacement, hypertension and urinary tract infection (UTI). The plan of care dated 05/9/14, listed the U.S.	F 329	REVIEW IS FREE FROM UNNECESSARY DRUGS: Corrective Action for residents R137 Adverse side effect monitoring has been put in place for R137 per the care plan for antiarrhythmic medication Digoxin. Antiarrhythmic medication Amiodarone was decreased from 200mg to 100mg on 1- 27-15 with a plan to discontinue this medication once the resident adjusted to the decrease. This medication was discontinued on 2-26-15. Administrator and Director of Nursing met with Medical Director (R137□s Physician) on 3-12-15 to discuss F-329. Medical Director will complete a medical review of R137□s Antiarrhythmic medication and other medications for indications of continued use as well as possible adverse effects. How to identify other residents with the same issue All residents who use Antiarrhythmic medications will be reviewed for clinical indications for continued use and possible adverse effects of these medications upon admission, quarterly, and with change of condition. Possible adverse effects will be care planned and monitoring in effect upon admission, quarterly, and with change of condition. Medications will be reviewed quarterly, and with change of condition for reduction. Recurrance will be prevented by Re-education to all nurses will be provided. Auditing will be completed to review records for adequate identification, and monitoring of clinical indications as well as side effects for continued use of	

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F 329	Continued From page 13 Food and Drug Administration (FDA) black box warning for amiodarone use as: "Risk of potentially fatal toxicities including pulmonary toxicity (lung damage) and hepatic injury (liver damage), hypothyroidism (low thyroid levels in the blood), exacerbation of existing arrhythmia and heart failure (worse heart beat problems). Potential adverse effects include arrhythmia formation or exacerbation (heart rate problems), bradycardia (low heart rate), dizziness, dyspnea (difficulty breathing), hypotension (low blood pressure), nausea, visual disturbances, vomiting." The nursing staff failed to follow the care plan and consistently monitor, document and inform the physician on these identified serious and fatal adverse effects. The nursing progress notes dated, 10/9/14 through 11/19/14 revealed, R137 had been nauseated numerous times, refused meals and complained of being unwell. A progress noted dated 11/19/14, revealed R137 had complained: "I'm so hot. I feel like I am going to throw up," and "feeling dizzy, feels sick to her stomach. Nauseated. Had a small emesis of thick yellow mucous mixed with a small amount of blood;" On this date the nurse practitioner (NP) started R137 on omeprazole 20 mg due to gastric reflux and nausea without properly assessing R137 for potential adverse effects of digoxin and amiodarone use. Furthermore, the documentation lacked evidence identifying clinical indications for the continued use of digoxin and amiodarone. Review of NP's documentation dated 11/19/14, indicated R137 complained of nausea and had vomited bile in a plastic bin. The documentation indicated the resident had complained of being	F 329	antiarrhythmic medications as outlined below. Medical Director, Consultant Pharmacist and interdisciplinary team will meet monthly for review and gradual dose reduction. These issues will be monitored in the following manner Director of Nursing, and Nurse Managers will complete audits weekly for one month, then monthly for one quarter and then quarterly for residents who use Antiarrhythmic medications. Audits will be brought to the quality assurance committee for further review and recommendation.	

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F 329	Continued From page 14	F 329		

dizzy during the day, usually when getting up from naps, and stated, "My head was so dizzy last night," The documentation further revealed the resident complained of headache in the temple area. The NP ordered a urinalysis to rule out urinary tract infection and ordered omeprazole 20 mg daily for upset stomach and nausea. The NP documented R137's medications were reviewed and,"can find nothing that really stood out," and it was uncertain what caused nausea, vomiting and dizziness. On 11/19/14 NP ordered digoxin lab level to be checked and on 11/20/14 the results were documented as 1.3, within normal range, in the nursing progress notes.

The quarterly Minimum Data Set (MDS) assessment dated, 1/15/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty.

The current MD's orders dated, 01/25/15 indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily.

The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to causing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced concerns with nausea, vomiting and headaches in the past.

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F 329	Continued From page 15 During a phone interview on 02/25/15, at 9:00 a.m. the consulting pharmacist indicated he had conducted a medication regimen review for R137; but did not have her record in front of him to answer specific questions. The pharmacist indicated he remembered R137 was on amiodarone because she did not tolerate any Beta blocker drugs. The pharmacist added amiodarone and digoxin were not recommended in geriatric population and should be used with caution because of the high risk of fatal adverse effects. The pharmacist stated it was very important for the nursing staff to monitor residents closely that were using these potent drugs and inform the physician of any potential side effects. He stated he reviewed the nursing and physician's documentation during his monthly medication reviews and made necessary recommendations for the physician to follow-up. During a phone interview on 02/25/15, at 3:00 p.m. R13's NP indicated the resident had been admitted to the facility on digoxin and amiodarone. The NP indicated he did not promote amiodarone or digoxin use in geriatric population because it was not recommended for use in elderly population, was very toxic and had a potential for serious side effects. The NP added his focus had been to try to discontinue amiodarone for patients who were admitted on this medication. He said he would discontinue digoxin for R137 and monitor her amiodarone use closely. The NP stated the nursing staff needed to consistently monitor and document any potential side effects of these medications and update him as needed. On 02/26/15, at 9:30 a.m. registered nurse	F 329		

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F 329	Continued From page 16 (RN)-A stated after reviewing R137's electronic medical record that she was unable to find any other documentation, other than daily monitoring of heart rate and blood pressure, to show whether the nurses documented on potential medication adverse effects. RN-A indicated the nurses were trained to follow the care plan, monitor and document on any medication side effects and inform the physician promptly. After reviewing of in depth electronic progress notes, RN-A provided copy of NP's documentation, dated 1/27/15, in which, licensed practical nurse (LPN)-B reported to NP of R137 complaining of feeling nauseated and vomited in the past week. RN-A provided additional nursing progress notes, dated 10/09/14 through 11/19/14, in which R137 repeatedly complained of feeling nauseated, not feeling well, refusing to eat due to upset stomach, feeling lightheadedness and dizzy. RN-A stated these were the only documentation in R137's record related to potential medication side effects. RN-A further added, the nurses needed to read the Black Box warnings listed on R137's care plan, document and report anything unusual to the physician. On 02/26/15, at 10:00 a.m. LPN-C indicated R137 was alert and capable of informing the nurses if she was not feeling well; however, R137, " is one of those residents who didn't want to bother anyone with her complaints," LPN-C indicated typically she would ask residents on her unit how they were feeling and documented in the nursing progress notes if there was anything unusual. She stated for R137 prior to administering her medications they obtained blood pressure and heart rate because the physician ordered it and documented in the medication administration record. LPN-C stated	F 329		

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they would hold R137's heart medications if the pulse and/or blood pressure were out of range and notify the physician. After reviewing the current plan of care related to antiarrhythmic therapy for R137, LPN-C stated, the dizziness, nausea/vomiting and diarrhea could potentially be the adverse reactions of digoxin and amiodarone use and needed monitoring each shift. She added these findings needed to be documented in the nursing progress notes and the physician needed to be notified. LPN-C stated she was not aware R137 had been experiencing any dizziness, nausea or loose stools.

According to the Geriatric Dosage Handbook, 12th edition, dated 2007, amiodarone was, "potentially inappropriate medication for geriatrics," this medication was associated with increased risk with heart rate problems, thyroid problems (high or low levels), liver problems, dizziness, fatigue, headache, nausea, vomiting, anorexia, CHF, abdominal pain and needed extreme caution and close monitoring of patients. In addition, it may increase the digoxin levels and the physicians were advised to decrease digoxin dose by 50% and monitor digoxin blood levels closely. For digoxin use, it indicated to use it with caution in patients with thyroid problems and patients with advanced heart failure. The adverse effects included heart block, headache, weakness, dizziness, nausea, vomiting, diarrhea, abdominal pain, anorexia (lack of appetite), and with amiodarone use it may have additive effects on heart rate; therefore, reducing digoxin dose by 50% was recommended.

The facility policy/procedures, titled,"Administration of Medication," revised 11/14, directed staff to be familiar with action and

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F 329	Continued From page 18 adverse reactions of medications and to use a Drug Handbook as needed. Another policy/procedure, titled, "Notification of Condition Change And Observation," dated 9/2012, directed staff to notify the physician of any change in resident's status.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility's consulting pharmacist failed to identify and/or act upon identified drug irregularities for 2 of 5 residents (R147, R137) in the sample. R147 had a physician order for acetaminophen tablet 325 mg, give 1 tablet by mouth every 4 hours as needed for mild pain. The start date was 9/4/13. There was a second order that read, acetaminophen tablet 325 mg give 2 tablets by mouth every 4 hours as needed for moderate pain with a start date of 9/4/13. There was a third order which read, Norco tablet 5-325 MG (Hydrocodone-acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain with a	F 428	Plan of Correction General Disclaimer 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 facility is not in substantial compliance with Federal requirements of participation,	4/6/15

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F 428	Continued From page 19 start date of 4/1/14. These orders gave R147 the potential to take 7700 grams of acetaminophen in a twenty four hour period. There were no consultant pharmacist's medication review recommendations for the use of acetaminophen. The pharmacist was interviewed on 2/25/15 at 3:15 p.m. and verified the acetaminophen is to have a 3000 gram parameter in a 24 hour period according to the manufacturers recommendations. During an interview with the registered nurse (RN-B) on 2/26/15, at 9:45 a.m. revealed that the nursing staff were educated on 8/15/14, during mandatory training that the acetaminophen was to have parameters not to exceed 3000 grams (g) per day from all sources of medication containing Acetaminophen. R137's physician (MD)'s documentation dated, 4/9/13 indicated R137 had been taking digoxin and amiodarone for atrial fibrillation (to control heart rate); however, the facility lacked indication for continued use and potential adverse effects monitoring of these medications. The consulting pharmacist lacked to communicate irregularities to MD. On 02/26/15, at 8:51 a.m., alert resident, R137 stated, "Oh, yes, I feel dizzy all of the time and the dizziness increases when I tilt my head to the right side." R137 added the wheelchair she used kept her from falling down due to being dizzy. Regarding feeling nauseated, she stated, "I wake up during the night from nausea and they bring me my plastic pan to throw up in." R137	F 428	this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F428 483.60(c) Drug Regimen Review Corrective Action for residents R147 R137 The facility□s Administrator and Director of Nursing met with the Pharmacist on 3-12-15 regarding the drug regimen review, F-428, and the identification of drug irregularities for continued use of medications for R147 and R137. Pharmacist will review R147 and R137 to identify drug irregularities with next Drug Regimen Review scheduled for 3-19-15. Clinical monitoring for the continued use of antiarrhythmic medications and side effects will be ongoing. Administrator and Director of Nursing met with Medical Director (R148 and R137□s Physician) on 3-12-15 to discuss drug regimen review, report irregular, act on F-428. Medical Director will complete a medical review of R147 and R137□s medications and indications for use as well as adverse effects. R147 had received one dose of Tylenol (625mg) in the month of February. Parameters have been put in place so that R147 receives no more than 3000mg per 24 hour period. Side effect monitoring has been put in place for R137 per the care plan for antiarrhythmic medication Digoxin. Antiarrhythmic medication, Amiodarone, was decreased from 200mg to 100mg on 1- 27-15 with a plan to discontinue this medication once the resident adjusted to the decrease. This	

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F 428	Continued From page 20 indicated it happened quite often during the night and had informed the NP. R137 further stated she experienced stomach problems and had loose stools at least twice a day; R137 voiced frustrations of not feeling well and stated she had told the nurses who gave her medications that she did not feel well. R137 was admitted to the facility on 4/29/13 the admission history and physical dated, 05/02/13 had diagnoses that included hypothyroidism, congestive heart failure (CHF), diabetes mellitus, chronic kidney disease stage II, aortic valve replacement, hypertension and urinary tract infection (UTI). The plan of care dated 05/9/14, listed the U.S. Food and Drug Administration (FDA) black box warning for amiodarone use as: "Risk of potentially fatal toxicities including pulmonary toxicity (lung damage) and hepatic injury (liver damage), hypothyroidism (low thyroid levels in the blood), exacerbation of existing arrhythmia and heart failure (worse heart beat problems). Potential adverse effects include arrhythmia formation or exacerbation (heart rate problems), bradycardia (low heart rate), dizziness, dyspnea (difficulty breathing), hypotension (low blood pressure), nausea, visual disturbances, vomiting." The nursing staff failed to follow the care plan and consistently monitor, document and inform the physician on these identified serious and fatal adverse effects. The nursing progress notes dated, 10/9/14 through 11/19/14 revealed, R137 had been nauseated numerous times, refused meals and complained of being unwell. A progress noted dated 11/19/14, revealed R137 had complained:	F 428	medication was discontinued on 2-26-15. How to identify other residents with the same issue Medical records will be reviewed for all residents in the facility taking Acetaminophen. Parameters for Acetaminophen use will be put in place for all residents receiving Acetaminophen. Residents taking antiarrhythmic medications will be monitored for side effects per facility policy. The Pharmacist will review to identify any drug irregularities monthly and report these to the Physician and Director of Nursing. The facility will monitor that these are acted upon through audits. Gradual dose reductions will be completed per policy and per orders for all residents as indicated. Recurrence will be prevented by Re-education to all nurses regarding the above procedure will be provided. Consultant Pharmacist, Medical Director, and interdisciplinary team will meet monthly for gradual dose reduction. Administrator and Director of Nursing met with the Consultant Pharmacist on 3-12-15 to review deficiencies and pharmacist expectations for monthly reviews. Medical Director, Consultant Pharmacist and interdisciplinary team will meet monthly for medication review and gradual dose reduction. Auditing will be completed to review drug regimen reports for pharmacist identification of drug irregularities and that physicians/nurse practitioners have addressed these	

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F 428	Continued From page 21 "I'm so hot. I feel like I am going to throw up," and "feeling dizzy, feels sick to her stomach. Nauseated. Had a small emesis of thick yellow mucous mixed with a small amount of blood;" On this date the nurse practitioner (NP) started R137 on omeprazole 20 mg due to gastric reflux and nausea without properly assessing R137 for potential adverse effects of digoxin and amiodarone use. Furthermore, the documentation lacked evidence identifying clinical indications for the continued use of digoxin and amiodarone. Review of NP's documentation dated 11/19/14, indicated R137 complained of nausea and had vomited bile in a plastic bin. The documentation indicated the resident had complained of being dizzy during the day, usually when getting up from naps, and stated, "My head was so dizzy last night," The documentation further revealed the resident complained of headache in the temple area. The NP ordered a urinalysis to rule out urinary tract infection and ordered omeprazole 20 mg daily for upset stomach and nausea. The NP documented R137's medications were reviewed and,"can find nothing that really stood out," and it was uncertain what caused nausea, vomiting and dizziness. On 11/19/14 NP ordered digoxin lab level to be checked and on 11/20/14 the results were documented as 1.3, within normal range, in the nursing progress notes. The quarterly Minimum Data Set (MDS) assessment dated, 1/15/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty. The current MD's orders dated, 01/25/15	F 428	reports and that these reports are acted upon. These issues will be monitored in the following manner Director of Nursing and Nurse Managers will complete audits to review the recommendations made by the Pharmacist to ensure the above procedure is being followed and that appropriate documentation has been obtained by Physician. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily.

The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to causing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced concerns with nausea, vomiting and headaches in the past.

During a phone interview on 02/25/15, at 9:00 a.m. the consulting pharmacist indicated he had conducted a medication regimen review for R137; but did not have her record in front of him to answer specific questions. The pharmacist indicated he remembered R137 was on amiodarone because she did not tolerate any Beta blocker drugs. The pharmacist added amiodarone and digoxin were not recommended in geriatric population and should be used with caution because of the high risk of fatal adverse effects. The pharmacist stated it was very important for the nursing staff to monitor residents closely that were using these potent drugs and inform the physician of any potential side effects. He stated he reviewed the nursing and physician's documentation during his monthly medication reviews and made necessary recommendations for the physician to follow-up.

During a phone interview on 02/25/15, at 3:00

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F 428	Continued From page 23 p.m. R13's NP indicated the resident had been admitted to the facility on digoxin and amiodarone. The NP indicated he did not promote amiodarone or digoxin use in geriatric population because it was not recommended for use in elderly population, was very toxic and had a potential for serious side effects. The NP added his focus had been to try to discontinue amiodarone for patients who were admitted on this medication. He said he would discontinue digoxin for R137 and monitor her amiodarone use closely. The NP stated the nursing staff needed to consistently monitor and document any potential side effects of these medications and update him as needed. On 02/26/15, at 9:30 a.m. registered nurse (RN)-A stated after reviewing R137's electronic medical record that she was unable to find any other documentation, other than daily monitoring of heart rate and blood pressure, to show whether the nurses documented on potential medication adverse effects. RN-A indicated the nurses were trained to follow the care plan, monitor and document on any medication side effects and inform the physician promptly. After reviewing of in depth electronic progress notes, RN-A provided copy of NP's documentation, dated 1/27/15, in which, licensed practical nurse (LPN)-B reported to NP of R137 complaining of feeling nauseated and vomited in the past week. RN-A provided additional nursing progress notes, dated 10/09/14 through 11/19/14, in which R137 repeatedly complained of feeling nauseated, not feeling well, refusing to eat due to upset stomach, feeling lightheadedness and dizzy. RN-A stated these were the only documentation in R137's record related to potential medication side effects. RN-A further added, the nurses needed to read the	F 428		

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F 428	Continued From page 24 Black Box warnings listed on R137's care plan, document and report anything unusual to the physician. On 02/26/15, at 10:00 a.m. LPN-C indicated R137 was alert and capable of informing the nurses if she was not feeling well; however, R137, " is one of those residents who didn't want to bother anyone with her complaints," LPN-C indicated typically she would ask residents on her unit how they were feeling and documented in the nursing progress notes if there was anything unusual. She stated for R137 prior to administering her medications they obtained blood pressure and heart rate because the physician ordered it and documented in the medication administration record. LPN-C stated they would hold R137's heart medications if the pulse and/or blood pressure were out of range and notify the physician. After reviewing the current plan of care related to antiarrhythmic therapy for R137, LPN-C stated, the dizziness, nausea/vomiting and diarrhea could potentially be the adverse reactions of digoxin and amiodarone use and needed monitoring each shift. She added these findings needed to be documented in the nursing progress notes and the physician needed to be notified. LPN-C stated she was not aware R137 had been experiencing any dizziness, nausea or loose stools. According to the Geriatric Dosage Handbook, 12th edition, dated 2007, amiodarone was, "potentially inappropriate medication for geriatrics," this medication was associated with increased risk with heart rate problems, thyroid problems (high or low levels), liver problems, dizziness, fatigue, headache, nausea, vomiting, anorexia, CHF, abdominal pain and needed	F 428		

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F 428	Continued From page 25 extreme caution and close monitoring of patients. In addition, it may increase the digoxin levels and the physicians were advised to decrease digoxin dose by 50% and monitor digoxin blood levels closely. For digoxin use, it indicated to use it with caution in patients with thyroid problems and patients with advanced heart failure. The adverse effects included heart block, headache, weakness, dizziness, nausea, vomiting, diarrhea, abdominal pain, anorexia (lack of appetite), and with amiodarone use it may have additive effects on heart rate; therefore, reducing digoxin dose by 50% was recommended. The facility policy/procedures, titled,"Administration of Medication," revised 11/14, directed staff to be familiar with action and adverse reactions of medications and to use a Drug Handbook as needed. Another policy/procedure, titled, "Notification of Condition Change And Observation," dated 9/2012, directed staff to notify the physician of any change in resident's status.	F 428		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation,	F 441		4/6/15

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F 441	Continued From page 26 should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy on Tuberculosis screening of residents, which included documentation of the induration of the tuberculin skin test (TST); and for 4 of 5 (R224, R170, R52, R252) newly admitted residents the facility failed to consistently document either the results of the TST according to policy and/or the induration of the TST. Findings include:	F 441	F441 483.65, Infection Control Corrective Action for residents R224, R170, R52, R252 The policy and procedure has been re-developed for tuberculosis screening of residents including documentation of results of skin tests including induration. Nurses involved have been retrained immediately regarding charting results of tuberculin skin tests including induration. R224,R170,R52 and R252 had negative	

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F 441	Continued From page 27 The facility's 11/14 revised policy and procedure titled Screening of Resident for Tuberculosis indicated that a two-step Mantoux method was to be used for the tuberculin skin test (TST.) The policy indicated that the TST was to be administered upon admission and read 48-72 hours after administration; and a second TST was to be administered if the first TST was negative, one to three weeks after placement of the first test. The second test was to be read 48-72 hours after administration. However, the policy did not indicate the induration of the results were to be recorded as part of the TST. R224 was admitted to the facility on 12/12/14. The Immunization section of the electronic health record (eHR) revealed the first TST was administered on 12/14/14. According to the medication administration record (MAR) found in the eHR, the TST was read on 12/16/14, as "negative", but there was no indication as to the induration of the area read. A second TST was recorded as negative on 12/21/14, with a 0 millimeter (mm) induration on 12/21/14. R170 was admitted to the facility on 1/20/15. The Immunization section of the eHR revealed the first TST was administered on 1/20/15. According to the MAR found in the eHR, the TST was read on 1/22/15, but there was no indication as to whether the results were positive or negative; and there was no indication as to the induration of the area read. According to the MAR found in the eHR, a second TST was given on 1/27/15, and read on 1/29/15. However, there was no indication as to whether or not the results were positive or negative, and there was no indication as to the induration of the area read.	F 441	results for their most recent tuberculin skin test and these have been recorded. How to identify other residents with the same issue An audit was completed of all newly admitted residents to identify other residents who may have the same issue. Going forward, weekly audits will be completed to ensure that nursing staff are charting results of tuberculin skin tests including induration for residents who have received a tuberculin test. Re-education will be given to nurses ongoing as needed. Recurrence will be prevented by Re-education will be given to all nurses regarding the policy and procedure for tuberculin skin testing and charting results for tuberculin skin tests including induration. Audits will continue to assure compliance with the policy and procedure as outlined below. These issues will be monitored in the following manner The Director of Nursing, and Nurse Managers, will complete audits weekly for one month, then monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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According to the eHR R52 had several admissions to the facility. The first admission was recorded as 11/14/14, and according to the MAR found in the eHR the first TST was read on 11/16/14, as negative, but the induration was not recorded. A second TST was read and recorded as negative on 11/21/14, with a 0 mm induration.

R52 was then discharged and readmitted to the facility on 1/30/15. According the MAR found in the eHR the first TST was read and recorded as negative on 2/1/15, but the induration was not recorded. A second TST was read and recorded as negative on 2/8/15, but again, the induration was not recorded.

R252 was admitted to the facility on 2/9/15. The Immunization section of the eHR revealed the first TST was administered on 1/20/15. According to the MAR found in the eHR, the TST was read and recorded as negative on 2/11/15, but there was no indication as to the induration of the area read. According to the MAR found in the eHR, a second TST was read and recorded as negative on 2/18/15, but again, there was no indication as to the induration of the area read.

On 2/24/15 at 12:00 p.m. registered nurse (RN)-A stated the results of TST's should include the induration of the readings, and verified this documentation was not consistently documented for first and second TST readings for R224, R170, R52, R252.

On 2/25/15, at 10:00 a.m. RN-A stated they had reviewed the facility's policy on Screening of Residents for Tuberculosis. RN-A verified the policy and procedure did not indicate the

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F 441	Continued From page 29 induration of the TST's were to be documented. RN-A also stated the 1/15/15, policy for PointClickCare-TB Two Step Mantoux Skin Test Order Entry and Tracking Purpose did not include directions for recording the induration of TST's. A review of the policy by the surveyor verified the PointClickCare computer instructions did not include instructions for recording the induration of the TST. The PointClickCare computer directions directed the staff to go to the "Immunization" tab in the eHR and record the results by selecting "negative" or "positive", and if there were results related to a chest x-ray staff were to enter that information in the "Notes" field. There were no directions to staff to include the induration of the TST's.	F 441		
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comfortable room environment for 2 of 82 residents (R26, R83); and failed to ensure a clean, attractive and well maintained environment in 7 out of 34 resident rooms and bathrooms, 1 of 4 tub and shower rooms reviewed and the hallway with rooms 14 through 25 and the laundry processing room. This had the potential to impact 22 of 82 residents residing in the building.	F 465	GENERAL DISCLAIMER 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 the 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	4/6/15

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F 465	Continued From page 30 Findings include: Two residents, R26 and R83, had personal room windows which were poorly maintained, resulting in a cold draft which impacted their comfort. On 2/23/15 at 4:56 p.m. in room 007, a small broken piece of glass was noted in the window frame. A cold draft was noted coming from the window. This cold draft was felt several feet away from the window where R26 was seated. When asked if the room felt drafty, R26 responded "yes." R26's annual MDS assessment noted R26's cognitive status as severely impaired, as well as problems with short and long term memory. On 2/23/15 at 6:38 p.m. the outside window in room 103 was noted to not close properly, which resulted in a cold draft being felt. Several towels were noted along the base of window, but the draft could still be felt when the curtains were opened. R83 was interviewed regarding the temperature of the room, and stated she had expressed concerns to the maintenance assistant [MA], nursing assistants and her family about the cold room and the window not closing properly. R83 stated her family had brought in extra blankets and a nursing assistant had placed the towels along the base of the window to stop the draft. R83's most recent minimum data set [MDS], dated 12/11/14, indicated she was cognitively intact. During an environmental tour with the director of environmental services [DES] on 2/24/15 between 1:29 p.m. and 2:30 p.m. the DES confirmed there was a draft coming from the window in Room 103, even with the towels in place. The outside window did not shut fully. The DES also confirmed the draft coming from the window in room 007, which could be felt a few feet away from the window.	F 465	the purposes of any allegation that the facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facilities allegation of compliance with section 7305. F465 483.70h Other Environmental Conditions- The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. 1. Corrective Action: a. Additional weather stripping has been installed on windows in rooms 7 and 103. b. the bathroom walls in room 107 (not 111 as stated) was repainted all in one color. c. cracked wall in room 17 bed 1 was repaired and repainted. d. bathroom floor is being replaced in rooms 15&17 and the floor in 10& 12 was deep cleaned and stain removed. e. ceiling tiles in bathrooms 15&17 and 10&12 have been replaced. f. The tape on the toilet assist bars was removed in restroom 15&17. g. unfinished repairs in bathroom 101 have been finished and restroom repainted. h. wall in room 103 containing brown mark was repainted. i. The N.E shower room has been deep cleaned however after assessment will be getting a full modernization.	

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F 465	Continued From page 31 During stage I of the survey, there were several observations revealing concerns with the environment not being attractive, clean or well maintained. On 2/23/15, at 2:10 p.m. the wall behind the toilet in the bathroom of room 111 had a square patch measuring approximately two feet by two feet which was unpainted. On 2/23/15, at 2:13 p.m. peeling paint was noted on the upper portion of the wall behind the toilet, in the bathroom used by room 107. The area of peeling paint was also a different color than the rest of the wall. On 2/23/15, at 3:08 p.m. a large crack, approximately the length of half the wall, was observed between the two beds in room 17. The bathroom, shared with room 15 had a large rust colored stain around the toilet, which resulted in a surface which could not be cleaned. The grab bars near the toilet had pieces of tape on them which were stained brown. The wall by bed one was gouged and contained peeling paint. On 2/23/15, at 5:25 p.m. two patched and plastered areas, measuring approximately four by four inches were noted by the towel rack in the bathroom shared by rooms 101. These patched areas had not been sanded and prepped for painting. On 2/23/15, at 6:04 p.m. in the bathroom shared between room 15 and room 17 soiled tape was noted on the grab bars by the toilet and a brown stained ceiling tile was noted above the toilet. During environmental tour with the director of environmental services [DES] on 2/24/15, between 1:29 p.m. and 2:30 p.m. the following concerns were noted, which were confirmed by the DES. In the bathroom of room 107, the DES confirmed	F 465	j. The issue with the water fountain in the NE hall has been corrected and all stains cleaned. k. The entire floor of the laundry will be retiled. 2. Other Residents: An audit will be completed on all resident rooms and bathrooms to identify any further issues, and repaired as needed. 3. Recurrence will be prevented by: A meeting was held with all environmental services staff to re-educate on reporting of issues/ or repair needs to Environmental Services Director so action can be take immediately. Audits will continue as specified below, and repairs completed as needed. 4. These issues will be monitored in following manner: Periodic audits will be done by the Director of Environmental Services- monthly for one quarter and quarterly then after to ensure compliance. Audits will be brought to the Q.A. committee for review. 5. Completion dates All corrective actions will be completed by April 6, 2015 with the exception of the NE shower floor and walls. The NE shower floor and walls will be completed by CFS Flooring by May 15 2015 due to product lead times. The NE	

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F 465	Continued From page 32 the peeling paint and the area was a different color than the rest of the wall. The DES reported he was not aware of the concern. In room 103, a brown mark was noted on the wall. R83 reported the mark had been there since she was admitted. The DES was unaware of the concern. The DES confirmed the wall in the bathroom of room 101 had been patched, but not sanded or prepped for painting. The DES explained the patch work on the wall had not been finished. The DES was not aware of the concern. The DES confirmed soiled tape on the toilet grab bars near the toilet, the red ring around the toilet base and the dark spot on the ceiling in the bathroom between rooms 15 and 17. The DES reported the tape on the handle bars was not a cleanable surface and was not sure why it would be there. The shower and tub room on the North Unit was toured with the DES. Cobwebs were found in the corner. The black non-skid tape on the floor was peeling off. There were brownish/red marks in the grout between the tiles of the floor and wall of the shower. Cracks were found in several tiles near the floor. The DES reported he was unaware of the maintenance and cleanliness issues. The wall on the North Unit had a reddish brown line coming from the water fountain, down to the floor. A small reddish brown mark was on the carpet under the water fountain. The DES confirmed the concerns. In the bathroom between rooms 10 and 12 a	F 465	shower funding has been approved financially and signed off for completion.	

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reddish brown ring was found on the floor. A round brown mark was found on the ceiling tiles. The DES reported he had previously repaired the ceiling tiles, but they returned.

On 2/24/15, the DES reported there was a preventative maintenance schedule posted on the wall in the maintenance room. This document directed staff to perform preventative maintenance in the resident rooms on an annual basis only. None had been completed yet. The DES explained when staffing in the maintenance department changed, there were tasks which were not completed as it was unclear who was responsible for them. The DES reported no preventative maintenance audits or inspections were done for resident bathrooms and resident rooms and was unable to provide documentation of any audits or resident room/bathroom inspections.

The Whirlpool-Shower Room policy, last revised November 2006, directed staff to: "2. Damp dust all sills and ledges using a soft clean cloth and disinfectant cleaner solution. 3. Spot clean walls, doors and partitions to remove smudges. Use soft, clean cloth with disinfectant cleaner solution and wipe dry. 4. Damp dust all surfaces (the outside of cabinets and storage areas with soft clean cloth and disinfectant cleaner solution. Wipe dry to avoid spotting. 5. Clean sink and faucets chrome areas with disinfectant cleaner, wipe to shine with dry clean cloth. 6. Dust mop all hard floor surfaces with a clean dust mop. 7. Using a damp floor mop and neutral cleaner solution, damp mop all hard floor surfaces. Repeat if floor is heavily soiled. 8. If hard water stains/soap films occur, use a neutral detergent cleaner."

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F 465	Continued From page 34 The Restroom Cleaning Procedure, last revised November 2006, directed staff to: "2. Sanitize toilet bowls; place disinfectant cleaners/or toilet bowl cleaner in toilet bowl; do not scrub at this time. 3. Spray all fixtures with disinfectant cleaner solution. Wipe dry with clean cloth. Include mirror, light fixtures, pipes under sink, etc. 4. Clean wash stands; use disinfectant cleaner solution. Dry and/or polish with soft rag. 5. Apply bowl cleaner to the swab/brush and vigorously scrub the bowl. Wipe top bottom of seats with disinfectant cleaner dispensed from spray bottle. 6. Replenish supplies: paper towels, toilet paper, liquid or bar soap and dispensing machine supplies. 7. Dust mop floor, see Section II. L. 8. Damp mop floor; follow Damp Mopping Procedure (Section II. M). Notify supervisor if floor requires additional attention. 9. Once a week, clean the mop boards in the restrooms with a solution of neutral cleaner solution." The DES was not able to provide any additional housekeeping or preventative maintenance procedures. On 2/25/15, at 8:30 a.m. the floor tiles in the laundry processing, storage, soiled linen area were observed to be peeling away from the floor or missing, exposing the concrete beneath. On 2/25/15, at 9:20 a.m. the DES was interviewed regarding the missing and peeling floor tiles in the laundry. The DES stated "I guess I never really noticed." the condition of the floor tiles in the laundry. On 2/26/15, at 11:15 a.m. the administrator stated they were not aware of the condition of the	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	02/26/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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F 465	Continued From page 35 laundry room floor tiles.	F 465		

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2015**

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE** **MAPLEWOOD, MN 55117**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS 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. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/19/2015

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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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2015**

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K 000	Continued From page 1 Or by email to: Angela.Kappenman@state.mn.us and Marian.Whitney@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. Maplewood Good Samaritan Center is a 2-story building with no basement. The building was constructed at three different times. In 1965 the nursing home was built and was determined to be of Type II(111) construction. In 1967 an addition was constructed to the south of the main building, that was determined to be of Type II(111) construction. In 1997 an addition was constructed to the south and west of the 1967 building that was determined to be of Type II(111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the	K 000		

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/25/2015**

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K 000	Continued From page 2 fire alarm system in accordance with the Minnesota State Fire Code. The sleeping rooms in the 1997 addition have single smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code. The facility has a capacity of 96 beds and had a census of 80 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 020 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5.6. 19.3.1.1. This STANDARD is not met as evidenced by: Based on observation and interview, the facility has failed to maintain vertical opening protection as required by NFPA 101 - 2000 edition, section 19.3.1.1. This deficiency could affect 10 residents within the smoke compartment. Findings include: On facility tour between 09:00 AM and 02:00 PM on 02/25/2015, it was observed that the 2nd floor soiled linen chute across from room 242. did not automatically close and positive latch when tested. This deficiency was verified by the facility Director	K 020	K-020 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least on hour. An atrium may be used in accordance with 8.2.5.6 19.3.1.1 A. How corrective action will be accomplished for those residents found to have been affected by the deficient practices- The latch mechanism was replaced by Whitebear Locksmith on March 10, 2015 so that the door will make a positive latch after each use.	4/6/15

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K 020	Continued From page 3 of Environmental Services (JK).	K 020	B. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur- The maintenance department was instructed to include both of the laundry chute doors in the monthly inspection of the hallway doors as well as demonstrated how to inspect specifically both laundry chute doors in the building. C. Date of correction-	

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: March 9, 2015

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5221026

Dear Ms. Jensen:

The above facility was surveyed on February 23, 2015 through February 26, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Please feel free to call me with any questions about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00900	A. BUILDING: _____ B. WING _____	02/26/2015

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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 February 23, 24, 25 and 26, 2015, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 560	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 observation, interview and document review, the facility failed to develop an individualized plan of care for 1 of 1 residents (R147) reviewed for dehydration. Findings include: R147 was at risk for dehydration related to chronic diarrhea, medications with anticholinergic properties and abnormal laboratory (lab) values indicative of dehydration. However, the facility lacked monitoring to ensure R147 received the recommended amount of fluids per day to prevent dehydration. R147 was observed to drink 360 cc's [cubic centimeter] of fluids with the evening meal tray on 2/23/15, at 6:00 p.m.	2 560	"corrected"	4/6/15

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2 560	Continued From page 3 During an interview with R147 on 2/25/15, at 2:30 p.m. observation of mouth, lips, tongue and teeth appeared dry. R147 stated, "Yes I need to drink more fluids, I get so dry at night and when I wake in the morning my mouth is bone dry." R147 had a significant change minimum data assessment (MDS) completed 12/2/14, and indicated an alteration in cognition to severely impaired. The care area assessment (CAA) further read, "Resident is able to make some day to day decisions but does present with forgetfulness and confusion at times." The CAA indicated Alzheimer's Disease of other dementia's. According to the nutritional assessment dated 12/1/14, the dietitian recommended R147 receive 2100-2500 cc/day (centimeter per) of fluid according to individual body weight. This information was not on the plan of care and there were no quantifying records to support R147 received the recommended cc's of fluid intake per day. Document review for R147's plan of care dated 12/9/14, read, "The resident has bowel incontinence potential R/T [related to] chronic diarrhea E/B [episodes/bouts] occasional to frequent bowel incontinence." The plan of care did not address the stool sample tested for the toxigenic clostridium difficile [bacterium that causes diarrhea] on 4/27/13 which was negative for clostridium difficile to rule out a possible cause for chronic diarrhea. R147 received chemotherapy for malignant neoplasm of the bladder. One of the side effects for the chemotherapy and addressed on the plan	2 560		

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2 560	Continued From page 4 of care lists but was not limited to diarrhea, nausea, lips dry and or cracked lips. An intervention read, "Drink plenty of fluids." Medications R147 received, included Prozac for depression, which had a warning for adverse effects which included but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral neuropathy and the side effects included but were not limited to dry mouth, dry throat and nausea. R147 had taken Aricept for cognitive function and the side effects were not limited to but did include nausea, diarrhea and dehydration. R147 had abnormal laboratory values for creatinine (chemical waste molecule that is generated from muscle metabolism) and blood urea nitrogen (indicator of kidney disease and/or dehydration) The abnormal lab values were not addressed on the individual plan of care for R147 which could be an indicator for dehydration. A review of the facility policy dated 11/13, and titled, Intake and Output, indicated a nurse could choose to initiate intake and output on a resident at risk for imbalances such as potential for dehydration, diuretic use, renal disease and diarrhea. When interviewed on 2/25/15, at 2:00 p.m. RN-C, nursing assistant NA-B and NA-C did not know what the minimum fluid requirements were per day for R147 or the number of cc's they should strive for when encouraging fluids. All three staff verified R147 had bouts of diarrhea.	2 560		

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2 560	Continued From page 5 SUGGESTED METHOD OF CORRECTION: The facility should review the assessments for residents at the time of admission, a significant change and/or quarterly and then review and revise the resident care plan as necessary to ensure the care plan is an accurate reflection of the resident's needs. Monitoring could be done at the time of the quarterly care conference to ensure the accuracy of the care plan the care plan. The monitoring could be assigned to the nursing staff responsible for attending the resident care conference. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the plan of care for antiarrhythmic and psychoactive medication adverse side effects were monitored for 1 of 5 (R137) residents in the sample. Findings include: On 02/25/15 R137's medical record was reviewed; the care plan dated, 05/09/14 reflected that R137 was on antiarrhythmic therapy and the	2 565	"corrected"	4/6/15

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2 565	Continued From page 6	2 565		

goal indicated R137 would be free from adverse reactions related to digoxin and Amiodarone use. The care plan interventions directed staff to monitor for adverse reactions of these two medications which included hypothyroidism, dizziness, nausea, and vomiting and the black box warning signs and report to the physician or nurse practitioner.

On 02/26/15, at 8:51 a.m., when asked if R137 felt dizzy, R137 stated, "oh, yes, I feel dizzy all of the time and the dizziness increases when I tilt my head to the right side." R137 added the wheelchair she used kept her from falling down due to being dizzy. When asked if she felt nauseated, R137 stated, "I wake up during the night from nausea and they bring me my plastic pan to throw up in." R137 explained that it happened quite often during the night and that she informed her nurse practitioner(R137 identified the nurse practitioner by name.)R137 further stated that she experienced stomach problems and had loose stools at least twice a day; R137 voiced frustrations of not feeling well and stated she had told the nurses who give her medications that she did not feel well.

On 02/26/15, at 9:30 a.m. registered nurse (RN)-A stated after reviewing R137's electronic medical record that she was unable to find any other documentation, other than daily monitoring of heart rate and blood pressure, to show whether the nurses documented on potential medication adverse effects. RN-A indicated the nurses were trained to follow the care plan, monitor and document on any medication side effects and inform the physician promptly. After reviewing of in depth electronic progress notes, RN-A provided copy of NP's documentation, dated 1/27/15, in which, licensed practical nurse (LPN)-B reported

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2 565	Continued From page 7 to NP of R137 complaining of feeling nauseated and vomited in the past week. RN-A provided additional nursing progress notes, dated 10/09/14 through 11/19/14, in which R137 repeatedly complained of feeling nauseated, not feeling well, refusing to eat due to upset stomach, feeling lightheadedness and dizzy. RN-A stated these were the only documentation in R137's record related to potential medication side effects. RN-A further added, the nurses needed to read the Black Box warnings listed on R137's care plan, document and report anything unusual to the physician. On 02/26/15, at 10:00 a.m. LPN-C indicated R137 was alert and capable of informing the nurses if she was not feeling well; however, R137, " is one of those residents who didn't want to bother anyone with her complaints," LPN-C indicated typically she would ask residents on her unit how they were feeling and documented in the nursing progress notes if there was anything unusual. She stated for R137 prior to administering her medications they obtained blood pressure and heart rate because the physician ordered it and documented in the medication administration record. LPN-C stated they would hold R137's heart medications if the pulse and/or blood pressure were out of range and notify the physician. After reviewing the current plan of care related to antiarrhythmic therapy for R137, LPN-C stated, the dizziness, nausea/vomiting and diarrhea could potentially be the adverse reactions of digoxin and amiodarone use and needed monitoring each shift. She added these findings needed to be documented in the nursing progress notes and the physician needed to be notified. LPN-C stated she was not aware R137 had been experiencing any dizziness, nausea or loose stools.	2 565		

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2 565	Continued From page 8 The facility policy/procedures, titled,"Administration of Medication," revised 11/14, directed staff to be familiar with action and adverse reactions of medications and to use a Drug Handbook as needed. Another policy/procedures, titled, "Notification of Condition Change And Observation," dated 9/2012, directed staff to notify physician of any change in resident's status. SUGGESTED METHOD OF CORRECTION: The director of nurses or assigned designee could monitor the provision of patient care and then review the care plan to ensure the care plan is an accurate reflection of a resident's needs. The care plan should be revised as necessary to ensure continual accuracy in the provision of resident care. Staff providing care to the resident could then be educated on the care plan revision to again ensure continual accuracy in the provision of resident care. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 940	MN Rule 4658.0525 Subp. 9 Rehab - Hydration Subp. 9. Hydration. Residents must be offered and receive adequate water and other fluids to maintain proper hydration and health, unless fluids are restricted. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to adequately monitor	2 940	"corrected"	4/6/15

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2 940	Continued From page 9 and/or provide recommended fluid intake for 1 of 1 resident(R147) identified as at risk for dehydration. Findings include: R147 was at risk for dehydration related to chronic diarrhea, medications with anticholinergic properties and abnormal laboratory (lab) values indicative of dehydration. However, the facility lacked monitoring to ensure R147 received the recommended amount of fluids per day to prevent dehydration. During an interview with R147 on 2/25/15, at 2:30 p.m. observation of mouth, lips, tongue and teeth appeared dry. R147 stated, "Yes I need to drink more fluids, I get so dry at night and when I wake in the morning my mouth is bone dry." R147 had a significant change minimum data assessment (MDS) completed 12/2/14, and indicated an alteration in cognition to severely impaired. The care area assessment (CAA) further read, "Resident is able to make some day to day decisions but does present with forgetfulness and confusion at times." The CAA indicated Alzheimer's Disease of other dementia's. R147 did not receive adequate fluid intake monitoring according to the nutritional assessment dated 12/1/14, which recommended R147 receive 2100-2500 cc/day [cubic centimeter per] of fluid according to individual body weight. There was no accurate quantifying data for fluid intake numbers to support R147 received the recommended cc's of fluid intake per day. R147 averaged 5 episodes of diarrhea each	2 940		

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2 940	Continued From page 10 month in the months of November and December of 2014 and in January of 2015. The month of February 2015 there were 6 recorded episodes of diarrhea. The medication Imodium was given following the bouts of diarrhea, and the adverse reactions for Imodium were not limited to but did include, dry mouth and nausea. Imodium was given for diarrhea February 4, 9, 11, 16, 17, and 20/2015. The number of fluid intake cc's recorded on the Food and Fluid Intake form all fell below the assessed requirement for R147 of 2100-2500 cc's of fluid per day. Fluid intake cc's for R147 on the days diarrhea was documented were; 2/4/15, 400 cc's, 2/9/15, 1010cc's, 2/11/14, 1260 cc's, 2/16/15, 1070 cc's, 2/17/15, 1320 cc's and 2/20/15, 650 cc's. During an interview on 2/26/15, at 9:45 a.m. RN-B verified she could not prove with quantifying data R147 took in orally 2100-2500 cc's of fluid in a twenty-four hour period but the staff visually could see R147 consumed pop and fluids throughout the day. There was observation of the water pitcher at R147's bedside each day of the survey. R147 received chemotherapy for malignant neoplasm of the bladder. One of the side effects for the chemotherapy, and addressed on the plan of care, listed but was not limited to diarrhea, nausea, lips dry and or cracked lips. An intervention read, "Drink plenty of fluids." On 1/10/15, R147 received an order for Biotene Dry Mouth Gel after the family requested due to complaints of dry mouth. R147 was receiving Artificial Tears Solution 1.4% 2 drops in both eyes at bedtime for dry eyes since 1/10/14.	2 940		

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2 940	Continued From page 11 Medications R147 had taken included Prosac for depression which had a warning for adverse effects which include but was not limited to diarrhea, dry mouth, and nausea. R147 received Gabapentin for peripheral neuropathy and the adverse effects include but are not limited to dry mouth, dry throat and nausea. R147 had taken Aricept for cognitive function and the adverse effects are not limited to but do include nausea, diarrhea and dehydration. The blood creatinine blood level (chemical waste molecule that is generated from muscle metabolism) had been above normal since admission at 1.21 mg.dLwith the expected value range of 0.60 to 1.10. The 2/3/15, creatinine continues to rise currently at 1.97 mg/dL. The blood urea nitrogen (BUN) (indicator of kidney disease and/or dehydration) on 9/12/13, was 25 with a expected value range of 8 to 28 mg/dL. The BUN on 12/5/14, remained within range at 27 mg/dL. The most recent BUN on 2/3/15, exceeded the expected value range at 40 mg/dL. R147 was seen at the Medical Oncology clinic 0n 2/3/15, by a certified nurse practitioner (CNP-A) who reviewed the labs and wrote on the referral, "Worsening kidney function." Under the Plan #4. "Encourage her to drink more fluids. Her BUN is also elevated suggesting at least partly dehydrated." Furthermore, the CNP addressed an increase in the diarrhea, and complaints of urinary frequency, urgency, and not being able to fully empty her bladder. The returned form titled Clinic Referral dated 2/3/15, signed by CNP-A read, "Hemoglobin 10.7 Kidney function creatinine 1.97-likely dehydrated." Under the order section of the referral was written no new	2 940		

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2 940	Continued From page 12 orders, but on page 2, the plan read, "Encourage her to drink more fluids. Her BUN is also elevated suggesting at least partly dehydration." When interviewed on 2/25/15, at 2:00 p.m. RN-C, nursing assistant NA-B and NA-C did not know what the minimum fluid requirements were per day for R147 or the number of cc's they should strive for when encouraging fluids. All three staff verified R147 had bouts of diarrhea and had bladder cancer. When interviewed on 2/26/15, at 9:45 a.m. Registered Nurse (RN-B) produced a form titled, Food and Fluid Intake, and designated on 2/25/15, R147 was added into the computer task section so that the staff would record the number of fluid cc's R147 consumed in a twenty four hour period. The number recorded was 1380 cc's which was 720 cc's less than the minimum recommended fluid intake for R147. When interviewed about R147's fluid intake on 2/26/15, at 9:45 a.m. RN-B expressed, because the plan of care said to encourage fluids, there did not need to be any further direction for staff. RN-B acknowledged there was not accurate quantifying data for R147's fluid intake per day and stated, "We see her taking fluids all the time." Furthermore, RN-B discredited CNP-A's progress notes and plan by saying the nurse practitioner did not know R147 because this was the first time CNP-A had seen R147 in the clinic. A review of the facility policy dated 11/13, and titled, Intake and Output, indicated a nurse could choose to initiate intake and output on a resident at risk for imbalances such as potential for dehydration, diuretic use, renal disease and diarrhea.	2 940		

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2 940	Continued From page 13 The policy titled, Hydration of Residents, dated September 2012, addressed maintaining the hydration status by the registered dietitian (RD) who will estimate the individual fluid requirements by taking the resident weight in kilograms times 30 millimeters gives the estimated resident requirements. When interviewed on 2/25/15, at 2:00 p.m. the RD verified R147's assessment recommending 2100 to 2500 cc's of fluid per day to maintain hydration was accurate. SUGGESTED METHOD OF CORRECTION: The dietary director could review the dietary assessments to identify residents at risk for dehydration. For any residents identified as at risk for dehydration the dietary director or designee could review the care plan to ensure the resident's hydration needs were being addressed and monitored. Nursing staff could then be educated on those residents at risk for dehydration and how to monitor the resident is receiving enough fluids to maintain adequate hydration. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 940		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and	21390		4/6/15

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21390	Continued From page 14 control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to develop a policy on Tuberculosis screening of residents, which included documentation of the induration of the tuberculin skin test (TST); and for 4 of 5 (R224, R170, R52, R252) newly admitted residents the facility failed to consistently document either the results of the TST according to policy and/or the induration of the TST. Findings include: The facility's 11/14 revised policy and procedure titled Screening of Resident for Tuberculosis	21390	"corrected"	

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21390	Continued From page 15 indicated that a two-step Mantoux method was to be used for the tuberculin skin test (TST.) The policy indicated that the TST was to be administered upon admission and read 48-72 hours after administration; and a second TST was to be administered if the first TST was negative, one to three weeks after placement of the first test. The second test was to be read 48-72 hours after administration. However, the policy did not indicate the induration of the results were to be recorded as part of the TST. R224 was admitted to the facility on 12/12/14. The Immunization section of the electronic health record (eHR) revealed the first TST was administered on 12/14/14. According to the medication administration record (MAR) found in the eHR, the TST was read on 12/16/14, as "negative", but there was no indication as to the induration of the area read. A second TST was recorded as negative on 12/21/14, with a 0 millimeter (mm) induration on 12/21/14. R170 was admitted to the facility on 1/20/15. The Immunization section of the eHR revealed the first TST was administered on 1/20/15. According to the MAR found in the eHR, the TST was read on 1/22/15, but there was no indication as to whether the results were positive or negative; and there was no indication as to the induration of the area read. According to the MAR found in the eHR, a second TST was given on 1/27/15, and read on 1/29/15. However, there was no indication as to whether or not the results were positive or negative, and there was no indication as to the induration of the area read. According to the eHR R52 had several admissions to the facility. The first admission was recorded as 11/14/14, and according to the MAR	21390		

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21390	Continued From page 16	21390		

found in the eHR the first TST was read on 11/16/14, as negative, but the induration was not recorded. A second TST was read and recorded as negative on 11/21/14, with a 0 mm induration.

R52 was then discharged and readmitted to the facility on 1/30/15. According the MAR found in the eHR the first TST was read and recorded as negative on 2/1/15, but the induration was not recorded. A second TST was read and recorded as negative on 2/8/15, but again, the induration was not recorded.

R252 was admitted to the facility on 2/9/15. The Immunization section of the eHR revealed the first TST was administered on 1/20/15. According to the MAR found in the eHR, the TST was read and recorded as negative on 2/11/15, but there was no indication as to the induration of the area read. According to the MAR found in the eHR, a second TST was read and recorded as negative on 2/18/15, but again, there was no indication as to the induration of the area read.

On 2/24/15 at 12:00 p.m. registered nurse (RN)-A stated the results of TST's should include the induration of the readings, and verified this documentation was not consistently documented for first and second TST readings for R224, R170, R52, R252.

On 2/25/15, at 10:00 a.m. RN-A stated they had reviewed the facility's policy on Screening of Residents for Tuberculosis. RN-A verified the policy and procedure did not indicate the induration of the TST's were to be documented.

RN-A also stated the 1/15/15, policy for PointClickCare-TB Two Step Mantoux Skin Test Order Entry and Tracking Purpose did not include

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21390	Continued From page 17 directions for recording the induration of TST's. A review of the policy by the surveyor verified the PointClickCare computer instructions did not include instructions for recording the induration of the TST. The PointClickCare computer directions directed the staff to go to the "Immunization" tab in the eHR and record the results by selecting "negative" or "positive", and if there were results related to a chest x-ray staff were to enter that information in the "Notes" field. There were no directions to staff to include the induration of the TST's. SUGGESTED METHOD OF CORRECTION: The director of infection control could review and revise as necessary the facility's policy and procedure regarding how to document the results of Tuberculin skin tests (TST), to include the induration of the injected site. Staff responsible for reading and record the TST reaction could be educated on the revised policy. A member of the nursing or medical records staff could be assigned the role to randomly audit newly admitted residents electronic health records (eHR) to ensure staff are correctly documenting the TST results. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be 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	21530		4/6/15

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21530	Continued From page 18 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. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility's consulting pharmacist failed to identify and/or act upon identified drug irregularities for 2 of 5 residents (R147, R137) in the sample.	21530	"corrected"	

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21530	Continued From page 19 R147 had a physician order for acetaminophen tablet 325 mg, give 1 tablet by mouth every 4 hours as needed for mild pain. The start date was 9/4/13. There was a second order that read, acetaminophen tablet 325 mg give 2 tablets by mouth every 4 hours as needed for moderate pain with a start date of 9/4/13. There was a third order which read, Norco tablet 5-325 MG (Hydrocodone-acetaminophen) Give 1 tablet by mouth every 4 hours as needed for pain with a start date of 4/1/14. These orders gave R147 the potential to take 7700 grams of acetaminophen in a twenty four hour period. There were no consultant pharmacist's medication review recommendations for the use of acetaminophen. The pharmacist was interviewed on 2/25/15 at 3:15 p.m. and verified the acetaminophen is to have a 3000 gram parameter in a 24 hour period according to the manufacturers recommendations. During an interview with the registered nurse (RN-B) on 2/26/15, at 9:45 a.m. revealed that the nursing staff were educated on 8/15/14, during mandatory training that the acetaminophen was to have parameters not to exceed 3000 grams (g) per day from all sources of medication containing Acetaminophen. R137's physician (MD)'s documentation dated, 4/9/13 indicated R137 had been taking digoxin and amiodarone for atrial fibrillation (to control heart rate); however, the facility lacked indication for continued use and potential adverse effects monitoring of these medications. The consulting pharmacist lacked to communicate irregularities to MD.	21530		

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21530	Continued From page 20 On 02/26/15, at 8:51 a.m., alert resident, R137 stated, "Oh, yes, I feel dizzy all of the time and the dizziness increases when I tilt my head to the right side." R137 added the wheelchair she used kept her from falling down due to being dizzy. Regarding feeling nauseated, she stated, "I wake up during the night from nausea and they bring me my plastic pan to throw up in." R137 indicated it happened quite often during the night and had informed the NP. R137 further stated she experienced stomach problems and had loose stools at least twice a day; R137 voiced frustrations of not feeling well and stated she had told the nurses who gave her medications that she did not feel well. R137 was admitted to the facility on 4/29/13 the admission history and physical dated, 05/02/13 had diagnoses that included hypothyroidism, congestive heart failure (CHF), diabetes mellitus, chronic kidney disease stage II, aortic valve replacement, hypertension and urinary tract infection (UTI). The plan of care dated 05/9/14, listed the U.S. Food and Drug Administration (FDA) black box warning for amiodarone use as: "Risk of potentially fatal toxicities including pulmonary toxicity (lung damage) and hepatic injury (liver damage), hypothyroidism (low thyroid levels in the blood), exacerbation of existing arrhythmia and heart failure (worse heart beat problems). Potential adverse effects include arrhythmia formation or exacerbation (heart rate problems), bradycardia (low heart rate), dizziness, dyspnea (difficulty breathing), hypotension (low blood pressure), nausea, visual disturbances, vomiting." The nursing staff failed to follow the care plan and consistently monitor, document and inform the	21530		

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21530	Continued From page 21 physician on these identified serious and fatal adverse effects. The nursing progress notes dated, 10/9/14 through 11/19/14 revealed, R137 had been nauseated numerous times, refused meals and complained of being unwell. A progress noted dated 11/19/14, revealed R137 had complained: "I'm so hot. I feel like I am going to throw up," and "feeling dizzy, feels sick to her stomach. Nauseated. Had a small emesis of thick yellow mucous mixed with a small amount of blood;" On this date the nurse practitioner (NP) started R137 on omeprazole 20 mg due to gastric reflux and nausea without properly assessing R137 for potential adverse effects of digoxin and amiodarone use. Furthermore, the documentation lacked evidence identifying clinical indications for the continued use of digoxin and amiodarone. Review of NP's documentation dated 11/19/14, indicated R137 complained of nausea and had vomited bile in a plastic bin. The documentation indicated the resident had complained of being dizzy during the day, usually when getting up from naps, and stated, "My head was so dizzy last night," The documentation further revealed the resident complained of headache in the temple area. The NP ordered a urinalysis to rule out urinary tract infection and ordered omeprazole 20 mg daily for upset stomach and nausea. The NP documented R137's medications were reviewed and,"can find nothing that really stood out," and it was uncertain what caused nausea, vomiting and dizziness. On 11/19/14 NP ordered digoxin lab level to be checked and on 11/20/14 the results were documented as 1.3, within normal range, in the nursing progress notes.	21530		

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21530	Continued From page 22 The quarterly Minimum Data Set (MDS) assessment dated, 1/15/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty. The current MD's orders dated, 01/25/15 indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily. The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to causing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced concerns with nausea, vomiting and headaches in the past. During a phone interview on 02/25/15, at 9:00 a.m. the consulting pharmacist indicated he had conducted a medication regimen review for R137; but did not have her record in front of him to answer specific questions. The pharmacist indicated he remembered R137 was on amiodarone because she did not tolerate any Beta blocker drugs. The pharmacist added amiodarone and digoxin were not recommended in geriatric population and should be used with caution because of the high risk of fatal adverse effects. The pharmacist stated it was very important for the nursing staff to monitor residents closely that were using these potent drugs and inform the physician of any potential	21530		

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21530	Continued From page 23 side effects. He stated he reviewed the nursing and physician's documentation during his monthly medication reviews and made necessary recommendations for the physician to follow-up. During a phone interview on 02/25/15, at 3:00 p.m. R13's NP indicated the resident had been admitted to the facility on digoxin and amiodarone. The NP indicated he did not promote amiodarone or digoxin use in geriatric population because it was not recommended for use in elderly population, was very toxic and had a potential for serious side effects. The NP added his focus had been to try to discontinue amiodarone for patients who were admitted on this medication. He said he would discontinue digoxin for R137 and monitor her amiodarone use closely. The NP stated the nursing staff needed to consistently monitor and document any potential side effects of these medications and update him as needed. On 02/26/15, at 9:30 a.m. registered nurse (RN)-A stated after reviewing R137's electronic medical record that she was unable to find any other documentation, other than daily monitoring of heart rate and blood pressure, to show whether the nurses documented on potential medication adverse effects. RN-A indicated the nurses were trained to follow the care plan, monitor and document on any medication side effects and inform the physician promptly. After reviewing of in depth electronic progress notes, RN-A provided copy of NP's documentation, dated 1/27/15, in which, licensed practical nurse (LPN)-B reported to NP of R137 complaining of feeling nauseated and vomited in the past week. RN-A provided additional nursing progress notes, dated 10/09/14 through 11/19/14, in which R137 repeatedly complained of feeling nauseated, not feeling well,	21530		

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21530	Continued From page 24	21530		

refusing to eat due to upset stomach, feeling lightheadedness and dizzy. RN-A stated these were the only documentation in R137's record related to potential medication side effects. RN-A further added, the nurses needed to read the Black Box warnings listed on R137's care plan, document and report anything unusual to the physician.

On 02/26/15, at 10:00 a.m. LPN-C indicated R137 was alert and capable of informing the nurses if she was not feeling well; however, R137, " is one of those residents who didn't want to bother anyone with her complaints," LPN-C indicated typically she would ask residents on her unit how they were feeling and documented in the nursing progress notes if there was anything unusual. She stated for R137 prior to administering her medications they obtained blood pressure and heart rate because the physician ordered it and documented in the medication administration record. LPN-C stated they would hold R137's heart medications if the pulse and/or blood pressure were out of range and notify the physician. After reviewing the current plan of care related to antiarrhythmic therapy for R137, LPN-C stated, the dizziness, nausea/vomiting and diarrhea could potentially be the adverse reactions of digoxin and amiodarone use and needed monitoring each shift. She added these findings needed to be documented in the nursing progress notes and the physician needed to be notified. LPN-C stated she was not aware R137 had been experiencing any dizziness, nausea or loose stools.

According to the Geriatric Dosage Handbook, 12th edition, dated 2007, amiodarone was, "potentially inappropriate medication for geriatrics," this medication was associated with

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21530	Continued From page 25 increased risk with heart rate problems, thyroid problems (high or low levels), liver problems, dizziness, fatigue, headache, nausea, vomiting, anorexia, CHF, abdominal pain and needed extreme caution and close monitoring of patients. In addition, it may increase the digoxin levels and the physicians were advised to decrease digoxin dose by 50% and monitor digoxin blood levels closely. For digoxin use, it indicated to use it with caution in patients with thyroid problems and patients with advanced heart failure. The adverse effects included heart block, headache, weakness, dizziness, nausea, vomiting, diarrhea, abdominal pain, anorexia (lack of appetite), and with amiodarone use it may have additive effects on heart rate; therefore, reducing digoxin dose by 50% was recommended. The facility policy/procedures, titled,"Administration of Medication," revised 11/14, directed staff to be familiar with action and adverse reactions of medications and to use a Drug Handbook as needed. Another policy/procedure, titled, "Notification of Condition Change And Observation," dated 9/2012, directed staff to notify the physician of any change in resident's status. SUGGESTED METHOD OF CORRECTION: The administrator, director of nursing (DON) and consulting pharmacist could review and revise policies and procedures for proper monitoring of medication usage. Nursing staff could be educated as necessary to the importance of the pharmacist's review. The DON or designee, along with the pharmacist, could audit medication reviews on a regular basis to ensure compliance. TIME PERIOD FOR CORRECTION: Thirty (30)	21530		

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21530	Continued From page 26 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 by: Based on interview and document review, the facility failed to adequately identify and monitor clinical indications for continued use of antiarrhythmic medications and adverse effects for 1 of 5 (R137) residents in the sample. Findings include:	21540	"corrected"	4/6/15

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21540	Continued From page 27 R137's physician (MD)'s documentation dated, 4/9/13 indicated R137 had been taking digoxin and amiodarone for atrial fibrillation (to control heart rate); however, the facility lacked indication for continued use and potential adverse effects monitoring of these medications. On 02/26/15, at 8:51 a.m., alert resident, R137 stated, "Oh, yes, I feel dizzy all of the time and the dizziness increases when I tilt my head to the right side." R137 added the wheelchair she used kept her from falling down due to being dizzy. Regarding feeling nauseated, she stated, "I wake up during the night from nausea and they bring me my plastic pan to throw up in." R137 indicated it happened quite often during the night and had informed the NP. R137 further stated she experienced stomach problems and had loose stools at least twice a day; R137 voiced frustrations of not feeling well and stated she had told the nurses who gave her medications that she did not feel well. R137 was admitted to the facility on 4/29/13 the admission history and physical dated, 05/02/13 had diagnoses that included hypothyroidism, congestive heart failure (CHF), diabetes mellitus, chronic kidney disease stage II, aortic valve replacement, hypertension and urinary tract infection (UTI). The plan of care dated 05/9/14, listed the U.S. Food and Drug Administration (FDA) black box warning for amiodarone use as: "Risk of potentially fatal toxicities including pulmonary toxicity (lung damage) and hepatic injury (liver damage), hypothyroidism (low thyroid levels in the blood), exacerbation of existing arrhythmia and heart failure (worse heart beat problems). Potential adverse effects include arrhythmia	21540		

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formation or exacerbation (heart rate problems), bradycardia (low heart rate), dizziness, dyspnea (difficulty breathing), hypotension (low blood pressure), nausea, visual disturbances, vomiting." The nursing staff failed to follow the care plan and consistently monitor, document and inform the physician on these identified serious and fatal adverse effects.

The nursing progress notes dated, 10/9/14 through 11/19/14 revealed, R137 had been nauseated numerous times, refused meals and complained of being unwell. A progress noted dated 11/19/14, revealed R137 had complained: "I'm so hot. I feel like I am going to throw up," and "feeling dizzy, feels sick to her stomach. Nauseated. Had a small emesis of thick yellow mucous mixed with a small amount of blood;" On this date the nurse practitioner (NP) started R137 on omeprazole 20 mg due to gastric reflux and nausea without properly assessing R137 for potential adverse effects of digoxin and amiodarone use. Furthermore, the documentation lacked evidence identifying clinical indications for the continued use of digoxin and amiodarone.

Review of NP's documentation dated 11/19/14, indicated R137 complained of nausea and had vomited bile in a plastic bin. The documentation indicated the resident had complained of being dizzy during the day, usually when getting up from naps, and stated, "My head was so dizzy last night," The documentation further revealed the resident complained of headache in the temple area. The NP ordered a urinalysis to rule out urinary tract infection and ordered omeprazole 20 mg daily for upset stomach and nausea. The NP documented R137's medications were reviewed and,"can find nothing that really stood out," and it

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21540	Continued From page 29	21540		

was uncertain what caused nausea, vomiting and dizziness. On 11/19/14 NP ordered digoxin lab level to be checked and on 11/20/14 the results were documented as 1.3, within normal range, in the nursing progress notes.

The quarterly Minimum Data Set (MDS) assessment dated, 1/15/15 identified R137 as being moderately impaired of cognition and was able to understand others and be understood with minimal difficulty.

The current MD's orders dated, 01/25/15 indicated R137 was to receive amiodarone (an antiarrhythmic medication) 100 milligrams (mg) every day and digoxin (used for CHF and heart rate control) 125 micrograms (mcg) daily.

The pharmacy consultant made a recommendation to the MD on 2/24/15, indicating to consider discontinuing Robitussin since R137 had not used it in the past three months, and to review the use of omeprazole which was linked to causing pneumonia and bone fractures. Evidence was lacking to reflect whether the consulting pharmacist had noted any irregularities related to the continued use of digoxin and amiodarone, especially when R137 had voiced concerns with nausea, vomiting and headaches in the past.

During a phone interview on 02/25/15, at 9:00 a.m. the consulting pharmacist indicated he had conducted a medication regimen review for R137; but did not have her record in front of him to answer specific questions. The pharmacist indicated he remembered R137 was on amiodarone because she did not tolerate any Beta blocker drugs. The pharmacist added amiodarone and digoxin were not recommended

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in geriatric population and should be used with caution because of the high risk of fatal adverse effects. The pharmacist stated it was very important for the nursing staff to monitor residents closely that were using these potent drugs and inform the physician of any potential side effects. He stated he reviewed the nursing and physician's documentation during his monthly medication reviews and made necessary recommendations for the physician to follow-up.

During a phone interview on 02/25/15, at 3:00 p.m. R13's NP indicated the resident had been admitted to the facility on digoxin and amiodarone. The NP indicated he did not promote amiodarone or digoxin use in geriatric population because it was not recommended for use in elderly population, was very toxic and had a potential for serious side effects. The NP added his focus had been to try to discontinue amiodarone for patients who were admitted on this medication. He said he would discontinue digoxin for R137 and monitor her amiodarone use closely. The NP stated the nursing staff needed to consistently monitor and document any potential side effects of these medications and update him as needed.

On 02/26/15, at 9:30 a.m. registered nurse (RN)-A stated after reviewing R137's electronic medical record that she was unable to find any other documentation, other than daily monitoring of heart rate and blood pressure, to show whether the nurses documented on potential medication adverse effects. RN-A indicated the nurses were trained to follow the care plan, monitor and document on any medication side effects and inform the physician promptly. After reviewing of in depth electronic progress notes, RN-A provided copy of NP's documentation, dated 1/27/15, in

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which, licensed practical nurse (LPN)-B reported to NP of R137 complaining of feeling nauseated and vomited in the past week. RN-A provided additional nursing progress notes, dated 10/09/14 through 11/19/14, in which R137 repeatedly complained of feeling nauseated, not feeling well, refusing to eat due to upset stomach, feeling lightheadedness and dizzy. RN-A stated these were the only documentation in R137's record related to potential medication side effects. RN-A further added, the nurses needed to read the Black Box warnings listed on R137's care plan, document and report anything unusual to the physician.

On 02/26/15, at 10:00 a.m. LPN-C indicated R137 was alert and capable of informing the nurses if she was not feeling well; however, R137, " is one of those residents who didn't want to bother anyone with her complaints," LPN-C indicated typically she would ask residents on her unit how they were feeling and documented in the nursing progress notes if there was anything unusual. She stated for R137 prior to administering her medications they obtained blood pressure and heart rate because the physician ordered it and documented in the medication administration record. LPN-C stated they would hold R137's heart medications if the pulse and/or blood pressure were out of range and notify the physician. After reviewing the current plan of care related to antiarrhythmic therapy for R137, LPN-C stated, the dizziness, nausea/vomiting and diarrhea could potentially be the adverse reactions of digoxin and amiodarone use and needed monitoring each shift. She added these findings needed to be documented in the nursing progress notes and the physician needed to be notified. LPN-C stated she was not aware R137 had been experiencing any

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21540	Continued From page 32 dizziness, nausea or loose stools. According to the Geriatric Dosage Handbook, 12th edition, dated 2007, amiodarone was, "potentially inappropriate medication for geriatrics," this medication was associated with increased risk with heart rate problems, thyroid problems (high or low levels), liver problems, dizziness, fatigue, headache, nausea, vomiting, anorexia, CHF, abdominal pain and needed extreme caution and close monitoring of patients. In addition, it may increase the digoxin levels and the physicians were advised to decrease digoxin dose by 50% and monitor digoxin blood levels closely. For digoxin use, it indicated to use it with caution in patients with thyroid problems and patients with advanced heart failure. The adverse effects included heart block, headache, weakness, dizziness, nausea, vomiting, diarrhea, abdominal pain, anorexia (lack of appetite), and with amiodarone use it may have additive effects on heart rate; therefore, reducing digoxin dose by 50% was recommended. The facility policy/procedures, titled,"Administration of Medication," revised 11/14, directed staff to be familiar with action and adverse reactions of medications and to use a Drug Handbook as needed. Another policy/procedure, titled, "Notification of Condition Change And Observation," dated 9/2012, directed staff to notify the physician of any change in resident's status. SUGGESTED METHOD OF CORRECTION: The director of nurses or designee could review the drug regimen for all residents in the facility to ensure each medication had appropriate indications for use; that side effect monitoring	21540		

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	00900	A. BUILDING: _____ B. WING _____	02/26/2015

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21540	Continued From page 33 was being conducted per facility policy; and that if a resident was experiencing side effects that the physician was notified. Nursing staff could be educated on how to monitor and document drug side effects and when to report the presence of drug side effects to the physician. TIME PERIOD FOR CORRECTION: Thirty (30) days.	21540		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a comfortable room environment for 2 of 82 residents (R26, R83); and failed to ensure a clean, attractive and well maintained environment in 7 out of 34 resident rooms and bathrooms, 1 of 4 tub and shower rooms reviewed and the hallway with rooms 14 through 25 and the laundry processing room. This had the potential to impact 22 of 82 residents residing in the building. Findings include: Two residents, R26 and R83, had personal room windows which were poorly maintained, resulting in a cold draft which impacted their comfort. On 2/23/15 at 4:56 p.m. in room 007, a small broken piece of glass was noted in the window frame. A cold draft was noted coming from the window. This cold draft was felt several feet away from the window where R26 was seated. When	21665	"corrected"	4/6/15

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asked if the room felt drafty, R26 responded "yes." R26's annual MDS assessment noted R26's cognitive status as severely impaired, as well as problems with short and long term memory.
On 2/23/15 at 6:38 p.m. the outside window in room 103 was noted to not close properly, which resulted in a cold draft being felt. Several towels were noted along the base of window, but the draft could still be felt when the curtains were opened. R83 was interviewed regarding the temperature of the room, and stated she had expressed concerns to the maintenance assistant [MA], nursing assistants and her family about the cold room and the window not closing properly. R83 stated her family had brought in extra blankets and a nursing assistant had placed the towels along the base of the window to stop the draft. R83's most recent minimum data set [MDS], dated 12/11/14, indicated she was cognitively intact.
During an environmental tour with the director of environmental services [DES] on 2/24/15 between 1:29 p.m. and 2:30 p.m. the DES confirmed there was a draft coming from the window in Room 103, even with the towels in place. The outside window did not shut fully. The DES also confirmed the draft coming from the window in room 007, which could be felt a few feet away from the window.
During stage I of the survey, there were several observations revealing concerns with the environment not being attractive, clean or well maintained.
On 2/23/15, at 2:10 p.m. the wall behind the toilet in the bathroom of room 111 had a square patch measuring approximately two feet by two feet which was unpainted.
On 2/23/15, at 2:13 p.m. peeling paint was noted on the upper portion of the wall behind the toilet,

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in the bathroom used by room 107. The area of peeling paint was also a different color than the rest of the wall.
On 2/23/15, at 3:08 p.m. a large crack, approximately the length of half the wall, was observed between the two beds in room 17. The bathroom, shared with room 15 had a large rust colored stain around the toilet, which resulted in a surface which could not be cleaned. The grab bars near the toilet had pieces of tape on them which were stained brown. The wall by bed one was gouged and contained peeling paint.
On 2/23/15, at 5:25 p.m. two patched and plastered areas, measuring approximately four by four inches were noted by the towel rack in the bathroom shared by rooms 101. These patched areas had not been sanded and prepped for painting.
On 2/23/15, at 6:04 p.m. in the bathroom shared between room 15 and room 17 soiled tape was noted on the grab bars by the toilet and a brown stained ceiling tile was noted above the toilet.
During environmental tour with the director of environmental services [DES] on 2/24/15, between 1:29 p.m. and 2:30 p.m. the following concerns were noted, which were confirmed by the DES.

In the bathroom of room 107, the DES confirmed the peeling paint and the area was a different color than the rest of the wall. The DES reported he was not aware of the concern.

In room 103, a brown mark was noted on the wall. R83 reported the mark had been there since she was admitted. The DES was unaware of the concern.

The DES confirmed the wall in the bathroom of room 101 had been patched, but not sanded or

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prepped for painting. The DES explained the patch work on the wall had not been finished. The DES was not aware of the concern.

The DES confirmed soiled tape on the toilet grab bars near the toilet, the red ring around the toilet base and the dark spot on the ceiling in the bathroom between rooms 15 and 17. The DES reported the tape on the handle bars was not a cleanable surface and was not sure why it would be there.

The shower and tub room on the North Unit was toured with the DES. Cobwebs were found in the corner. The black non-skid tape on the floor was peeling off. There were brownish/red marks in the grout between the tiles of the floor and wall of the shower. Cracks were found in several tiles near the floor. The DES reported he was unaware of the maintenance and cleanliness issues.

The wall on the North Unit had a reddish brown line coming from the water fountain, down to the floor. A small reddish brown mark was on the carpet under the water fountain. The DES confirmed the concerns.

In the bathroom between rooms 10 and 12 a reddish brown ring was found on the floor. A round brown mark was found on the ceiling tiles. The DES reported he had previously repaired the ceiling tiles, but they returned.

On 2/24/15, the DES reported there was a preventative maintenance schedule posted on the wall in the maintenance room. This document directed staff to perform preventative maintenance in the resident rooms on an annual basis only. None had been completed yet. The DES explained when staffing in the maintenance

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department changed, there were tasks which were not completed as it was unclear who was responsible for them. The DES reported no preventative maintenance audits or inspections were done for resident bathrooms and resident rooms and was unable to provide documentation of any audits or resident room/bathroom inspections.

The Whirlpool-Shower Room policy, last revised November 2006, directed staff to: "2. Damp dust all sills and ledges using a soft clean cloth and disinfectant cleaner solution. 3. Spot clean walls, doors and partitions to remove smudges. Use soft, clean cloth with disinfectant cleaner solution and wipe dry. 4. Damp dust all surfaces (the outside of cabinets and storage areas with soft clean cloth and disinfectant cleaner solution. Wipe dry to avoid spotting. 5. Clean sink and faucets chrome areas with disinfectant cleaner, wipe to shine with dry clean cloth. 6. Dust mop all hard floor surfaces with a clean dust mop. 7. Using a damp floor mop and neutral cleaner solution, damp mop all hard floor surfaces. Repeat if floor is heavily soiled. 8. If hard water stains/soap films occur, use a neutral detergent cleaner."

The Restroom Cleaning Procedure, last revised November 2006, directed staff to: "2. Sanitize toilet bowls; place disinfectant cleaners/or toilet bowl cleaner in toilet bowl; do not scrub at this time. 3. Spray all fixtures with disinfectant cleaner solution. Wipe dry with clean cloth. Include mirror, light fixtures, pipes under sink, etc. 4. Clean wash stands; use disinfectant cleaner solution. Dry and/or polish with soft rag. 5. Apply bowl cleaner to the swab/brush and vigorously scrub the bowl. Wipe top bottom of seats with disinfectant cleaner dispensed from spray bottle. 6. Replenish

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21665	Continued From page 38 supplies: paper towels, toilet paper, liquid or bar soap and dispensing machine supplies. 7. Dust mop floor, see Section II. L. 8. Damp mop floor; follow Damp Mopping Procedure (Section II. M). Notify supervisor if floor requires additional attention. 9. Once a week, clean the mop boards in the restrooms with a solution of neutral cleaner solution." The DES was not able to provide any additional housekeeping or preventative maintenance procedures. On 2/25/15, at 8:30 a.m. the floor tiles in the laundry processing, storage, soiled linen area were observed to be peeling away from the floor or missing, exposing the concrete beneath. On 2/25/15, at 9:20 a.m. the DES was interviewed regarding the missing and peeling floor tiles in the laundry. The DES stated "I guess I never really noticed." the condition of the floor tiles in the laundry. On 2/26/15, at 11:15 a.m. the administrator stated they were not aware of the condition of the laundry room floor tiles. SUGGESTED METHOD OF CORRECTION:The administrator or designee, could educate staff regarding the importance of a safe, clean, functional and homelike environment. The administrator or designee, could coordinate with maintenance and housekeeping staff to repair and clean areas of concern and conduct periodic audits of areas residents frequent to ensure a safe, clean, functional and homelike environment is maintained to the extent possible.	21665		

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21665	Continued From page 39 TIME PERIOD FOR CORRECTION: Thirty (30) days.	21665		