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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: L513

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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 **01/12/18** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

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

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michelle Thompson, HFE NE II 01/25/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Assurance Supervisor 05/10/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(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
01/18/2018
(L33)

DETERMINATION APPROVAL

CCN: 24-5278

On December 1, 2017, an extended survey was completed at this facility. The most serious deficiency (F-689) was cited at S/S level of J. Conditions in the facility at the time of the survey constituted both Immediate Jeopardy (IJ) and Substandard Quality of Care (SQC) to resident health and safety. The IJ began on November 28, and the Director of Nursing and Director of Environmental Services were notified on 11/29/17, at 5:06 p.m. The IJ was removed on 12/1/2017 at 2:19 p.m., however, non-compliance remained at an isolated scope and severity that indicated no actual harm with potential for more than minimal harm (Level D).

As a result of the survey findings, the Department imposed the Category 1 remedy of State Monitoring, effective December 20, 2017.

In addition, we recommended the CMS RO impose the following enforcement action:

-Civil Monetary Penalty for deficiency cited at F-689.

The facility is subject to a two-year loss of NATCEP beginning November 28, 2017, as a result of the extended survey that identified the SQC.

On January 12, 2018, MDH surveyors completed an on-site PCR, and on December 28, 2017, the MN Department of Public Safety completed a PCR. They found that the facility had corrected the deficiencies based on its plan of correction as of December 29, 2017.

As result of the revisit findings, we discontinued the Category 1 Remedy of State Monitoring effective December 29, 2017.

In addition, we recommended to your office imposition of the following remedy:

-CMP for the deficiency cited at F-689.

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245278 January 25, 2018

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Dear Ms. Salonek:

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 December 29, 2017 the above facility is recommended for:

32 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 32 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 related to this electronic notice.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

Electronically delivered January 25, 2018

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

RE: Project Number S5278025

Dear Ms. Salonek:

On December 15, 2017, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 20, 2017. (42 CFR 488.422)

On December 15, 2017, we recommended to the Centers for Medicare and Medicaid Services (CMS) informed the following enforcement remedy be imposed:

- Civil money penalty for the deficiency cited at F-689. (42 CFR 488.430 through 488.444)

This was based on the deficiencies cited by this Department for an extended survey completed on December 1, 2017. The most serious deficiency was found to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required.

On January 12, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 28, 2017 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 an extended survey, completed on December 1, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 29, 2017. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our extended survey, completed on December 1, 2017, as of December 29, 2017.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective December 29, 2017.

However, as we notified you in our letter of December 15, 2017, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from December 1, 2017.

In addition, this Department recommended to the CMS Region V Office that the following enforcement remedy be imposed:

- Civil money penalty of for the deficiency cited at F-689. (42 CFR 488.430 through 488.444)

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

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 25, 2018

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Re: Reinspection Results - Project Number S5278025

Dear Ms. Salonek:

On January 12, 2018, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 1, 2017, with orders received by you on December 18, 2017. At this time these orders were found to be corrected.

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

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: L513

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00019

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245278**

2.STATE VENDOR OR MEDICAID NO.
(L2) **608716700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - HOWARD LAKE**
(L4) **413 13TH AVENUE**
(L5) **HOWARD LAKE, MN** (L6) **55349**

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 **12/01/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **32** (L18)
13.Total Certified Beds **32** (L17)

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	32			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE — Date :
Austin Fry, HFE-NE II — 12/29/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Anne Peterson, Enforcement Specialist — 01/16/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1985
(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

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

On 11/28/17-12/1/07, an extended survey was completed at this facility. The most serious deficiency, F-689, Free of Accident Hazards/Supervision/Devices, was cited at a scope and severity (S/S) of “J” and was also cited as substandard quality of care (SQC). The immediate jeopardy (IJ) began on 11/28/17 and was removed on 12/1/2017 at 2:19 p.m. But non-compliance remained at an isolated scope and severity that indicated no actual harm with potential for more than minimal harm (Level D). CMS was notified of the IJ on 11/29/2017. The facility has not been cited for a S/S of “G”-or-above deficiency in the last 2 calendar years.

Electronically delivered

December 15, 2017

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

RE: Project Number S5278025

Dear Ms. Salonek:

On December 1, 2017, an extended 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J) whereby corrections were required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

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

Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;

No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

Potential Consequences - the consequences of not attaining substantial compliance 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.

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on December 1, 2017, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

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:

Brenda Fischer, Unit Supervisor
St. Cloud A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: brenda.fischer@state.mn.us
Phone: (320) 223-7338
Fax: (320) 223-7348

NO OPPORTUNITY TO CORRECT - REMEDIES

CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when immediate jeopardy has been identified. Your facility meets this criterion. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 20, 2017. (42 CFR 488.422)

In addition, the Department recommended the enforcement remedy listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F-689. (42 CFR 488.430 through 488.444)

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Howard Lake is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective December 1, 2017. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an

administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is

acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the 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.

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 March 1, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 1, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

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

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245278	A. BUILDING _____ B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

(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 On 11/28/17. through 12/1/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ), substandard quality of care, at F689 when the facility failed to ensure a resident with known incidents of cigarette burns to clothing and skin was not comprehensively reassessed and new interventions developed to provide adequate safety with unsupervised smoking. The director of nursing (DON) and director of environmental services (DES) were notified of the IJ on 11/29/17, and it was removed on 12/1/17, at 2:19 p.m. when the facility implemented a removal plan which included reassessing the resident for safety with unsupervised smoking, providing education to direct care staff related to reporting burns and injuries, and completing an occupational therapy (OT) evaluation to help determine and implement interventions to allow the resident to smoke safely unsupervised. In addition, an extended survey was completed on 12/1/17, for substandard quality of care. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2017

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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F 000	Continued From page 1 Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 residents (R4) reviewed for urinary tract infection(s). Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2017, identified "Section I : Active Diagnoses" to be completed with an intent of generating, "an updated, accurate picture of the resident's current health status." Further, the manual provided several coding instructions directing staff to select any current diagnosis' including an option of, "I2300, urinary tract infections [UTI] (last 30 days)." R4's admission MDS dated 9/19/17, identified R4 had intact cognition. Further, "Section I - Active Diagnoses," of the MDS listed several active diagnosis' for R4 which included having I2300 selected for a UTI currently or within the last 30 day period.	F 641	Preparation and execution of this response and plan of correction does not constitute admission or agreement by the provider of the truth of the facts or 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 provision of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual. F641-Accuracy of Assessments – D level 1. R4's MDS was modified on Thursday, November 30th to reflect her accurate health status and that she did not have a UTI.	12/29/17

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F 641	Continued From page 2 When interviewed on 11/28/17, at 10:18 a.m. R4 stated she had a UTI a "couple years" prior, however, had no recent infections since adding she felt her health was good. R4's progress note dated 9/21/17, identified R4 had a history of urinary tract infection (UTI), however, "does not have a current diagnosis and is continent." R4's medical record was reviewed and lacked any evidence R4 had a current UTI or had been diagnosed with one in the 30 days prior to admission to the facility. When interviewed on 11/30/17, at 5:00 p.m. the assistant director of nursing (ADON) stated she completed the MDS' for the facility. R4 had a urine culture obtained and completed at the clinic just prior to her admission to the facility, however, it was negative for infection and no antibiotic had even been started. ADON explained the computer system had auto-populated the MDS answer on the MDS for R4 regarding UTI, however, again reiterated she did not have a UTI. Further, ADON stated a modification to the MDS would be completed adding it was important to code the MDS accurately, "to make sure we get the correct payment and [staff are] taking proper care of the resident." A facility Assessment (MDS) policy dated 11/2015, identified a purpose of ensuring resident assessments are completed "in compliance with appropriate regulations," and directed each individual who completes a portion of the assessment to "sign and certify the accuracy of that portion."	F 641	2. All current residents who have an active diagnosis of UTI coded on the most recent MDS will be reviewed to ensure MDS is coded accurately, to reflect their current health status of UTI. 3. MDS coordinator will be provided with re-education by DON or designee by 12/29/17 regarding active diagnosis entered upon admission and proper section I MDS coding. 4. The DON or designee will conduct MDS Section I audits for R4 and random other residents to ensure they are accurately coded weekly X 4, then monthly X 3. Audit results will be reviewed by the facility QAPI committee for further recommendations.	

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F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include urinary incontinence for 1 of 1 residents (R6) who was identified with urinary incontinence. Findings include: R6's most recent quarterly MDS dated 9/20/17,	F 657	F657-Care Plan Timing and Revision - D level 1. R6's care plan was updated 12/18/17 to reflect resident current health status for urinary incontinence. A new bladder assessment was initiated on 12/18/17 and will be completed by 12/21/17 and care	12/29/17

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F 657	Continued From page 4 identified R6 was cognitively intact and required limited assistance with toileting. Further, the MDS identified R6 was occasionally incontinent of urine (less than seven episodes of incontinence). R6's care plan dated 9/28/17, identified R6 had a self care performance deficit related to fatigue and limited mobility. The care plan did not indicate she was incontinent of urine as identified on her MDS. During interview on 11/30/17, at 1:35 p.m. nursing assistant (NA)-C stated that she worked the day shift and R6's was usually incontinent twice a shift when she was working. During interview 11/30/17, at 1:59 p.m. registered nurse (RN)-A stated R6 was occasionally incontinent of urine and it should have been identified and addressed on her care plan. A facility Comprehensive Care Plan and Care Conferences policy dated 9/17, identified a purpose of creating a "holistic and person-centered care plan" for each resident. The policy directed the care plan should be reviewed when each MDS is completed and care plans "must be revised as the resident's needs/status changes."	F 657	plan will be updated as appropriate. 2. All current residents who have been identified per the MDS for bladder incontinence have been reviewed to ensure that all assessments and plan of care documentation have been completed per facility policy and procedure. 3. The DON or designee will provide re-education on comprehensively assessing/re-assessing and care planning for urinary incontinence per GSS policy and procedure. 4. The DON or designee will conduct MDS Section H Bowel and Bladder continence audits for R6 and random other residents weekly X 4, and then monthly X 3 to ensure care plans reflect their urinary continence needs. Audit results will be reviewed by QAPI Committee for further recommendations	
F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate	F 689		12/29/17

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F 689	Continued From page 5 supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety with unsupervised smoking for 1 of 1 residents (R8) identified to have cigarette burns on their clothing and skin. This resulted in an immediate jeopardy (IJ) situation, substandard quality of care, for R8 who remained at risk for burns and serious injury with unsupervised smoking. The IJ began on 11/28/17, when it was identified R8 had sustained repeated incidents of cigarette burns to his clothing and skin from unsupervised smoking. Although direct care staff had knowledge of these incidents, they had not been addressed and R8 was not comprehensively reassessed and interventions developed to provide adequate safety with independent, unsupervised smoking. On 11/29/17, at 5:06 p.m. the director of nursing (DON) and director of environmental services (DES) were notified of the IJ for R8. The IJ was removed on 12/1/17, at 2:19 p.m., however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: R8's annual Minimum Data Set (MDS) dated 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. yelling, cursing) and did not display any episodes of rejection of care. R8's medical diagnoses	F 689	F689-Free of Accident Hazards/Supervision/Devices - J level 1. R8's care plan was updated on 11/29/17 to reflect safety hazards when smoking unsupervised. Smoking safety risk assessment completed on 11/29/17. Smoking cessation offered and declined by R8 11/29/17. Care plan was updated to include skin checks and inspection of clothing (for burns) daily at HS from 11/29/17 thru 12/13/2017. Weekly licensed nurse skin checks thereafter per facility policy and procedure. Occupational Therapy conducted a smoking safety evaluation on 11/30/17 and 12/1/17 to determine if R8 would accept any adaptive smoking equipment to increase safety. Cognitive testing was also offered. R8 declined any adaptive equipment. The cognitive testing results showed no change in cognition. R8's primary physician provided risks of smoking and offered smoking cessation products on 11/30/17, which R8 declined. His BIM score on 9/13/17 was 15/15 indicating he is capable of making these decisions. 2. R8 is the only resident in the facility that smokes. Any future residents who smoke that elect to be admitted despite the center's non-smoking policy will be assessed for smoking safety, and person centered approaches will be implemented.	

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F 689	Continued From page 6 included quadriplegia (paralysis of all four limbs) and muscle weakness. Further, R8 required extensive assistance with activities of daily living (ADLs), total assistance from staff for transfers, and currently used tobacco products, however, displayed no skin tears, burns (2nd or 3rd degree) or other open lesions on his skin. Further, R8's Medical Diagnosis listing printed 11/29/17, identified R8 had a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles, tendons or other tissues often leading to deformity or rigidity of a joint) to an unspecified site. R8's last completed Tobacco Use Assessment dated 9/14/16, identified R8 currently used tobacco and smoked over 10 times a day during all hours (i.e. morning, afternoon, night) with no desire to quit. R8 was able to make decisions regarding daily life independently and demonstrated no vision impairment(s), however, did have dexterity concerns which, "would affect his/her ability to smoke or use tobacco products" according to the assessment. The assessment did not identify what R8's identified dexterity concerns were, nor any information on how they would be addressed. R8 displayed no physical limitations which would interfere with their ability to get outside or back in the center. The assessment listed a section labeled, "Safety," which identified R8 was able to light his own cigarette and contained a question of, "Resident need for adaptive equipment," along with several choices to select including a smoking apron, cigarette holder, supervision, one to one assistance. The option for, "None of the above," was checked. Further, the assessment identified R8 had no history or incidents with dropping the cigarette, falling asleep while smoking, burning	F 689	3. DON provided 1:1 education for staff present on 11/29/17 and 11/30/17 and 12/01/17, and continued until all staff were educated (12/8/17). Topics of education included: using the eINTERACT stop and watch; the importance of communicating any changes noted in residents; and reporting safety hazards or injuries immediately. Laundry staff will notify DON or designee of any changes found in resident personal clothing. 4. Audits will be conducted for R8 and any residents that smoke weekly X 4, then monthly X 3 to ensure skin checks are completed and addressed appropriately. Audits will be conducted quarterly X 3, to ensure quarterly smoking assessment is completed and addressed appropriately. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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himself or clothing, or other unacceptable tobacco-related behavior(s) in the past. The assessment lacked any information on physical location for R8's smoking, his ability to hold a cigarette or ash during use, or any history of attempted interventions which had been refused or unsuccessful for R8.

R8's care plan printed 11/29/17, identified R8 had bilateral hand contractures due to a spinal cord injury along with limited physical mobility related to quadriplegia. R8 was unable to transfer without staff assistance and a mechanical lift device, and demonstrated potential mood concerns along with notation he, "easily angers towards staff." Further, the care plan identified R8 used tobacco products off facility grounds and listed a goal of, "[R8] will safely use tobacco products in designated area. I will be free from burns." The only intervention listed to help meet this goal was identified as, "I am independent with tobacco use, cigarettes and lighter are in a pouch on my wheelchair and always with me." The care plan lacked any further information, including any past offered or refused interventions, pertaining to R8's unsupervised smoking.

On 11/28/17, at 1:58 p.m. R8 was observed to smoke. R8 wheeled himself out of his room in an electric wheelchair and proceeded down the hallway. R8 had visible contractures of his fingers on both hands. R8 proceeded to wheel himself past the reception desk in the main lobby of the facility and did not sign himself out of the facility prior to exiting the nursing home and going down to the end of the driveway, however, he remained on the nursing home property. R8 removed an opened package of cigarettes from his gray colored hooded sweatshirt front pocket

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and turned it upside down on his lap exposing a cigarette and standard lighter with a plastic body and metal sparkwheel.

R8 picked up the cigarette using his thumb and pointer finger and placed it into his mouth, the rest of his fingers being contacted inwards towards his palm(s). R8 attempted several times to light the cigarette in his mouth using the lighter, however, was unable to after several attempts. R8 stated he had, "lots of years practice," lighting his cigarettes in the wind and removed it from his mouth. R8 then used his right hand to hold the cigarette with his thumb and first finger as the remaining fingers were contracted inwards towards the palm. R8 used his opposite hand to hold the lighter. R8 then pressed into his abdomen with both hands while flicking the lighter several times with visible sparks and open flame being held immediately next to his sweatshirt as he attempted to light the cigarette and bring it to his mouth. R8 lit the cigarette and used his right hand to bring it to his mouth.

R8 stated he smokes several times a day often going outside on his own to smoke, "once every hour and a half or so." R8 stated he has burned himself before while smoking as ash or the "cigarette cherry [red hot ash on the end of the lit cigarette]" will fall off and he is unable to feel it on his skin due to poor sensation from his shoulders downward. R8 stated he last burned himself a couple weeks prior and showed the surveyor a visible, light brown colored scabbed area surrounded by light pink colored skin on the inner aspect of his first finger of his right hand. The area was approximately 0.5 centimeters (cm) in diameter and R8 added he had sustained burns, just like the one he showed, before. In addition,

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R8 then lifted up his gray colored sweatshirt and showed a visible, approximately 2.5 cm in diameter, hole in the center of the front side of the sweatshirt. R8 stated it was from a cigarette ash which had fallen on it from awhile prior.

R8 stated none of the staff had spoken to him about his smoking, nor do they come outside with him while he smokes, however, when questioned about a smoking apron being used he replied, "heck no." R8 stated if he were to have a complication or potentially start his clothing on fire, he would use his cell phone to call the nursing home and ask for help. R8 finished smoking his cigarette at 2:08 p.m. and removed it from his mouth using his right hand and tossed the remaining filter and butt into the street. R8 did not extinguish the cigarette before disposing of it.

R8's most recently completed Skin Observation - V2 dated 11/21/17, identified R8 had a chronic pressure ulcer on his gluteal fold(s), however lacked any identified burns or skin injuries on his right hand.

When interviewed on 11/28/17, at 2:24 p.m. nursing assistant (NA)-A stated R8 goes out to smoke after he gets up for the day and then is typically "gone a few hours" around town. NA-A stated she had never personally helped or gone outside to observe R8 while smoking, however, had noticed burn holes in his clothing before. The most recent burn holes being on his winter jacket, however, NA-A stated she was not sure if these were old or new burn holes though as he owned the coat for awhile. Further, NA-A stated R8 was independent with his smoking and staff did not help him, nor did R8 wear or use any

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adaptive devices while smoking to her knowledge.

During interview on 11/28/17, at 2:28 p.m. NA-B stated R8 smoked independently and staff were, "not supposed to," help him as if a resident wanted to smoke while living at the nursing home, they had to be able to do it without staff assistance because, "That's just the policy here." NA-B stated she had noticed R8 to have cigarette burns on his hands before because it "gets too hot and creates a blister," adding this happened "every couple months." NA-B stated she last observed a burn on R8's hand approximately three months prior when completing range of motion on his hand(s) further adding, "that's how I always notice them." Further, NA-B stated she had reported these burns to the nurse(s), however, was unable to recall anyone specific it had been reported to. On 11/28/17, at 2:34 p.m. the surveyor and NA-B attempted to visit with R8 to observe his burn and go through his clothing to check for additional burn holes, however, R8 had left the facility and was not available.

During interview on 11/29/17, at 8:49 a.m. laundry assistant (LA)-A stated she completed all personal laundry for R8 and was aware he smoked adding his hands "aren't 100 percent functional." LA-A stated she had never noticed burn holes in his clothing before, however, added she doesn't "look at them that close." LA-A turned and removed several pieces of clothing which had been hanging on a rack in the laundry room. R8 had a plain green colored shirt with several holes in the front. LA-A stated she felt these were "wear holes" though. LA-A removed the gray colored sweatshirt R8 had worn the day prior, when observed to smoke by the surveyor,

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and inspected it. LA-A verified a hole in the front of the sweatshirt and stated, "I would say that was a cigarette burn." Further, LA-A stated she currently was not inspecting R8's clothing when completing his laundry, however, added "I guess I should be checking [his] clothes better."

When interviewed on 11/29/17, at 9:33 a.m. trained medication aide (TMA)-A stated R8 was a smoker and goes "down to the end of the property" to smoke after he gets up for the day. TMA-A stated R8 was independent with smoking and was able to safely use cigarettes and a lighter without assistance. TMA-A was unaware of any burns on R8's skin or clothing, however, stated staff should "report it right away" to the charge nurse and complete an Stop-and-Watch (an 'early warning tool' used when a change is identified while caring for a resident). TMA-A stated she "would assume" R8 would just put out the cigarette and/or fire, if one occurred, while he was smoking as R8 took "full responsibility" for himself when smoking. R8 was to check in and out using a paper log when going outside to smoke. TMA-A showed this log to the surveyor which identified several empty spaces when R8 failed to sign himself back into the facility when he returned. TMA-A reviewed the record and stated R8 "should be" filling out the sign in/out record as "he's been told to" use it. Further, TMA-A stated staff did not inspect R8's skin when he returned from smoking or from his outings around town.

An undated, blank "Stop and Watch Early Warning Tool" was provided. The form listed instructions to complete one when, "you have identified a change while caring for or observing a resident," then to provide the form to a nurse for

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follow-up. Some examples provided on the form to be watchful for included, "Seems different than usual," and, "Change in skin color or condition." R8's medical record lacked any evidence one of these had been completed for any burns in his skin or clothing.

R8's medical record was reviewed. A handwritten progress note dated 4/16/13, identified R8 to smoke and did not want to pursue quitting at the time further adding him to, "understands risk/benefit of all education and choices that he makes." The note lacked any information on what information related to safe smoking had been provided, nor what interventions, if any, were discussed and/or refused to ensure safe unsupervised smoking.

An electronic progress note dated 6/21/17, identified R8 "continues to be safe to smoke his cigarettes independently and hold them and the lighter at all times." The note lacked any observation, assessment or dictation to describe how this determination had been made of R8's unsupervised smoking abilities.

R8's physician progress note(s) dated 2/14/17, through 11/21/17 (most recent visit), were reviewed and identified R8 had been seen by his physician a total of seven times in the 10 month period. R8 was identified as a "current smoker" on each of the visits. On 2/14/17, R8 was identified as having quadriplegia and needed to remain on Valium (medication used to treat anxiety and muscle spasms) "for control of spasms". All of the provided notes lacked any dictation regarding smoking related injuries or his unsupervised smoking abilities.

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Further, the medical record lacked any identified reassessment of R8's unsupervised smoking abilities despite obtaining burns on clothing and skin described by NA-A and NA-B; any history of occupational therapy (OT) interventions for his smoking; nor evidence of other attempted interventions to promote safety with unsupervised smoking.

In addition, the record lacked any documented or recorded incident report(s) related to the cigarette burns sustained on his clothing and skin as described by NA-A and NA-B, nor any evidence the facility had attempted to provide on-going collaboration with R8 to develop and implement interventions or therapies related to his unsupervised smoking. The facility provided no additional notes or medical record entries regarding these items during the survey.

During interview on 11/29/17, at 12:47 p.m. NA-E stated she was aware R8 smoked and added it was the "first thing he does when he goes and gets up." R8 was independent with his smoking and when he leaves to smoke, he "is responsible for himself then." NA-E had never noticed or been told of any burns on R8's skin or clothing before; nor had she ever seen him wear a smoking apron before, however, felt it would "be a nice thing to have" as R8 was not someone to report incidents, like dropping the cigarette or burning himself, to the staff.

When interviewed on 11/29/17, at 12:54 p.m. NA-F stated staff "don't help him [R8]" with smoking. R8 goes outside and smokes on the street and, "whatever happens outside of this building, we don't know it." Further, NA-F stated staff were not completing any formal skin checks

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or other interventions upon his return, but merely asking him "how was it?"

On 11/29/17, at 1:03 p.m. registered nurse (RN)-C was interviewed and identified R8 was a quadriplegic, had poor sensation and contracted fingers on both hands and was supposed to sign himself out of the building each time he wanted to smoke as he was unable to smoke on facility grounds. RN-C was unaware of any burns on R8's clothing or skin resulted from cigarette smoking as "nothing got reported." RN-C stated if staff are noticing burns on his clothing and skin, it should be reported to the nurses immediately so the physician can be updated and an incident report can be completed. Further, RN-C stated R8 was independent with using his cigarettes and lighter, however, added she had never watched him smoke personally nor was she aware how he had been assessed to be safe with smoking before the survey.

During interview on 11/29/17, at 1:27 p.m. RN-B stated she had worked at the facility for approximately two and a half years and R8 had smoked "since he came" to the nursing home years prior. R8 typically gets assisted out of bed and then "does his own thing in the community" as he is unable to smoke on the campus grounds, however, RN-B added at times R8 will just go down to the end of the driveway and smoke in the later evening hours. RN-B stated she "would assume" a smoking assessment had been done on admission for R8, however, was not sure adding she had never assessed him with safe unsupervised smoking before. RN-B stated she was unaware R8 had been sustaining cigarette burns on his clothing and skin as it had not been reported to her or raised as a concern

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until now. RN-B stated she did not think OT had ever been consulted in the past to help address R8's unsupervised smoking adding, "not since I've been here." Further, RN-B stated R8 burning himself while smoking made her "feel like I should do something right now" to help him as "we got to be keeping him safe."

When interviewed on 11/29/17, at 1:55 p.m. RN-D stated she was aware R8 goes outside to smoke, however, added she did not know the physical location(s) he was smoking when outside as, "I don't feel like I'm his babysitter." R8 was "his person" when he left the facility. RN-D stated she was unaware R8 had a current cigarette burn on his hand, nor was she aware he had burn holes being observed in his clothing by staff. RN-D felt with R8's paralysis and poor sensation contributed that he, "might not know its [cigarette burning his skin or clothes] happening," and NA staff should be reporting those things to nursing so it could be addressed "for the resident's safety."

On 11/29/17, at 2:15 p.m. the assistant director of nursing (ADON) was interviewed. ADON stated she had worked at the nursing home for nearly four years and R8 had smoked during that entire time. R8 was last assessed by ADON for smoking in September 2016 (assessment dated 9/14/16), and she felt he was safe at the time. ADON stated R8 "uses his thumbs a lot with everything" including lighting his cigarettes, however, she was unable to recall how R8 lit the cigarette in 2016 when she last assessed him. ADON stated she was unaware R8 had been burning his clothes and skin with his cigarettes adding the NA staff had never reported those concerns to her. If the NA staff identify a new

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concern with a resident, like cigarette burns in clothing and/or on their skin, a stop-and-watch tool should have been completed so it could be addressed and R8 could be reassessed for his safety with smoking. Further, ADON stated she was unaware if anyone had discussed the risk of burns with R8, nor had OT ever been consulted to help develop interventions to ensure R8 was safe with his unsupervised smoking.

A provided UDA (user defined assessments) Reference Guide dated 12/1/17, was provided which identified it had been in use at the facility prior to survey. The guide listed several assessments along with their use, purpose and when to complete them. The Tobacco Use Assessment was listed which should be completed by a registered nurse or social worker, " ... on admission for residents who use tobacco products; required for all residents who smoke or use tobacco products when not previously completed; or when there is a change in cognitive ability, judgment, manual dexterity, and/or mobility." Further, the guide directed the assessment should be completed when an "incident" occurred and listed, "smoking injury" as an injury type.

During interview on 11/29/17, at 2:28 p.m. OT-A stated she was new to the nursing home and unaware of the facility's policies and procedures regarding having a smoking safety assessment completed. OT-A reviewed the therapy record and stated there was no history of OT being consulted for R8 for his unsupervised smoking, however, OT-A stated there were definitely "some compensatory methods" which could be used so R8 did not have use his abdomen or chest to light his cigarettes and potentially burn himself or start

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his clothing on fire; including assessing his cognition, looking at his dexterity and handling skills while using a cigarette and "just do a comprehensive assessment." R8 had impaired sensation and OT-A questioned, "Does he [R8] even know he's being burned?" Further, OT-A stated if someone with impaired dexterity and sensation was sustaining cigarette burns with unsupervised smoking, it would be OT appropriate to review them so as to "assess functional deficits and safety."

On 11/29/17, at 2:45 p.m. the director of nursing (DON) was interviewed regarding R8's unsupervised smoking. DON stated she started working at the nursing home in June 2017, and to her knowledge R8 had always refused interventions from staff for his smoking. R8 was "his own person and will do whatever he dang well pleases," and had a history of telling the staff things, then being upset about them the following day and yelling at them. DON stated the interventions offered to him in the past with his smoking were done as in passing conversations and they just had not been documented. DON stated she was unaware R8 had been burning himself while smoking as it had not been reported, however, if NA staff noticed cigarette burns in his clothing or on his skin, they should have completed a Stop-and-Watch so the burns could be treated and staff "can be looking at it." Further, DON stated the facility was ultimately responsible to ensure R8 was safe, however, when he signs himself out and leaves, he was his own person. During a follow up interview on 11/29/17, at 5:06 p.m. DON stated a report was made to the State agency (SA) regarding potential neglect for R8 since he had been sustaining cigarette burns from unsupervised

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smoking.

A facility Smoke-Free Locations policy dated 3/2016, identified it applied to skilled care and smoking inside Good Samaritan Society (GSS) buildings was not permitted. The policy directed, "All residents/clients who smoke or use tobacco products will be assessed." A procedure was listed which directed staff members would designate acceptable outdoor locations for resident smoking which "must be readily visible for staff member observation." Upon admission, residents who use tobacco will have a Tobacco Use Assessment completed. Further, additional assessments would be completed if a resident has a change in cognition, judgment, manual dexterity or mobility. The policy lacked any direction or procedure for staff to implement on how to address cigarette burn(s) on clothing and/or skin, should they occur.

A Smoking and Tobacco Use policy dated 4/2017, identified it applied to skilled care and listed a purpose of reaffirming the GSS commitment to "a safe and healthy environment for employees, residents and visitors." The policy directed smoking shall be done away from the main entrance of the facility in spaces which were "readily visible" to staff. Further, "Residents who smoke must not pose a safety hazard to themselves or others." The policy lacked any direction or procedure for staff to implement on how to address safety with smoking nor cigarette burn(s) on clothing and/or skin, should they occur.

No further policies or procedures related to smoking safety or unsupervised smoking were provided.

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The IJ which began on 11/28/17, was removed on 12/1/17, at 2:19 p.m. after the facility successfully implemented a removal plan which included the following:

- R8 was reassessed by nursing for unsupervised smoking which identified he required a smoking apron, cigarette holder, supervision and one on one assistance. R8 refused all of these interventions, however, R8 "agreed to [OT evaluation for safety]." Further, the assessment identified R8 to now have a history of smoking related incidents including "a self reported incident of burning his finger" which he failed to report as it was "not a big deal." A subsequent progress note for R8's smoking reassessment dated 11/29/17, at 6:45 p.m. was authored by ADON. ADON explained to R8 they had reported the burn(s) for potential neglect of care while R8 demonstrated how he smoked. R8 was identified as reporting he had a "shitty lighter" when observed by the surveyor on 11/28/17, and should have gotten a different one, "instead of fighting with the shitty one and almost burning my shirt."

- An OT consultation was made for R8 to screen, assess and develop interventions for safe, unsupervised smoking. A provided OT Daily Treatment Note dated 12/1/17, identified R8 as having an "incomplete SCI [spinal cord injury] at C5 - C7 [vertebrae]," who had impaired sensation, impaired upper body strength and impaired motor control. OT completed a smoking evaluation which identified R8 was able to strike the lighter away from his body, however, "[his] thumb still very near flame when lighting. Will need to further explore options to reduce risk of burn." Further, R8 agreed to trying a

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F 689	Continued From page 20 plastic-smoking adaptor and e-cigarettes, along with throwing out the cigarette mid-way "before hot end nears hand." - Educating all staff on ensuring cigarette burn(s) on clothing and/or skin were immediately reported and documented. On 12/1/17, from 2:01 p.m. to 2:18 p.m. nursing and direct care staff were interviewed to ensure training had been provided related to R8's unsupervised smoking including ensuring R8's skin and clothing was routinely monitored for potential burn injuries, use of the Stop-and-Watch tool and communicating changes in resident conditions timely, and documentation standards pertaining to a change in condition.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one	F 690		12/29/17

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F 690	Continued From page 21 is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively reassess 1 of 1 residents (R6) with a change in urinary continence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 6/21/17, indicated she was cognitively intact, had hypertension and diabetes mellitus. The MDS further indicated she was always continent of urine and was not on a toileting program. R6's quarterly MDS dated 9/20/17, indicated she was now occasionally incontinent of urine and was not on a toileting program. R6's care area assessment (CAA) dated 3/29/17, indicated she had urinary urgency and need for assist with toileting. The CAA indicated she received diuretics and did not indicate she was incontinent. R6's care plan dated 9/28/17, indicated she had	F 690	F690-Bowel/Bladder Incontinence, Catheter, UTI - D level 1. R6's care plan was updated 12/18/17 to reflect resident current health status for urinary incontinence. A new bladder assessment was initiated on 12/18/17 and will be completed by 12/21/17 and care plan will be updated as appropriate. 2. All current residents who have been identified per the MDS for bladder incontinence have been reviewed to ensure that all assessments and plan of care documentation have been completed per facility policy and procedure. 3. The DON or designee will provide re-education on comprehensively assessing/re-assessing and care planning for urinary incontinence per GSS policy	

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F 690	Continued From page 22 hypertension, type two diabetes and congestive heart failure. The care plan indicated she had activity of self care performance deficit related to fatigue and limited mobility. The care plan did not indicate she was incontinent of urine. R6's Bladder Incontinence Data Collection tool dated 10/2/16, indicated she was wet less often than daily with a medium amount and she wore a absorbent pad. The tool further indicated R6 denied incontinence and could not recall having trouble with it. R6 could not recall the two episodes documented since admission on 9/28/16. There were no further assessments done related to bladder incontinence. R6's Skin Observation dated 11/24/17, indicated she had excoriation to her right and left buttocks. R6's Point of Care (POC) response history for incontinence for the last 30 days indicated she was incontinent of urine 10 times in November. On 11/30/17, at 8:50 a.m. licensed practical nurse (LPN)- A and certified nursing assistant (CNA)- C were observed to place R6 onto the toilet. She was continent of urine and voided a small amount in the toilet. LPN-A was observed to clean R6's excoriated, reddened area that covered most of R6's right and left buttock. On 11/30/17, at 1:35 p.m. CNA-C stated that she worked the day shift and R6 was usually incontinent twice a shift when she worked. On 11/30/17, at 1:59 p.m. Registered Nurse (RN)-A stated R6 did not receive a bladder assessment after her change from continent of urine to occasionally incontinent of urine. RN-A stated the facility was aware this was an area	F 690	and procedure. 4. The DON or designee will conduct MDS Section H Bowel and Bladder continence audits for R6 and random other residents weekly X 4, and then monthly X 3 to ensure care plans reflect their urinary continence needs. Audit results will be reviewed by QAPI Committee for further recommendations.	

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F 690	Continued From page 23 they needed to work on and it was part of their performance improvement project. RN-A stated they wanted more residents to be continent of urine. RN-A further stated currently the computer program assessment tool did not provide an alert for quarterly bladder assessments so they were missed. In addition RN-A stated they were only able to print a history of incontinence going back 30 days based on nursing assistant documentation. During interview 12/1/17, at 8:03 a.m. CNA-D stated that when she worked with R6 she was usually continent of urine. Although R6 had a change in urinary incontinence the facility failed to reassess the incontinence to minimize the risk of further change. A facility policy Bladder Assessment revised 3/17, indicated the purpose is to review/assess bladder patterns, incontinence and frequency, to identify potentially reversible causes of incontinence and to identify the probable type of urinary incontinence and potential toileting programs. The Assessment indicated this should be done quarterly and care plan interventions should be individualized based on the CAA and modified as appropriate based on assessment/evaluation of the residents response to the interventions and success with attaining/maintaining bladder continence.	F 690		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program	F 880		12/29/17

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designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the

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F 880	Continued From page 25 least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a comprehensive infection control program which included data analysis of resident infections and trending to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 27 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from June 2017, through November 29, 2017. The facility provided a document, titled Monthly Report of Resident Infections In Center, with a	F 880	F880 Infection Prevention and Control - F level 1.&2. All residents had the potential to be affected. All residents were reviewed to determine if there were any infections requiring immediate action. None were noted. 3. The facility has implemented a system for identifying and documenting all infections. All infections will be noted by the attending nurse on the GSS 157 Infection tracking tool as they occur. The attending nurses will notify the Infection	

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F 880	Continued From page 26 line present for month and year. The headings on top of the graph identified the total number of infections, the number [of infections] center acquired (nosocomial), and the number community acquired. The columns on the logs included the following information: name, room number, date admitted, date of infection, site of infection, culture taken (yes or no), causative agent, antibiotic treatment, cautionary measure, isolation (yes or no), and center acquired (yes or no). This document did not have any designations for symptoms not treated with antibiotics or non-bacterial infections such as viral or fungal infections. The facility also provided documents titled Data Review Report, as well as a summary document titled monthly infection control report. The summary included a breakdown of infection types, and identified whether the infection was nosocomial or community acquired. Hand written entries at the bottom of the form were titled "Trends" and "Action Plan". A review of these logs identified the following: The document titled Monthly Report of Resident Infections in Center, dated June of 2017 identified six residents were treated with antibiotics for a total of 10 courses of antibiotic therapy. The categories of infection included the breakdown of infections as follows: Prophylactic antibiotic use - three residents; gastrointestinal (clostridium difficile - c. diff. a highly infectious bacterial illness which may cause diarrhea) - one resident; respiratory/lung infections - three residents; skin infections - two residents; and a urinary infection in one resident. A document titled Order Listing Report, dated June 28, 2017, identified residents	F 880	Control nurse when noting two or more like infections. The Infection Control nurse will utilize the GSS 157 tracking tool to conduct monthly trending of infections. These results will be reviewed by the QAPI committee monthly and action plans will be developed as appropriate. All nursing staff will be provided education on this process by the DON by 12/29/17. 4. Audits will be conducted by Infection Control nurse to ensure the GSS Infection tracking tool is being completed on a daily basis when a new infection is identified. These audits will be done weekly X 4, then monthly X 3. Audit results will be reviewed by the QAPI committee for further recommendations.	

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who had received antibiotics, antifungal's, antiviral's in the month of June. Although antifungal's and antiviral's were noted on the report, only those residents receiving antibiotics were listed on the report of infections. The Monthly Infection Control Report identified a total of one nosocomial infection and four community acquired infections, to total five identified infections, yet six residents were addressed on the document. A hand written narrative note, titled Trends, identified the presence of one continued infection from the previous month (May 2017), and identified the number of infections reflect a "Downward trend". Additional data was not included to identify the previous trends or any pattern identified. The action plan identified staff education on aspiration pneumonia with hard copy learning as well as urinary tract infections, and skin/soft tissue education. Although requested, a Data Review Report was not provided for 6/17.

The Monthly Report dated July of 2017, identified four residents were treated with antibiotics for a total of four courses of antibiotic therapy. The categories of infection included the following: respiratory/lung infections - three residents; skin infections - one resident; and a urinary infection in one resident. The Monthly Infection Control Report identified a total of one nosocomial infection, and two community acquired infections. A hand written narrative note titled Trends, identified a resolved urinary tract infection upon admission, with identified negative lab work. However, the resident continued on prophylactic antibiotic use. One incident was identified as skin/soft tissue healing without antibiotics. The initial log reflected intravenous antibiotics were implemented for treatment. The action plan

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identified staff education on handwashing and infection prevention provided at a staff meeting in July. A Data Review Report was provided for the month of 7/17. The positive findings identified one resident was treated for an upper respiratory tract infection, which was nosocomial. The infection remained isolated to one resident. The document additionally noted attempts to discontinue antibiotic therapy for a resident on a prophylactic antibiotic were successful. Although the review identified the data trending was positive, it did not provide a comparison to previous trends, nor did it identify a goal for the data measure, the goal was "to be determined". The document indicated the information had been reviewed by the QAPI (Quality Assurance Performance Improvement) group on 8/25/17, and no action was taken.

The report dated August 2017 identified three residents were treated with antibiotics for a total of three courses of antibiotic therapy. One resident was noted in each of the following categories: respiratory/lung infection, skin infection, and gastrointestinal. A document, titled Order Listing Report, dated 8/15/17, identified there was one resident being treated with antibiotic therapy through 8/18/17, and three individuals being treated with an antifungal powder. An Order Listing Report dated 9/1/17, identified one additional resident was treated with antibiotic therapy, and one resident continued to receive antifungal treatment. The Monthly Infection Control Report identified a total of two nosocomial infections, and one community acquired infection. A hand written narrative note, titled Trends, identified three infections of alternate sources with no trends noted. The note identified an episode of bronchitis was isolated

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with no spread of infection. The action plan identified staff re-education on isolation precautions related to recurrent problems with c. diff. A Data Review Report was provided for the month of 8/17. The positive findings identified one resident was treated for upper respiratory tract infection which was nosocomial, which remained isolated to one resident. The negative findings included prophylactic antibiotic treatment with risk versus benefit statement noted. It was also noted resident with c. diff positive culture will always test positive. The data review identified trending was positive, but no comparisons were provided. The data measure goal continued to indicate it was yet "to be determined". Although the review identified the data trending was positive, it did not provide a comparison to previous trends, nor did it identify a goal for the data measure. The information was noted to have been reviewed by the QAPI group on 9/20/17 with no action taken.

The Monthly Report for September of 2017 identified seven residents were treated with antibiotics for a total of eight courses of antibiotic therapy. Upon review of the entries, it was noted one entry was from 8/26/17. The categories of infection included the breakdown of infections as follows: skin infections - two residents, urinary infection in five residents, and c. diff. in one resident. An order listing report, dated 10/18/17, was provided for those receiving antibiotic and antifungal therapy. The Monthly Infection Control Report identified a total of three nosocomial infections, and five community acquired infections. A hand written narrative note, titled Trends, identified no trends were noted. A notation was also made identifying the c. diff. infection was isolated. It was noted three of five of the urinary tract infections were community

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acquired, one was nosocomial, and one was "procommunity admit." The action plan identified a "situation, background, assessment, recommendation (SBAR)" notification was provided to physicians, staff educated and interventions implemented. A note was written to monitor hand hygiene, however, it did identify how this would be done. A Data Review Report was requested but not provided for the month of 9/17.

The October 2017, report of resident infections in the center identified three residents with four courses of antibiotic therapy. The categories of infection included the breakdown of infections as follows: respiratory/lung - two residents, and gastrointestinal/colon - two residents. An order listing report, dated 11/13/17, was provided for those receiving antibiotic and antifungal therapy. The Monthly Infection Control Report identified a total of two nosocomial infections, and one community acquired infections. A hand written narrative note, titled Trends, identified no trends were noted. The action plan identified "flu [influenza]/pneumonia season approaching, noting reeducation was provided on precautions/vaccinations." A Data Review Report was provided for the month of October, 2017, and noted a positive data trending direction, however, the facility goal was yet to be determined. The information was noted to have been reviewed by the QAPI team on 11/17/17, and no action was taken.

The November 2017, report of resident infections in the center identified one resident, with only first name and first initial of the last name, with no additional documents provided. On three pink sticky notes there were four residents identified to have received antibiotic therapy on the following

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dates; 11/12/17, 11/17/17, 11/17/17, and 11/27/17. There were no additional documents provided when the Infection Control Log book was initially reviewed 11/28/17. Although requested, the Monthly Infection Control Report and Data Review report was not provided for 11/17.

During the interview on 12/1/17, at 9:43 a.m. the director of nursing (DON) stated the information regarding infections was obtained on residents admitting to the facility, with lab results recorded if received. The DON stated tracking and trending was monitored through QAPI. The DON stated the information on the infection control log is compiled monthly. Staff relayed information regarding current infections via the Communication Book and shift reports. However, the DON further stated the log was not used day to day as it was used for monthly tracking and trending. In reviewing training needs identified, the DON stated staff education had been provided for handwashing in 7/17. The DON identified an increase in prevalence of urinary tract infections in 9/17. The DON stated staff was monitored for ongoing handwashing techniques through observation. Although an increase in UTI's was identified, audits and/or return demonstrations of handwashing had not been implemented. The DON stated the infection rate was compared to the previous month, however there was no documentation to reflect this. A table titled Resident Infection Control Report, dated 2017 was provided with data entered from January thorough June, however, no analysis was provided regarding trending or interventions implemented.

A facility policy, titled Surveillance, reviewed

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F 880	Continued From page 32 10/17 identified surveillance as an activity to "find, analyze, control and prevent nosocomial infections." The definition further outlined the process as date collection, analysis of data, establishment of trends, passing the information on to those who need to take action and documentation in conclusion.	F 880		

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E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 11/28/17, through 12/1/17, during a recertification survey. The facility was in full compliance and no deficiencies are issued.	E 000		
F 000	INITIAL COMMENTS On 11/28/17. through 12/1/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with the regulations at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The survey resulted in an Immediate Jeopardy (IJ), substandard quality of care, at F689 when the facility failed to ensure a resident with known incidents of cigarette burns to clothing and skin was not comprehensively reassessed and new interventions developed to provide adequate safety with unsupervised smoking. The director of nursing (DON) and director of environmental services (DES) were notified of the IJ on 11/29/17, and it was removed on 12/1/17, at 2:19 p.m. when the facility implemented a removal plan which included reassessing the resident for safety with unsupervised smoking, providing education to direct care staff related to reporting burns and injuries, and completing an occupational therapy (OT) evaluation to help determine and implement interventions to allow the resident to smoke safely unsupervised. In addition, an extended survey was completed on 12/1/17, for substandard quality of care.	F 000		

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

Electronically Signed | 12/22/2017

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F 000	Continued From page 1 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 will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to accurately code the Minimum Data Set (MDS) for 1 of 1 residents (R4) reviewed for urinary tract infection(s). Findings include: The Centers for Medicare and Medicaid (CMS) Long-Term Care Resident Facility Assessment Instrument (RAI) 3.0 User's Manual dated 10/2017, identified "Section I : Active Diagnoses" to be completed with an intent of generating, "an updated, accurate picture of the resident's current health status." Further, the manual provided several coding instructions directing staff to select any current diagnosis' including an option of,	F 641	Preparation and execution of this response and plan of correction does not constitute admission or agreement by the provider of the truth of the facts or 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 provision of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual.	12/29/17

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F 641	Continued From page 2 "I2300, urinary tract infections [UTI] (last 30 days)." R4's admission MDS dated 9/19/17, identified R4 had intact cognition. Further, "Section I - Active Diagnoses," of the MDS listed several active diagnosis' for R4 which included having I2300 selected for a UTI currently or within the last 30 day period. When interviewed on 11/28/17, at 10:18 a.m. R4 stated she had a UTI a "couple years" prior, however, had no recent infections since adding she felt her health was good. R4's progress note dated 9/21/17, identified R4 had a history of urinary tract infection (UTI), however, "does not have a current diagnosis and is continent." R4's medical record was reviewed and lacked any evidence R4 had a current UTI or had been diagnosed with one in the 30 days prior to admission to the facility. When interviewed on 11/30/17, at 5:00 p.m. the assistant director of nursing (ADON) stated she completed the MDS' for the facility. R4 had a urine culture obtained and completed at the clinic just prior to her admission to the facility, however, it was negative for infection and no antibiotic had even been started. ADON explained the computer system had auto-populated the MDS answer on the MDS for R4 regarding UTI, however, again reiterated she did not have a UTI. Further, ADON stated a modification to the MDS would be completed adding it was important to code the MDS accurately, "to make sure we get the correct payment and [staff are] taking proper	F 641	F641-Accuracy of Assessments – D level 1. R4's MDS was modified on Thursday, November 30th to reflect her accurate health status and that she did not have a UTI. 2. All current residents who have an active diagnosis of UTI coded on the most recent MDS will be reviewed to ensure MDS is coded accurately, to reflect their current health status of UTI. 3. MDS coordinator will be provided with re-education by DON or designee by 12/29/17 regarding active diagnosis entered upon admission and proper section I MDS coding. 4. The DON or designee will conduct MDS Section I audits for R4 and random other residents to ensure they are accurately coded weekly X 4, then monthly X 3. Audit results will be reviewed by the facility QAPI committee for further recommendations.	

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F 641	Continued From page 3 care of the resident." A facility Assessment (MDS) policy dated 11/2015, identified a purpose of ensuring resident assessments are completed "in compliance with appropriate regulations," and directed each individual who completes a portion of the assessment to "sign and certify the accuracy of that portion."	F 641		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review	F 657		12/29/17

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F 657	Continued From page 4 assessments. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include urinary incontinence for 1 of 1 residents (R6) who was identified with urinary incontinence. Findings include: R6's most recent quarterly MDS dated 9/20/17, identified R6 was cognitively intact and required limited assistance with toileting. Further, the MDS identified R6 was occasionally incontinent of urine (less than seven episodes of incontinence). R6's care plan dated 9/28/17, identified R6 had a self care performance deficit related to fatigue and limited mobility. The care plan did not indicate she was incontinent of urine as identified on her MDS. During interview on 11/30/17, at 1:35 p.m. nursing assistant (NA)-C stated that she worked the day shift and R6's was usually incontinent twice a shift when she was working. During interview 11/30/17, at 1:59 p.m. registered nurse (RN)-A stated R6 was occasionally incontinent of urine and it should have been identified and addressed on her care plan. A facility Comprehensive Care Plan and Care Conferences policy dated 9/17, identified a purpose of creating a "holistic and person-centered care plan" for each resident. The policy directed the care plan should be reviewed when each MDS is completed and care plans "must be revised as the resident's	F 657	F657-Care Plan Timing and Revision - D level 1. R6's care plan was updated 12/18/17 to reflect resident current health status for urinary incontinence. A new bladder assessment was initiated on 12/18/17 and will be completed by 12/21/17 and care plan will be updated as appropriate. 2. All current residents who have been identified per the MDS for bladder incontinence have been reviewed to ensure that all assessments and plan of care documentation have been completed per facility policy and procedure. 3. The DON or designee will provide re-education on comprehensively assessing/re-assessing and care planning for urinary incontinence per GSS policy and procedure. 4. The DON or designee will conduct MDS Section H Bowel and Bladder continence audits for R6 and random other residents weekly X 4, and then monthly X 3 to ensure care plans reflect their urinary continence needs. Audit results will be reviewed by QAPI Committee for further recommendations	

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F 689 SS=J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety with unsupervised smoking for 1 of 1 residents (R8) identified to have cigarette burns on their clothing and skin. This resulted in an immediate jeopardy (IJ) situation, substandard quality of care, for R8 who remained at risk for burns and serious injury with unsupervised smoking. The IJ began on 11/28/17, when it was identified R8 had sustained repeated incidents of cigarette burns to his clothing and skin from unsupervised smoking. Although direct care staff had knowledge of these incidents, they had not been addressed and R8 was not comprehensively reassessed and interventions developed to provide adequate safety with independent, unsupervised smoking. On 11/29/17, at 5:06 p.m. the director of nursing (DON) and director of environmental services (DES) were notified of the IJ for R8. The IJ was removed on 12/1/17, at 2:19 p.m., however, non-compliance remained at	F 689	F689-Free of Accident Hazards/Supervision/Devices - J level 1. R8's care plan was updated on 11/29/17 to reflect safety hazards when smoking unsupervised. Smoking safety risk assessment completed on 11/29/17. Smoking cessation offered and declined by R8 11/29/17. Care plan was updated to include skin checks and inspection of clothing (for burns) daily at HS from 11/29/17 thru 12/13/2017. Weekly licensed nurse skin checks thereafter per facility policy and procedure. Occupational Therapy conducted a smoking safety evaluation on 11/30/17 and 12/1/17 to determine if R8 would accept any adaptive smoking equipment to increase safety. Cognitive testing was also offered. R8 declined any adaptive equipment. The cognitive testing results showed no change in cognition. R8's primary physician provided risks of smoking and offered smoking cessation products on	12/29/17

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F 689	Continued From page 6 an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: R8's annual Minimum Data Set (MDS) dated 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. yelling, cursing) and did not display any episodes of rejection of care. R8's medical diagnoses included quadriplegia (paralysis of all four limbs) and muscle weakness. Further, R8 required extensive assistance with activities of daily living (ADLs), total assistance from staff for transfers, and currently used tobacco products, however, displayed no skin tears, burns (2nd or 3rd degree) or other open lesions on his skin. Further, R8's Medical Diagnosis listing printed 11/29/17, identified R8 had a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles, tendons or other tissues often leading to deformity or rigidity of a joint) to an unspecified site. R8's last completed Tobacco Use Assessment dated 9/14/16, identified R8 currently used tobacco and smoked over 10 times a day during all hours (i.e. morning, afternoon, night) with no desire to quit. R8 was able to make decisions regarding daily life independently and demonstrated no vision impairment(s), however, did have dexterity concerns which, "would affect his/her ability to smoke or use tobacco products" according to the assessment. The assessment did not identify what R8's identified dexterity concerns were, nor any information on how they would be addressed. R8 displayed no physical limitations which would interfere with their ability	F 689	11/30/17, which R8 declined. His BIM score on 9/13/17 was 15/15 indicating he is capable of making these decisions. 2. R8 is the only resident in the facility that smokes. Any future residents who smoke that elect to be admitted despite the center's non-smoking policy will be assessed for smoking safety, and person centered approaches will be implemented. 3. DON provided 1:1 education for staff present on 11/29/17 and 11/30/17 and 12/01/17, and continued until all staff were educated (12/8/17). Topics of education included: using the eINTERACT stop and watch; the importance of communicating any changes noted in residents; and reporting safety hazards or injuries immediately. Laundry staff will notify DON or designee of any changes found in resident personal clothing. 4. Audits will be conducted for R8 and any residents that smoke weekly X 4, then monthly X 3 to ensure skin checks are completed and addressed appropriately. Audits will be conducted quarterly X 3, to ensure quarterly smoking assessment is completed and addressed appropriately. Audit results will be reviewed by the QAPI Committee for further recommendations.	

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to get outside or back in the center. The assessment listed a section labeled, "Safety," which identified R8 was able to light his own cigarette and contained a question of, "Resident need for adaptive equipment," along with several choices to select including a smoking apron, cigarette holder, supervision, one to one assistance. The option for, "None of the above," was checked. Further, the assessment identified R8 had no history or incidents with dropping the cigarette, falling asleep while smoking, burning himself or clothing, or other unacceptable tobacco-related behavior(s) in the past. The assessment lacked any information on physical location for R8's smoking, his ability to hold a cigarette or ash during use, or any history of attempted interventions which had been refused or unsuccessful for R8.

R8's care plan printed 11/29/17, identified R8 had bilateral hand contractures due to a spinal cord injury along with limited physical mobility related to quadriplegia. R8 was unable to transfer without staff assistance and a mechanical lift device, and demonstrated potential mood concerns along with notation he, "easily angers towards staff." Further, the care plan identified R8 used tobacco products off facility grounds and listed a goal of, "[R8] will safely use tobacco products in designated area. I will be free from burns." The only intervention listed to help meet this goal was identified as, "I am independent with tobacco use, cigarettes and lighter are in a pouch on my wheelchair and always with me." The care plan lacked any further information, including any past offered or refused interventions, pertaining to R8's unsupervised smoking.

On 11/28/17, at 1:58 p.m. R8 was observed to

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smoke. R8 wheeled himself out of his room in an electric wheelchair and proceeded down the hallway. R8 had visible contractures of his fingers on both hands. R8 proceeded to wheel himself past the reception desk in the main lobby of the facility and did not sign himself out of the facility prior to exiting the nursing home and going down to the end of the driveway, however, he remained on the nursing home property. R8 removed an opened package of cigarettes from his gray colored hooded sweatshirt front pocket and turned it upside down on his lap exposing a cigarette and standard lighter with a plastic body and metal sparkwheel.

R8 picked up the cigarette using his thumb and pointer finger and placed it into his mouth, the rest of his fingers being contacted inwards towards his palm(s). R8 attempted several times to light the cigarette in his mouth using the lighter, however, was unable to after several attempts. R8 stated he had, "lots of years practice," lighting his cigarettes in the wind and removed it from his mouth. R8 then used his right hand to hold the cigarette with his thumb and first finger as the remaining fingers were contracted inwards towards the palm. R8 used his opposite hand to hold the lighter. R8 then pressed into his abdomen with both hands while flicking the lighter several times with visible sparks and open flame being held immediately next to his sweatshirt as he attempted to light the cigarette and bring it to his mouth. R8 lit the cigarette and used his right hand to bring it to his mouth.

R8 stated he smokes several times a day often going outside on his own to smoke, "once every hour and a half or so." R8 stated he has burned himself before while smoking as ash or the

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"cigarette cherry [red hot ash on the end of the lit cigarette]" will fall off and he is unable to feel it on his skin due to poor sensation from his shoulders downward. R8 stated he last burned himself a couple weeks prior and showed the surveyor a visible, light brown colored scabbed area surrounded by light pink colored skin on the inner aspect of his first finger of his right hand. The area was approximately 0.5 centimeters (cm) in diameter and R8 added he had sustained burns, just like the one he showed, before. In addition, R8 then lifted up his gray colored sweatshirt and showed a visible, approximately 2.5 cm in diameter, hole in the center of the front side of the sweatshirt. R8 stated it was from a cigarette ash which had fallen on it from awhile prior.

R8 stated none of the staff had spoken to him about his smoking, nor do they come outside with him while he smokes, however, when questioned about a smoking apron being used he replied, "heck no." R8 stated if he were to have a complication or potentially start his clothing on fire, he would use his cell phone to call the nursing home and ask for help. R8 finished smoking his cigarette at 2:08 p.m. and removed it from his mouth using his right hand and tossed the remaining filter and butt into the street. R8 did not extinguish the cigarette before disposing of it.

R8's most recently completed Skin Observation - V2 dated 11/21/17, identified R8 had a chronic pressure ulcer on his gluteal fold(s), however lacked any identified burns or skin injuries on his right hand.

When interviewed on 11/28/17, at 2:24 p.m. nursing assistant (NA)-A stated R8 goes out to

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smoke after he gets up for the day and then is typically "gone a few hours" around town. NA-A stated she had never personally helped or gone outside to observe R8 while smoking, however, had noticed burn holes in his clothing before. The most recent burn holes being on his winter jacket, however, NA-A stated she was not sure if these were old or new burn holes though as he owned the coat for awhile. Further, NA-A stated R8 was independent with his smoking and staff did not help him, nor did R8 wear or use any adaptive devices while smoking to her knowledge.

During interview on 11/28/17, at 2:28 p.m. NA-B stated R8 smoked independently and staff were, "not supposed to," help him as if a resident wanted to smoke while living at the nursing home, they had to be able to do it without staff assistance because, "That's just the policy here." NA-B stated she had noticed R8 to have cigarette burns on his hands before because it "gets too hot and creates a blister," adding this happened "every couple months." NA-B stated she last observed a burn on R8's hand approximately three months prior when completing range of motion on his hand(s) further adding, "that's how I always notice them." Further, NA-B stated she had reported these burns to the nurse(s), however, was unable to recall anyone specific it had been reported to. On 11/28/17, at 2:34 p.m. the surveyor and NA-B attempted to visit with R8 to observe his burn and go through his clothing to check for additional burn holes, however, R8 had left the facility and was not available.

During interview on 11/29/17, at 8:49 a.m. laundry assistant (LA)-A stated she completed all personal laundry for R8 and was aware he

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smoked adding his hands "aren't 100 percent functional." LA-A stated she had never noticed burn holes in his clothing before, however, added she doesn't "look at them that close." LA-A turned and removed several pieces of clothing which had been hanging on a rack in the laundry room. R8 had a plain green colored shirt with several holes in the front. LA-A stated she felt these were "wear holes" though. LA-A removed the gray colored sweatshirt R8 had worn the day prior, when observed to smoke by the surveyor, and inspected it. LA-A verified a hole in the front of the sweatshirt and stated, "I would say that was a cigarette burn." Further, LA-A stated she currently was not inspecting R8's clothing when completing his laundry, however, added "I guess I should be checking [his] clothes better."

When interviewed on 11/29/17, at 9:33 a.m. trained medication aide (TMA)-A stated R8 was a smoker and goes "down to the end of the property" to smoke after he gets up for the day. TMA-A stated R8 was independent with smoking and was able to safely use cigarettes and a lighter without assistance. TMA-A was unaware of any burns on R8's skin or clothing, however, stated staff should "report it right away" to the charge nurse and complete an Stop-and-Watch (an 'early warning tool' used when a change is identified while caring for a resident). TMA-A stated she "would assume" R8 would just put out the cigarette and/or fire, if one occurred, while he was smoking as R8 took "full responsibility" for himself when smoking. R8 was to check in and out using a paper log when going outside to smoke. TMA-A showed this log to the surveyor which identified several empty spaces when R8 failed to sign himself back into the facility when he returned. TMA-A reviewed the record and

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stated R8 "should be" filling out the sign in/out record as "he's been told to" use it. Further, TMA-A stated staff did not inspect R8's skin when he returned from smoking or from his outings around town.

An undated, blank "Stop and Watch Early Warning Tool" was provided. The form listed instructions to complete one when, "you have identified a change while caring for or observing a resident," then to provide the form to a nurse for follow-up. Some examples provided on the form to be watchful for included, "Seems different than usual," and, "Change in skin color or condition." R8's medical record lacked any evidence one of these had been completed for any burns in his skin or clothing.

R8's medical record was reviewed. A handwritten progress note dated 4/16/13, identified R8 to smoke and did not want to pursue quitting at the time further adding him to, "understands risk/benefit of all education and choices that he makes." The note lacked any information on what information related to safe smoking had been provided, nor what interventions, if any, were discussed and/or refused to ensure safe unsupervised smoking.

An electronic progress note dated 6/21/17, identified R8 "continues to be safe to smoke his cigarettes independently and hold them and the lighter at all times." The note lacked any observation, assessment or dictation to describe how this determination had been made of R8's unsupervised smoking abilities.

R8's physician progress note(s) dated 2/14/17, through 11/21/17 (most recent visit), were

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reviewed and identified R8 had been seen by his physician a total of seven times in the 10 month period. R8 was identified as a "current smoker" on each of the visits. On 2/14/17, R8 was identified as having quadriplegia and needed to remain on Valium (medication used to treat anxiety and muscle spasms) "for control of spasms". All of the provided notes lacked any dictation regarding smoking related injuries or his unsupervised smoking abilities.

Further, the medical record lacked any identified reassessment of R8's unsupervised smoking abilities despite obtaining burns on clothing and skin described by NA-A and NA-B; any history of occupational therapy (OT) interventions for his smoking; nor evidence of other attempted interventions to promote safety with unsupervised smoking.

In addition, the record lacked any documented or recorded incident report(s) related to the cigarette burns sustained on his clothing and skin as described by NA-A and NA-B, nor any evidence the facility had attempted to provide on-going collaboration with R8 to develop and implement interventions or therapies related to his unsupervised smoking. The facility provided no additional notes or medical record entries regarding these items during the survey.

During interview on 11/29/17, at 12:47 p.m. NA-E stated she was aware R8 smoked and added it was the "first thing he does when he goes and gets up." R8 was independent with his smoking and when he leaves to smoke, he "is responsible for himself then." NA-E had never noticed or been told of any burns on R8's skin or clothing before; nor had she ever seen him wear a

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smoking apron before, however, felt it would "be a nice thing to have" as R8 was not someone to report incidents, like dropping the cigarette or burning himself, to the staff.

When interviewed on 11/29/17, at 12:54 p.m. NA-F stated staff "don't help him [R8]" with smoking. R8 goes outside and smokes on the street and, "whatever happens outside of this building, we don't know it." Further, NA-F stated staff were not completing any formal skin checks or other interventions upon his return, but merely asking him "how was it?"

On 11/29/17, at 1:03 p.m. registered nurse (RN)-C was interviewed and identified R8 was a quadriplegic, had poor sensation and contracted fingers on both hands and was supposed to sign himself out of the building each time he wanted to smoke as he was unable to smoke on facility grounds. RN-C was unaware of any burns on R8's clothing or skin resulted from cigarette smoking as "nothing got reported." RN-C stated if staff are noticing burns on his clothing and skin, it should be reported to the nurses immediately so the physician can be updated and an incident report can be completed. Further, RN-C stated R8 was independent with using his cigarettes and lighter, however, added she had never watched him smoke personally nor was she aware how he had been assessed to be safe with smoking before the survey.

During interview on 11/29/17, at 1:27 p.m. RN-B stated she had worked at the facility for approximately two and a half years and R8 had smoked "since he came" to the nursing home years prior. R8 typically gets assisted out of bed and then "does his own thing in the community"

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as he is unable to smoke on the campus grounds, however, RN-B added at times R8 will just go down to the end of the driveway and smoke in the later evening hours. RN-B stated she "would assume" a smoking assessment had been done on admission for R8, however, was not sure adding she had never assessed him with safe unsupervised smoking before. RN-B stated she was unaware R8 had been sustaining cigarette burns on his clothing and skin as it had not been reported to her or raised as a concern until now. RN-B stated she did not think OT had ever been consulted in the past to help address R8's unsupervised smoking adding, "not since I've been here." Further, RN-B stated R8 burning himself while smoking made her "feel like I should do something right now" to help him as "we got to be keeping him safe."

When interviewed on 11/29/17, at 1:55 p.m. RN-D stated she was aware R8 goes outside to smoke, however, added she did not know the physical location(s) he was smoking when outside as, "I don't feel like I'm his babysitter." R8 was "his person" when he left the facility. RN-D stated she was unaware R8 had a current cigarette burn on his hand, nor was she aware he had burn holes being observed in his clothing by staff. RN-D felt with R8's paralysis and poor sensation contributed that he, "might not know its [cigarette burning his skin or clothes] happening," and NA staff should be reporting those things to nursing so it could be addressed "for the resident's safety."

On 11/29/17, at 2:15 p.m. the assistant director of nursing (ADON) was interviewed. ADON stated she had worked at the nursing home for nearly four years and R8 had smoked during that entire

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time. R8 was last assessed by ADON for smoking in September 2016 (assessment dated 9/14/16), and she felt he was safe at the time. ADON stated R8 "uses his thumbs a lot with everything" including lighting his cigarettes, however, she was unable to recall how R8 lit the cigarette in 2016 when she last assessed him. ADON stated she was unaware R8 had been burning his clothes and skin with his cigarettes adding the NA staff had never reported those concerns to her. If the NA staff identify a new concern with a resident, like cigarette burns in clothing and/or on their skin, a stop-and-watch tool should have been completed so it could be addressed and R8 could be reassessed for his safety with smoking. Further, ADON stated she was unaware if anyone had discussed the risk of burns with R8, nor had OT ever been consulted to help develop interventions to ensure R8 was safe with his unsupervised smoking.

A provided UDA (user defined assessments) Reference Guide dated 12/1/17, was provided which identified it had been in use at the facility prior to survey. The guide listed several assessments along with their use, purpose and when to complete them. The Tobacco Use Assessment was listed which should be completed by a registered nurse or social worker, " ... on admission for residents who use tobacco products; required for all residents who smoke or use tobacco products when not previously completed; or when there is a change in cognitive ability, judgment, manual dexterity, and/or mobility." Further, the guide directed the assessment should be completed when an "incident" occurred and listed, "smoking injury" as an injury type.

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During interview on 11/29/17, at 2:28 p.m. OT-A stated she was new to the nursing home and unaware of the facility's policies and procedures regarding having a smoking safety assessment completed. OT-A reviewed the therapy record and stated there was no history of OT being consulted for R8 for his unsupervised smoking, however, OT-A stated there were definitely "some compensatory methods" which could be used so R8 did not have use his abdomen or chest to light his cigarettes and potentially burn himself or start his clothing on fire; including assessing his cognition, looking at his dexterity and handling skills while using a cigarette and "just do a comprehensive assessment." R8 had impaired sensation and OT-A questioned, "Does he [R8] even know he's being burned?" Further, OT-A stated if someone with impaired dexterity and sensation was sustaining cigarette burns with unsupervised smoking, it would be OT appropriate to review them so as to "assess functional deficits and safety."

On 11/29/17, at 2:45 p.m. the director of nursing (DON) was interviewed regarding R8's unsupervised smoking. DON stated she started working at the nursing home in June 2017, and to her knowledge R8 had always refused interventions from staff for his smoking. R8 was "his own person and will do whatever he dang well pleases," and had a history of telling the staff things, then being upset about them the following day and yelling at them. DON stated the interventions offered to him in the past with his smoking were done as in passing conversations and they just had not been documented. DON stated she was unaware R8 had been burning himself while smoking as it had not been reported, however, if NA staff noticed cigarette

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burns in his clothing or on his skin, they should have completed a Stop-and-Watch so the burns could be treated and staff "can be looking at it." Further, DON stated the facility was ultimately responsible to ensure R8 was safe, however, when he signs himself out and leaves, he was his own person. During a follow up interview on 11/29/17, at 5:06 p.m. DON stated a report was made to the State agency (SA) regarding potential neglect for R8 since he had been sustaining cigarette burns from unsupervised smoking.

A facility Smoke-Free Locations policy dated 3/2016, identified it applied to skilled care and smoking inside Good Samaritan Society (GSS) buildings was not permitted. The policy directed, "All residents/clients who smoke or use tobacco products will be assessed." A procedure was listed which directed staff members would designate acceptable outdoor locations for resident smoking which "must be readily visible for staff member observation." Upon admission, residents who use tobacco will have a Tobacco Use Assessment completed. Further, additional assessments would be completed if a resident has a change in cognition, judgment, manual dexterity or mobility. The policy lacked any direction or procedure for staff to implement on how to address cigarette burn(s) on clothing and/or skin, should they occur.

A Smoking and Tobacco Use policy dated 4/2017, identified it applied to skilled care and listed a purpose of reaffirming the GSS commitment to "a safe and healthy environment for employees, residents and visitors." The policy directed smoking shall be done away from the main entrance of the facility in spaces which were

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"readily visible" to staff. Further, "Residents who smoke must not pose a safety hazard to themselves or others." The policy lacked any direction or procedure for staff to implement on how to address safety with smoking nor cigarette burn(s) on clothing and/or skin, should they occur.

No further policies or procedures related to smoking safety or unsupervised smoking were provided.

The IJ which began on 11/28/17, was removed on 12/1/17, at 2:19 p.m. after the facility successfully implemented a removal plan which included the following:

- R8 was reassessed by nursing for unsupervised smoking which identified he required a smoking apron, cigarette holder, supervision and one on one assistance. R8 refused all of these interventions, however, R8 "agreed to [OT evaluation for safety]." Further, the assessment identified R8 to now have a history of smoking related incidents including "a self reported incident of burning his finger" which he failed to report as it was "not a big deal." A subsequent progress note for R8's smoking reassessment dated 11/29/17, at 6:45 p.m. was authored by ADON. ADON explained to R8 they had reported the burn(s) for potential neglect of care while R8 demonstrated how he smoked. R8 was identified as reporting he had a "shitty lighter" when observed by the surveyor on 11/28/17, and should have gotten a different one, "instead of fighting with the shitty one and almost burning my shirt."

- An OT consultation was made for R8 to screen, assess and develop interventions for safe,

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F 689	Continued From page 20 unsupervised smoking. A provided OT Daily Treatment Note dated 12/1/17, identified R8 as having an "incomplete SCI [spinal cord injury] at C5 - C7 [vertebrae]," who had impaired sensation, impaired upper body strength and impaired motor control. OT completed a smoking evaluation which identified R8 was able to strike the lighter away from his body, however, "[his] thumb still very near flame when lighting. Will need to further explore options to reduce risk of burn." Further, R8 agreed to trying a plastic-smoking adaptor and e-cigarettes, along with throwing out the cigarette mid-way "before hot end nears hand." - Educating all staff on ensuring cigarette burn(s) on clothing and/or skin were immediately reported and documented. On 12/1/17, from 2:01 p.m. to 2:18 p.m. nursing and direct care staff were interviewed to ensure training had been provided related to R8's unsupervised smoking including ensuring R8's skin and clothing was routinely monitored for potential burn injuries, use of the Stop-and-Watch tool and communicating changes in resident conditions timely, and documentation standards pertaining to a change in condition.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.	F 690		12/29/17

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F 690	Continued From page 21 §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively reassess 1 of 1 residents (R6) with a change in urinary continence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 6/21/17, indicated she was cognitively intact, had hypertension and diabetes mellitus. The MDS	F 690	F690-Bowel/Bladder Incontinence, Catheter, UTI - D level 1. R6's care plan was updated 12/18/17 to reflect resident current health status for urinary incontinence. A new bladder assessment was initiated on 12/18/17 and will be completed by 12/21/17 and care plan will be updated as appropriate.	

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F 690	Continued From page 22 further indicated she was always continent of urine and was not on a toileting program. R6's quarterly MDS dated 9/20/17, indicated she was now occasionally incontinent of urine and was not on a toileting program. R6's care area assessment (CAA) dated 3/29/17, indicated she had urinary urgency and need for assist with toileting. The CAA indicated she received diuretics and did not indicate she was incontinent. R6's care plan dated 9/28/17, indicated she had hypertension, type two diabetes and congestive heart failure. The care plan indicated she had activity of self care performance deficit related to fatigue and limited mobility. The care plan did not indicate she was incontinent of urine. R6's Bladder Incontinence Data Collection tool dated 10/2/16, indicated she was wet less often than daily with a medium amount and she wore a absorbent pad. The tool further indicated R6 denied incontinence and could not recall having trouble with it. R6 could not recall the two episodes documented since admission on 9/28/16. There were no further assessments done related to bladder incontinence. R6's Skin Observation dated 11/24/17, indicated she had excoriation to her right and left buttocks. R6's Point of Care (POC) response history for incontinence for the last 30 days indicated she was incontinent of urine 10 times in November. On 11/30/17, at 8:50 a.m. licensed practical nurse (LPN)- A and certified nursing assistant (CNA)- C were observed to place R6 onto the toilet. She was continent of urine and voided a small amount in the toilet. LPN-A was observed to clean R6's excoriated, reddened area that covered most of	F 690	2. All current residents who have been identified per the MDS for bladder incontinence have been reviewed to ensure that all assessments and plan of care documentation have been completed per facility policy and procedure. 3. The DON or designee will provide re-education on comprehensively assessing/re-assessing and care planning for urinary incontinence per GSS policy and procedure. 4. The DON or designee will conduct MDS Section H Bowel and Bladder continence audits for R6 and random other residents weekly X 4, and then monthly X 3 to ensure care plans reflect their urinary continence needs. Audit results will be reviewed by QAPI Committee for further recommendations.	

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F 690	Continued From page 23 R6's right and left buttock. On 11/30/17, at 1:35 p.m. CNA-C stated that she worked the day shift and R6 was usually incontinent twice a shift when she worked. On 11/30/17, at 1:59 p.m. Registered Nurse (RN)-A stated R6 did not receive a bladder assessment after her change from continent of urine to occasionally incontinent of urine. RN-A stated the facility was aware this was an area they needed to work on and it was part of their performance improvement project. RN-A stated they wanted more residents to be continent of urine. RN-A further stated currently the computer program assessment tool did not provide an alert for quarterly bladder assessments so they were missed. In addition RN-A stated they were only able to print a history of incontinence going back 30 days based on nursing assistant documentation. During interview 12/1/17, at 8:03 a.m. CNA-D stated that when she worked with R6 she was usually continent of urine. Although R6 had a change in urinary incontinence the facility failed to reassess the incontinence to minimize the risk of further change. A facility policy Bladder Assessment revised 3/17, indicated the purpose is to review/assess bladder patterns, incontinence and frequency, to identify potentially reversible causes of incontinence and to identify the probable type of urinary incontinence and potential toileting programs. The Assessment indicated this should be done quarterly and care plan interventions should be individualized based on the CAA and	F 690		

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F 690	Continued From page 24 modified as appropriate based on assessment/evaluation of the residents response to the interventions and success with attaining/maintaining bladder continence.	F 690		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of	F 880		12/29/17

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F 880	Continued From page 25 communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to develop a comprehensive infection control program which included data analysis of resident infections and trending to reduce the risk of spread of infections	F 880	F880 Infection Prevention and Control - F level 1.&2. All residents had the potential to be affected. All residents were reviewed to	

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F 880	Continued From page 26 to other residents in the facility. This had the potential to affect all 27 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from June 2017, through November 29, 2017. The facility provided a document, titled Monthly Report of Resident Infections In Center, with a line present for month and year. The headings on top of the graph identified the total number of infections, the number [of infections] center acquired (nosocomial), and the number community acquired. The columns on the logs included the following information: name, room number, date admitted, date of infection, site of infection, culture taken (yes or no), causative agent, antibiotic treatment, cautionary measure, isolation (yes or no), and center acquired (yes or no). This document did not have any designations for symptoms not treated with antibiotics or non-bacterial infections such as viral or fungal infections. The facility also provided documents titled Data Review Report, as well as a summary document titled monthly infection control report. The summary included a breakdown of infection types, and identified whether the infection was nosocomial or community acquired. Hand written entries at the bottom of the form were titled "Trends" and "Action Plan". A review of these logs identified the following: The document titled Monthly Report of Resident Infections in Center, dated June of 2017 identified six residents were treated with antibiotics for a	F 880	determine if there were any infections requiring immediate action. None were noted. 3. The facility has implemented a system for identifying and documenting all infections. All infections will be noted by the attending nurse on the GSS 157 Infection tracking tool as they occur. The attending nurses will notify the Infection Control nurse when noting two or more like infections. The Infection Control nurse will utilize the GSS 157 tracking tool to conduct monthly trending of infections. These results will be reviewed by the QAPI committee monthly and action plans will be developed as appropriate. All nursing staff will be provided education on this process by the DON by 12/29/17. 4. Audits will be conducted by Infection Control nurse to ensure the GSS Infection tracking tool is being completed on a daily basis when a new infection is identified. These audits will be done weekly X 4, then monthly X 3. Audit results will be reviewed by the QAPI committee for further recommendations.	

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total of 10 courses of antibiotic therapy. The categories of infection included the breakdown of infections as follows: Prophylactic antibiotic use - three residents; gastrointestinal (clostridium difficile - c. diff. a highly infectious bacterial illness which may cause diarrhea) - one resident; respiratory/lung infections - three residents; skin infections - two residents; and a urinary infection in one resident. A document titled Order Listing Report, dated June 28, 2017, identified residents who had received antibiotics, antifungal's, antiviral's in the month of June. Although antifungal's and antiviral's were noted on the report, only those residents receiving antibiotics were listed on the report of infections. The Monthly Infection Control Report identified a total of one nosocomial infection and four community acquired infections, to total five identified infections, yet six residents were addressed on the document. A hand written narrative note, titled Trends, identified the presence of one continued infection from the previous month (May 2017), and identified the number of infections reflect a "Downward trend". Additional data was not included to identify the previous trends or any pattern identified. The action plan identified staff education on aspiration pneumonia with hard copy learning as well as urinary tract infections, and skin/soft tissue education. Although requested, a Data Review Report was not provided for 6/17.

The Monthly Report dated July of 2017, identified four residents were treated with antibiotics for a total of four courses of antibiotic therapy. The categories of infection included the following: respiratory/lung infections - three residents; skin infections - one resident; and a urinary infection in one resident. The Monthly Infection Control

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 28	F 880		

Report identified a total of one nosocomial infection, and two community acquired infections. A hand written narrative note titled Trends, identified a resolved urinary tract infection upon admission, with identified negative lab work. However, the resident continued on prophylactic antibiotic use. One incident was identified as skin/soft tissue healing without antibiotics. The initial log reflected intravenous antibiotics were implemented for treatment. The action plan identified staff education on handwashing and infection prevention provided at a staff meeting in July. A Data Review Report was provided for the month of 7/17. The positive findings identified one resident was treated for an upper respiratory tract infection, which was nosocomial. The infection remained isolated to one resident. The document additionally noted attempts to discontinue antibiotic therapy for a resident on a prophylactic antibiotic were successful. Although the review identified the data trending was positive, it did not provide a comparison to previous trends, nor did it identify a goal for the data measure, the goal was "to be determined". The document indicated the information had been reviewed by the QAPI (Quality Assurance Performance Improvement) group on 8/25/17, and no action was taken.

The report dated August 2017 identified three residents were treated with antibiotics for a total of three courses of antibiotic therapy. One resident was noted in each of the following categories: respiratory/lung infection, skin infection, and gastrointestinal. A document, titled Order Listing Report, dated 8/15/17, identified there was one resident being treated with antibiotic therapy through 8/18/17, and three individuals being treated with an antifungal

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	245278	A. BUILDING _____ B. WING _____	12/01/2017

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GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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F 880	Continued From page 29	F 880		

powder. An Order Listing Report dated 9/1/17, identified one additional resident was treated with antibiotic therapy, and one resident continued to receive antifungal treatment. The Monthly Infection Control Report identified a total of two nosocomial infections, and one community acquired infection. A hand written narrative note, titled Trends, identified three infections of alternate sources with no trends noted. The note identified an episode of bronchitis was isolated with no spread of infection. The action plan identified staff re-education on isolation precautions related to recurrent problems with c. diff. A Data Review Report was provided for the month of 8/17. The positive findings identified one resident was treated for upper respiratory tract infection which was nosocomial, which remained isolated to one resident. The negative findings included prophylactic antibiotic treatment with risk versus benefit statement noted. It was also noted resident with c. diff positive culture will always test positive. The data review identified trending was positive, but no comparisons were provided. The data measure goal continued to indicate it was yet "to be determined". Although the review identified the data trending was positive, it did not provide a comparison to previous trends, nor did it identify a goal for the data measure. The information was noted to have been reviewed by the QAPI group on 9/20/17 with no action taken.

The Monthly Report for September of 2017 identified seven residents were treated with antibiotics for a total of eight courses of antibiotic therapy. Upon review of the entries, it was noted one entry was from 8/26/17. The categories of infection included the breakdown of infections as follows: skin infections - two residents, urinary infection in five residents, and c. diff. in one

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resident. An order listing report, dated 10/18/17, was provided for those receiving antibiotic and antifungal therapy. The Monthly Infection Control Report identified a total of three nosocomial infections, and five community acquired infections. A hand written narrative note, titled Trends, identified no trends were noted. A notation was also made identifying the c. diff. infection was isolated. It was noted three of five of the urinary tract infections were community acquired, one was nosocomial, and one was "procommunity admit." The action plan identified a "situation, background, assessment, recommendation (SBAR)" notification was provided to physicians, staff educated and interventions implemented. A note was written to monitor hand hygiene, however, it did identify how this would be done. A Data Review Report was requested but not provided for the month of 9/17.

The October 2017, report of resident infections in the center identified three residents with four courses of antibiotic therapy. The categories of infection included the breakdown of infections as follows: respiratory/lung - two residents, and gastrointestinal/colon - two residents. An order listing report, dated 11/13/17, was provided for those receiving antibiotic and antifungal therapy. The Monthly Infection Control Report identified a total of two nosocomial infections, and one community acquired infections. A hand written narrative note, titled Trends, identified no trends were noted. The action plan identified "flu [influenza]/pneumonia season approaching, noting reeducation was provided on precautions/vaccinations." A Data Review Report was provided for the month of October, 2017, and noted a positive data trending direction, however, the facility goal was yet to be determined. The

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F 880	Continued From page 31	F 880		

information was noted to have been reviewed by the QAPI team on 11/17/17, and no action was taken.

The November 2017, report of resident infections in the center identified one resident, with only first name and first initial of the last name, with no additional documents provided. On three pink sticky notes there were four residents identified to have received antibiotic therapy on the following dates; 11/12/17, 11/17/17, 11/17/17, and 11/27/17. There were no additional documents provided when the Infection Control Log book was initially reviewed 11/28/17. Although requested, the Monthly Infection Control Report and Data Review report was not provided for 11/17.

During the interview on 12/1/17, at 9:43 a.m. the director of nursing (DON) stated the information regarding infections was obtained on residents admitting to the facility, with lab results recorded if received. The DON stated tracking and trending was monitored through QAPI. The DON stated the information on the infection control log is compiled monthly. Staff relayed information regarding current infections via the Communication Book and shift reports. However, the DON further stated the log was not used day to day as it was used for monthly tracking and trending. In reviewing training needs identified, the DON stated staff education had been provided for handwashing in 7/17. The DON identified an increase in prevalence of urinary tract infections in 9/17. The DON stated staff was monitored for ongoing handwashing techniques through observation. Although an increase in UTI's was identified, audits and/or return demonstrations of handwashing had not been

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F 880	Continued From page 32 implemented. The DON stated the infection rate was compared to the previous month, however there was no documentation to reflect this. A table titled Resident Infection Control Report, dated 2017 was provided with data entered from January thorough June, however, no analysis was provided regarding trending or interventions implemented. A facility policy, titled Surveillance, reviewed 10/17 identified surveillance as an activity to "find, analyze, control and prevent nosocomial infections." The definition further outlined the process as date collection, analysis of data, establishment of trends, passing the information on to those who need to take action and documentation in conclusion.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS FORM-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE 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. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 28, 2017. At the time of this survey, Good Samaritan Society Howard Lake was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/22/2017

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society Howard Lake is a one-story building with no basement. The original building was constructed in 1971, with building additions constructed in 1983 and 1994. All buildings are fully fire sprinkler protected and were determined to be of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. The facility has a capacity of 32 beds and had a census of 27 at time of the survey.	K 000		

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on documentation review and interview, the Facility failed to test and maintain the Fire Alarm System in accordance with NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. The deficient practice could affect 27 out of 27 residents. Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.7.5, 9.7.7, 9.7.8, and NFPA 25.	K 345	K345 – Discrepancy in the amount of detectors and switches from the 2016 to the 2017 fire alarm annual inspection. 1. The documentation discrepancies in the number of detectors and switches from the year to year reports has been clarified to reflect the accurate number of devices onsite. 2. Fire Protection company verified this on 12/04/2017. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	12/4/17

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K 345	Continued From page 3 Findings include: On facility tour between 9:15 AM and 1:15 PM on 11/28/2017, documentation reviewed revealed there were discrepancies in the amount Photo detectors, Duct detectors, Heat Detectors and Supervisory Switches from the Fire alarm report 2016 to the current 2017. This deficient practice was verified by Environmental Services Director.	K 345		
K 353 SS=F	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source _____ Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of documentation and an interview with staff, it was determined that the Sprinkler Suppression system is not in	K 353	K353 No quarterly sprinkler inspections 1. We will resume quarterly testing of the	12/20/17

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K 353	Continued From page 4 accordance with NFPA 101 The Life Safety Code (edition 2012), Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25. This deficient practice could cause a delay in extinguishing a fire affecting the safety of an undetermined amount of staff and visitors. Findings Include: During documentation review between 9:15 AM and 1:15 PM on 11/28/2017, documentation review and staff interview revealed that the facility performed semi-annual Sprinkler Test and failed to perform any quarterly inspections. This deficient practice was verified by Environmental Services Director.	K 353	Sprinkler Suppression System, along with semi annual testing. The system will have a quarterly inspection in December 2017; after that, either a semi annual or quarterly every quarter as required. 2. Quarterly Inspection was completed on 12/20/17. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	
K 712 SS=C	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and	K 712		12/4/17

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K 712	Continued From page 5 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 18.7.1.4 through 18.7.1.7, 19.7.1.4 through 19.7.1.7 Findings include: During documentation review between 9:15 AM and 1:15 PM on 11/28/2017, revealed review of the available fire drill reports for the last 12 months and interview with the Environmental Services Director, it was revealed that the facility failed to complete the paperwork required for the night shift in the third quarter. This deficient practice was verified by Environmental Services Director.	K 712	K712 Incomplete paperwork for one fire drill. 1. The missing date on the fire drill paperwork has been entered. Moving forward, fire drill paperwork will be completed promptly and completely after a drill. 2. 12/04/2017. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	
K 901 SS=F	Fundamentals - Building System Categories CFR(s): NFPA 101 Fundamentals - Building System Categories Building systems are designed to meet Category	K 901		12/21/17

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K 901	Continued From page 6 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. Chapter 4 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on documentation review and staff interview, the facility failed to inspect the building systems are designed to meet Category 1 through 4 requirements as detailed in NFPA 99. Categories are determined by a formal and documented risk assessment procedure performed by qualified personnel. The deficient practice could affect all residents. Findings include: During documentation review between 9:15 AM and 1:15 PM on 11/28/2017, documentation review and staff interview revealed the required risk assessment NFPA 99 had not been started at the time of the survey. This deficient practice was verified by Environmental Services Director.	K 901	K901 Building Risk Assessment not completed 1. The required building Risk Assessment NFPA 99 has been completed. 2. It was reviewed and accepted by center Safety committee on 12/21/2017. 3. The Director of Environmental Services is responsible for this correction and monitoring to prevent a recurrence of this deficiency.	

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 15, 2017

Ms. Laura Salonek, Administrator
Good Samaritan Society - Howard Lake
413 13th Avenue
Howard Lake, MN 55349

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5278025

Dear Ms. Salonek:

The above facility was surveyed on November 28, 2017 through December 1, 2017 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute or rule after the statement, "This MN Requirement is not met as evidenced by." Following the surveyors findings are

the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Unit Supervisor Brenda Fischer at brenda.fischer@state.mn.us or (320) 223-7338.

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 related to this letter.

Sincerely,

Anne Peterson

Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
anne.peterson@state.mn.us
Telephone #: 651-201-4206 Fax #: 651-215-9697

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00019	A. BUILDING: _____ B. WING _____	12/01/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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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 (MDH) 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 11/28/17 to 12/1/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		

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2 570	MN Rule 4658.0405 Subp. 4 Comprehensive Plan of Care; Revision Subp. 4. Revision. A comprehensive plan of care must be reviewed and revised by an interdisciplinary team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, with the participation of the resident, the resident's legal guardian or chosen representative at least quarterly and within seven days of the revision of the comprehensive resident assessment required by part 4658.0400, subpart 3, item B. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to revise the care plan to include urinary incontinence for 1 of 1 residents (R6) who was identified with urinary incontinence. Findings include: R6's most recent quarterly MDS dated 9/20/17, identified R6 was cognitively intact and required limited assistance with toileting. Further, the MDS identified R6 was occasionally incontinent of urine (less than seven episodes of incontinence). R6's care plan dated 9/28/17, identified R6 had a self care performance deficit related to fatigue and limited mobility. The care plan did not indicate she was incontinent of urine as identified on her MDS. During interview on 11/30/17, at 1:35 p.m. nursing assistant (NA)-C stated that she worked the day	2 570	corrected	12/29/17

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2 570	Continued From page 3 shift and R6's was usually incontinent twice a shift when she was working. During interview 11/30/17, at 1:59 p.m. registered nurse (RN)-A stated R6 was occasionally incontinent of urine and it should have been identified and addressed on her care plan. A facility Comprehensive Care Plan and Care Conferences policy dated 9/17, identified a purpose of creating a "holistic and person-centered care plan" for each resident. The policy directed the care plan should be reviewed when each MDS is completed and care plans "must be revised as the resident's needs/status changes." SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could inservice staff regarding ensuring the plan of care is updated for accuracy in a timely manner. The DON or designee could audit to ensure ongoing compliance and report the audit results to the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 570		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a	2 830		12/29/17

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2 830	Continued From page 4 written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively reassess and develop interventions to provide adequate supervision and safety with unsupervised smoking for 1 of 1 residents (R8) identified to have cigarette burns on their clothing and skin. This resulted in an immediate jeopardy (IJ) situation for R8 who remained at risk for burns and serious injury with unsupervised smoking. The IJ began on 11/28/17, when it was identified R8 had sustained repeated incidents of cigarette burns to his clothing and skin from unsupervised smoking. Although direct care staff had knowledge of these incidents, they had not been addressed and R8 was not comprehensively reassessed and interventions developed to provide adequate safety with independent, unsupervised smoking. On 11/29/17, at 5:06 p.m. the director of nursing (DON) and director of environmental services (DES) were notified of the IJ for R8. The IJ was removed on 12/1/17, at 2:19 p.m., however, non-compliance remained at an isolated scope and severity which indicated no actual harm with potential for more than minimal harm (Level D). Findings include: R8's annual Minimum Data Set (MDS) dated	2 830	corrected	

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2 830	Continued From page 5 9/13/17, identified R8 had intact cognition, displayed verbal behavioral symptoms (i.e. yelling, cursing) and did not display any episodes of rejection of care. R8's medical diagnoses included quadriplegia (paralysis of all four limbs) and muscle weakness. Further, R8 required extensive assistance with activities of daily living (ADLs), total assistance from staff for transfers, and currently used tobacco products, however, displayed no skin tears, burns (2nd or 3rd degree) or other open lesions on his skin. Further, R8's Medical Diagnosis listing printed 11/29/17, identified R8 had a history of muscle spasms and contracture of the muscle(s) (shortening or hardening of the muscles, tendons or other tissues often leading to deformity or rigidity of a joint) to an unspecified site. R8's last completed Tobacco Use Assessment dated 9/14/16, identified R8 currently used tobacco and smoked over 10 times a day during all hours (i.e. morning, afternoon, night) with no desire to quit. R8 was able to make decisions regarding daily life independently and demonstrated no vision impairment(s), however, did have dexterity concerns which, "would affect his/her ability to smoke or use tobacco products" according to the assessment. The assessment did not identify what R8's identified dexterity concerns were, nor any information on how they would be addressed. R8 displayed no physical limitations which would interfere with their ability to get outside or back in the center. The assessment listed a section labeled, "Safety," which identified R8 was able to light his own cigarette and contained a question of, "Resident need for adaptive equipment," along with several choices to select including a smoking apron, cigarette holder, supervision, one to one assistance. The option for, "None of the above,"	2 830		

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2 830	Continued From page 6	2 830		

was checked. Further, the assessment identified R8 had no history or incidents with dropping the cigarette, falling asleep while smoking, burning himself or clothing, or other unacceptable tobacco-related behavior(s) in the past. The assessment lacked any information on physical location for R8's smoking, his ability to hold a cigarette or ash during use, or any history of attempted interventions which had been refused or unsuccessful for R8.

R8's care plan printed 11/29/17, identified R8 had bilateral hand contractures due to a spinal cord injury along with limited physical mobility related to quadriplegia. R8 was unable to transfer without staff assistance and a mechanical lift device, and demonstrated potential mood concerns along with notation he, "easily angers towards staff." Further, the care plan identified R8 used tobacco products off facility grounds and listed a goal of, "[R8] will safely use tobacco products in designated area. I will be free from burns." The only intervention listed to help meet this goal was identified as, "I am independent with tobacco use, cigarettes and lighter are in a pouch on my wheelchair and always with me." The care plan lacked any further information, including any past offered or refused interventions, pertaining to R8's unsupervised smoking.

On 11/28/17, at 1:58 p.m. R8 was observed to smoke. R8 wheeled himself out of his room in an electric wheelchair and proceeded down the hallway. R8 had visible contractures of his fingers on both hands. R8 proceeded to wheel himself past the reception desk in the main lobby of the facility and did not sign himself out of the facility prior to exiting the nursing home and going down to the end of the driveway, however, he remained on the nursing home property. R8

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removed an opened package of cigarettes from his gray colored hooded sweatshirt front pocket and turned it upside down on his lap exposing a cigarette and standard lighter with a plastic body and metal sparkwheel.

R8 picked up the cigarette using his thumb and pointer finger and placed it into his mouth, the rest of his fingers being contacted inwards towards his palm(s). R8 attempted several times to light the cigarette in his mouth using the lighter, however, was unable to after several attempts. R8 stated he had, "lots of years practice," lighting his cigarettes in the wind and removed it from his mouth. R8 then used his right hand to hold the cigarette with his thumb and first finger as the remaining fingers were contracted inwards towards the palm. R8 used his opposite hand to hold the lighter. R8 then pressed into his abdomen with both hands while flicking the lighter several times with visible sparks and open flame being held immediately next to his sweatshirt as he attempted to light the cigarette and bring it to his mouth. R8 lit the cigarette and used his right hand to bring it to his mouth.

R8 stated he smokes several times a day often going outside on his own to smoke, "once every hour and a half or so." R8 stated he has burned himself before while smoking as ash or the "cigarette cherry [red hot ash on the end of the lit cigarette]" will fall off and he is unable to feel it on his skin due to poor sensation from his shoulders downward. R8 stated he last burned himself a couple weeks prior and showed the surveyor a visible, light brown colored scabbed area surrounded by light pink colored skin on the inner aspect of his first finger of his right hand. The area was approximately 0.5 centimeters (cm) in diameter and R8 added he had sustained burns,

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just like the one he showed, before. In addition, R8 then lifted up his gray colored sweatshirt and showed a visible, approximately 2.5 cm in diameter, hole in the center of the front side of the sweatshirt. R8 stated it was from a cigarette ash which had fallen on it from awhile prior.

R8 stated none of the staff had spoken to him about his smoking, nor do they come outside with him while he smokes, however, when questioned about a smoking apron being used he replied, "heck no." R8 stated if he were to have a complication or potentially start his clothing on fire, he would use his cell phone to call the nursing home and ask for help. R8 finished smoking his cigarette at 2:08 p.m. and removed it from his mouth using his right hand and tossed the remaining filter and butt into the street. R8 did not extinguish the cigarette before disposing of it.

R8's most recently completed Skin Observation - V2 dated 11/21/17, identified R8 had a chronic pressure ulcer on his gluteal fold(s), however lacked any identified burns or skin injuries on his right hand.

When interviewed on 11/28/17, at 2:24 p.m. nursing assistant (NA)-A stated R8 goes out to smoke after he gets up for the day and then is typically "gone a few hours" around town. NA-A stated she had never personally helped or gone outside to observe R8 while smoking, however, had noticed burn holes in his clothing before. The most recent burn holes being on his winter jacket, however, NA-A stated she was not sure if these were old or new burn holes though as he owned the coat for awhile. Further, NA-A stated R8 was independent with his smoking and staff did not help him, nor did R8 wear or use any

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2 830	Continued From page 9 adaptive devices while smoking to her knowledge. During interview on 11/28/17, at 2:28 p.m. NA-B stated R8 smoked independently and staff were, "not supposed to," help him as if a resident wanted to smoke while living at the nursing home, they had to be able to do it without staff assistance because, "That's just the policy here." NA-B stated she had noticed R8 to have cigarette burns on his hands before because it "gets too hot and creates a blister," adding this happened "every couple months." NA-B stated she last observed a burn on R8's hand approximately three months prior when completing range of motion on his hand(s) further adding, "that's how I always notice them." Further, NA-B stated she had reported these burns to the nurse(s), however, was unable to recall anyone specific it had been reported to. On 11/28/17, at 2:34 p.m. the surveyor and NA-B attempted to visit with R8 to observe his burn and go through his clothing to check for additional burn holes, however, R8 had left the facility and was not available. During interview on 11/29/17, at 8:49 a.m. laundry assistant (LA)-A stated she completed all personal laundry for R8 and was aware he smoked adding his hands "aren't 100 percent functional." LA-A stated she had never noticed burn holes in his clothing before, however, added she doesn't "look at them that close." LA-A turned and removed several pieces of clothing which had been hanging on a rack in the laundry room. R8 had a plain green colored shirt with several holes in the front. LA-A stated she felt these were "wear holes" though. LA-A removed the gray colored sweatshirt R8 had worn the day prior, when observed to smoke by the surveyor, and inspected it. LA-A verified a hole in the front	2 830		

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of the sweatshirt and stated, "I would say that was a cigarette burn." Further, LA-A stated she currently was not inspecting R8's clothing when completing his laundry, however, added "I guess I should be checking [his] clothes better."

When interviewed on 11/29/17, at 9:33 a.m. trained medication aide (TMA)-A stated R8 was a smoker and goes "down to the end of the property" to smoke after he gets up for the day. TMA-A stated R8 was independent with smoking and was able to safely use cigarettes and a lighter without assistance. TMA-A was unaware of any burns on R8's skin or clothing, however, stated staff should "report it right away" to the charge nurse and complete an Stop-and-Watch (an 'early warning tool' used when a change is identified while caring for a resident). TMA-A stated she "would assume" R8 would just put out the cigarette and/or fire, if one occurred, while he was smoking as R8 took "full responsibility" for himself when smoking. R8 was to check in and out using a paper log when going outside to smoke. TMA-A showed this log to the surveyor which identified several empty spaces when R8 failed to sign himself back into the facility when he returned. TMA-A reviewed the record and stated R8 "should be" filling out the sign in/out record as "he's been told to" use it. Further, TMA-A stated staff did not inspect R8's skin when he returned from smoking or from his outings around town.

An undated, blank "Stop and Watch Early Warning Tool" was provided. The form listed instructions to complete one when, "you have identified a change while caring for or observing a resident," then to provide the form to a nurse for follow-up. Some examples provided on the form to be watchful for included, "Seems different than

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usual," and, "Change in skin color or condition." R8's medical record lacked any evidence one of these had been completed for any burns in his skin or clothing.

R8's medical record was reviewed. A handwritten progress note dated 4/16/13, identified R8 to smoke and did not want to pursue quitting at the time further adding him to, "understands risk/benefit of all education and choices that he makes." The note lacked any information on what information related to safe smoking had been provided, nor what interventions, if any, were discussed and/or refused to ensure safe unsupervised smoking.

An electronic progress note dated 6/21/17, identified R8 "continues to be safe to smoke his cigarettes independently and hold them and the lighter at all times." The note lacked any observation, assessment or dictation to describe how this determination had been made of R8's unsupervised smoking abilities.

R8's physician progress note(s) dated 2/14/17, through 11/21/17 (most recent visit), were reviewed and identified R8 had been seen by his physician a total of seven times in the 10 month period. R8 was identified as a "current smoker" on each of the visits. On 2/14/17, R8 was identified as having quadriplegia and needed to remain on Valium (medication used to treat anxiety and muscle spasms) "for control of spasms". All of the provided notes lacked any dictation regarding smoking related injuries or his unsupervised smoking abilities.

Further, the medical record lacked any identified reassessment of R8's unsupervised smoking abilities despite obtaining burns on clothing and

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2 830	Continued From page 12 skin described by NA-A and NA-B; any history of occupational therapy (OT) interventions for his smoking; nor evidence of other attempted interventions to promote safety with unsupervised smoking. In addition, the record lacked any documented or recorded incident report(s) related to the cigarette burns sustained on his clothing and skin as described by NA-A and NA-B, nor any evidence the facility had attempted to provide on-going collaboration with R8 to develop and implement interventions or therapies related to his unsupervised smoking. The facility provided no additional notes or medical record entries regarding these items during the survey. During interview on 11/29/17, at 12:47 p.m. NA-E stated she was aware R8 smoked and added it was the "first thing he does when he goes and gets up." R8 was independent with his smoking and when he leaves to smoke, he "is responsible for himself then." NA-E had never noticed or been told of any burns on R8's skin or clothing before; nor had she ever seen him wear a smoking apron before, however, felt it would "be a nice thing to have" as R8 was not someone to report incidents, like dropping the cigarette or burning himself, to the staff. When interviewed on 11/29/17, at 12:54 p.m. NA-F stated staff "don't help him [R8]" with smoking. R8 goes outside and smokes on the street and, "whatever happens outside of this building, we don't know it." Further, NA-F stated staff were not completing any formal skin checks or other interventions upon his return, but merely asking him "how was it?" On 11/29/17, at 1:03 p.m. registered nurse	2 830		

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2 830	Continued From page 13 (RN)-C was interviewed and identified R8 was a quadriplegic, had poor sensation and contracted fingers on both hands and was supposed to sign himself out of the building each time he wanted to smoke as he was unable to smoke on facility grounds. RN-C was unaware of any burns on R8's clothing or skin resulted from cigarette smoking as "nothing got reported." RN-C stated if staff are noticing burns on his clothing and skin, it should be reported to the nurses immediately so the physician can be updated and an incident report can be completed. Further, RN-C stated R8 was independent with using his cigarettes and lighter, however, added she had never watched him smoke personally nor was she aware how he had been assessed to be safe with smoking before the survey. During interview on 11/29/17, at 1:27 p.m. RN-B stated she had worked at the facility for approximately two and a half years and R8 had smoked "since he came" to the nursing home years prior. R8 typically gets assisted out of bed and then "does his own thing in the community" as he is unable to smoke on the campus grounds, however, RN-B added at times R8 will just go down to the end of the driveway and smoke in the later evening hours. RN-B stated she "would assume" a smoking assessment had been done on admission for R8, however, was not sure adding she had never assessed him with safe unsupervised smoking before. RN-B stated she was unaware R8 had been sustaining cigarette burns on his clothing and skin as it had not been reported to her or raised as a concern until now. RN-B stated she did not think OT had ever been consulted in the past to help address R8's unsupervised smoking adding, "not since I've been here." Further, RN-B stated R8 burning himself while smoking made her "feel like I	2 830		

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2 830	Continued From page 14 should do something right now" to help him as "we got to be keeping him safe." When interviewed on 11/29/17, at 1:55 p.m. RN-D stated she was aware R8 goes outside to smoke, however, added she did not know the physical location(s) he was smoking when outside as, "I don't feel like I'm his babysitter." R8 was "his person" when he left the facility. RN-D stated she was unaware R8 had a current cigarette burn on his hand, nor was she aware he had burn holes being observed in his clothing by staff. RN-D felt with R8's paralysis and poor sensation contributed that he, "might not know its [cigarette burning his skin or clothes] happening," and NA staff should be reporting those things to nursing so it could be addressed "for the resident's safety." On 11/29/17, at 2:15 p.m. the assistant director of nursing (ADON) was interviewed. ADON stated she had worked at the nursing home for nearly four years and R8 had smoked during that entire time. R8 was last assessed by ADON for smoking in September 2016 (assessment dated 9/14/16), and she felt he was safe at the time. ADON stated R8 "uses his thumbs a lot with everything" including lighting his cigarettes, however, she was unable to recall how R8 lit the cigarette in 2016 when she last assessed him. ADON stated she was unaware R8 had been burning his clothes and skin with his cigarettes adding the NA staff had never reported those concerns to her. If the NA staff identify a new concern with a resident, like cigarette burns in clothing and/or on their skin, a stop-and-watch tool should have been completed so it could be addressed and R8 could be reassessed for his safety with smoking. Further, ADON stated she was unaware if anyone had discussed the risk of	2 830		

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2 830	Continued From page 15 burns with R8, nor had OT ever been consulted to help develop interventions to ensure R8 was safe with his unsupervised smoking. A provided UDA (user defined assessments) Reference Guide dated 12/1/17, was provided which identified it had been in use at the facility prior to survey. The guide listed several assessments along with their use, purpose and when to complete them. The Tobacco Use Assessment was listed which should be completed by a registered nurse or social worker, " ... on admission for residents who use tobacco products; required for all residents who smoke or use tobacco products when not previously completed; or when there is a change in cognitive ability, judgment, manual dexterity, and/or mobility." Further, the guide directed the assessment should be completed when an "incident" occurred and listed, "smoking injury" as an injury type. During interview on 11/29/17, at 2:28 p.m. OT-A stated she was new to the nursing home and unaware of the facility's policies and procedures regarding having a smoking safety assessment completed. OT-A reviewed the therapy record and stated there was no history of OT being consulted for R8 for his unsupervised smoking, however, OT-A stated there were definitely "some compensatory methods" which could be used so R8 did not have use his abdomen or chest to light his cigarettes and potentially burn himself or start his clothing on fire; including assessing his cognition, looking at his dexterity and handling skills while using a cigarette and "just do a comprehensive assessment." R8 had impaired sensation and OT-A questioned, "Does he [R8] even know he's being burned?" Further, OT-A stated if someone with impaired dexterity and	2 830		

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2 830	Continued From page 16 sensation was sustaining cigarette burns with unsupervised smoking, it would be OT appropriate to review them so as to "assess functional deficits and safety." On 11/29/17, at 2:45 p.m. the director of nursing (DON) was interviewed regarding R8's unsupervised smoking. DON stated she started working at the nursing home in June 2017, and to her knowledge R8 had always refused interventions from staff for his smoking. R8 was "his own person and will do whatever he dang well pleases," and had a history of telling the staff things, then being upset about them the following day and yelling at them. DON stated the interventions offered to him in the past with his smoking were done as in passing conversations and they just had not been documented. DON stated she was unaware R8 had been burning himself while smoking as it had not been reported, however, if NA staff noticed cigarette burns in his clothing or on his skin, they should have completed a Stop-and-Watch so the burns could be treated and staff "can be looking at it." Further, DON stated the facility was ultimately responsible to ensure R8 was safe, however, when he signs himself out and leaves, he was his own person. During a follow up interview on 11/29/17, at 5:06 p.m. DON stated a report was made to the State agency (SA) regarding potential neglect for R8 since he had been sustaining cigarette burns from unsupervised smoking. A facility Smoke-Free Locations policy dated 3/2016, identified it applied to skilled care and smoking inside Good Samaritan Society (GSS) buildings was not permitted. The policy directed, "All residents/clients who smoke or use tobacco products will be assessed." A procedure was	2 830		

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2 830	Continued From page 17 listed which directed staff members would designate acceptable outdoor locations for resident smoking which "must be readily visible for staff member observation." Upon admission, residents who use tobacco will have a Tobacco Use Assessment completed. Further, additional assessments would be completed if a resident has a change in cognition, judgment, manual dexterity or mobility. The policy lacked any direction or procedure for staff to implement on how to address cigarette burn(s) on clothing and/or skin, should they occur. A Smoking and Tobacco Use policy dated 4/2017, identified it applied to skilled care and listed a purpose of reaffirming the GSS commitment to "a safe and healthy environment for employees, residents and visitors." The policy directed smoking shall be done away from the main entrance of the facility in spaces which were "readily visible" to staff. Further, "Residents who smoke must not pose a safety hazard to themselves or others." The policy lacked any direction or procedure for staff to implement on how to address safety with smoking nor cigarette burn(s) on clothing and/or skin, should they occur. No further policies or procedures related to smoking safety or unsupervised smoking were provided. The IJ which began on 11/28/17, was removed on 12/1/17, at 2:19 p.m. after the facility successfully implemented a removal plan which included the following: - R8 was reassessed by nursing for unsupervised smoking which identified he required a smoking apron, cigarette holder, supervision and one on	2 830		

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2 830	Continued From page 18	2 830		

one assistance. R8 refused all of these interventions, however, R8 "agreed to [OT evaluation for safety]." Further, the assessment identified R8 to now have a history of smoking related incidents including "a self reported incident of burning his finger" which he failed to report as it was "not a big deal." A subsequent progress note for R8's smoking reassessment dated 11/29/17, at 6:45 p.m. was authored by ADON. ADON explained to R8 they had reported the burn(s) for potential neglect of care while R8 demonstrated how he smoked. R8 was identified as reporting he had a "shitty lighter" when observed by the surveyor on 11/28/17, and should have gotten a different one, "instead of fighting with the shitty one and almost burning my shirt."

- An OT consultation was made for R8 to screen, assess and develop interventions for safe, unsupervised smoking. A provided OT Daily Treatment Note dated 12/1/17, identified R8 as having an "incomplete SCI [spinal cord injury] at C5 - C7 [vertebrae]," who had impaired sensation, impaired upper body strength and impaired motor control. OT completed a smoking evaluation which identified R8 was able to strike the lighter away from his body, however, "[his] thumb still very near flame when lighting. Will need to further explore options to reduce risk of burn." Further, R8 agreed to trying a plastic-smoking adaptor and e-cigarettes, along with throwing out the cigarette mid-way "before hot end nears hand."

- Educating all staff on ensuring cigarette burn(s) on clothing and/or skin were immediately reported and documented.

On 12/1/17, from 2:01 p.m. to 2:18 p.m. nursing and direct care staff were interviewed to ensure

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2 830	Continued From page 19 training had been provided related to R8's unsupervised smoking including ensuring R8's skin and clothing was routinely monitored for potential burn injuries, use of the Stop-and-Watch tool and communicating changes in resident conditions timely, and documentation standards pertaining to a change in condition. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise any applicable unsupervised smoking assessment and safety policies/procedures and educate all staf. The DON or designee could audit to ensure ongoing compliance and report the audit results to the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible.	2 910		12/29/17

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2 910	Continued From page 20 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to comprehensively reassess 1 of 1 residents (R6) with a change in urinary continence. Findings include: R6's quarterly Minimum Data Set (MDS) dated 6/21/17, indicated she was cognitively intact, had hypertension and diabetes mellitus. The MDS further indicated she was always continent of urine and was not on a toileting program. R6's quarterly MDS dated 9/20/17, indicated she was now occasionally incontinent of urine and was not on a toileting program. R6's care area assessment (CAA) dated 3/29/17, indicated she had urinary urgency and need for assist with toileting. The CAA indicated she received diuretics and did not indicate she was incontinent. R6's care plan dated 9/28/17, indicated she had hypertension, type two diabetes and congestive heart failure. The care plan indicated she had activity of self care performance deficit related to fatigue and limited mobility. The care plan did not indicate she was incontinent of urine. R6's Bladder Incontinence Data Collection tool dated 10/2/16, indicated she was wet less often than daily with a medium amount and she wore a absorbent pad. The tool further indicated R6 denied incontinence and could not recall having trouble with it. R6 could not recall the two episodes documented since admission on 9/28/16. There were no further assessments done related to bladder incontinence. R6's Skin	2 910	corrected	

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2 910	Continued From page 21 Observation dated 11/24/17, indicated she had excoriation to her right and left buttocks. R6's Point of Care (POC) response history for incontinence for the last 30 days indicated she was incontinent of urine 10 times in November. On 11/30/17, at 8:50 a.m. licensed practical nurse (LPN)- A and certified nursing assistant (CNA)- C were observed to place R6 onto the toilet. She was continent of urine and voided a small amount in the toilet. LPN-A was observed to clean R6's excoriated, reddened area that covered most of R6's right and left buttock. On 11/30/17, at 1:35 p.m. CNA-C stated that she worked the day shift and R6 was usually incontinent twice a shift when she worked. On 11/30/17, at 1:59 p.m. Registered Nurse (RN)-A stated R6 did not receive a bladder assessment after her change from continent of urine to occasionally incontinent of urine. RN-A stated the facility was aware this was an area they needed to work on and it was part of their performance improvement project. RN-A stated they wanted more residents to be continent of urine. RN-A further stated currently the computer program assessment tool did not provide an alert for quarterly bladder assessments so they were missed. In addition RN-A stated they were only able to print a history of incontinence going back 30 days based on nursing assistant documentation. During interview 12/1/17, at 8:03 a.m. CNA-D stated that when she worked with R6 she was usually continent of urine. Although R6 had a change in urinary incontinence	2 910		

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2 910	Continued From page 22 the facility failed to reassess the incontinence to minimize the risk of further change. A facility policy Bladder Assessment revised 3/17, indicated the purpose is to review/assess bladder patterns, incontinence and frequency, to identify potentially reversible causes of incontinence and to identify the probable type of urinary incontinence and potential toileting programs. The Assessment indicated this should be done quarterly and care plan interventions should be individualized based on the CAA and modified as appropriate based on assessment/evaluation of the residents response to the interventions and success with attaining/maintaining bladder continence. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could ensure policies and procedures are reviewed and updated for resident toileting needs. The DON or designee could educate all appropriate staff. The DON or designee could audit to ensure ongoing compliance and report the audit results to the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 910		
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 control of outbreaks of infectious diseases;	21390		12/29/17

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21390	Continued From page 23 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 observation, interview and record review the facility failed to develop a comprehensive infection control program which included data analysis of resident infections and trending to reduce the risk of spread of infections to other residents in the facility. This had the potential to affect all 27 residents who resided in the facility. Findings include: The facility's infection control logs were reviewed from June 2017, through November 29, 2017. The facility provided a document, titled Monthly Report of Resident Infections In Center, with a line present for month and year. The headings	21390	corrected	

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on top of the graph identified the total number of infections, the number [of infections] center acquired (nosocomial), and the number community acquired. The columns on the logs included the following information: name, room number, date admitted, date of infection, site of infection, culture taken (yes or no), causative agent, antibiotic treatment, cautionary measure, isolation (yes or no), and center acquired (yes or no). This document did not have any designations for symptoms not treated with antibiotics or non-bacterial infections such as viral or fungal infections.

The facility also provided documents titled Data Review Report, as well as a summary document titled monthly infection control report. The summary included a breakdown of infection types, and identified whether the infection was nosocomial or community acquired. Hand written entries at the bottom of the form were titled "Trends" and "Action Plan".

A review of these logs identified the following:

The document titled Monthly Report of Resident Infections in Center, dated June of 2017 identified six residents were treated with antibiotics for a total of 10 courses of antibiotic therapy. The categories of infection included the breakdown of infections as follows: Prophylactic antibiotic use - three residents; gastrointestinal (clostridium difficile - c. diff. a highly infectious bacterial illness which may cause diarrhea) - one resident; respiratory/lung infections - three residents; skin infections - two residents; and a urinary infection in one resident. A document titled Order Listing Report, dated June 28, 2017, identified residents who had received antibiotics, antifungal's, antiviral's in the month of June. Although

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antifungal's and antiviral's were noted on the report, only those residents receiving antibiotics were listed on the report of infections. The Monthly Infection Control Report identified a total of one nosocomial infection and four community acquired infections, to total five identified infections, yet six residents were addressed on the document. A hand written narrative note, titled Trends, identified the presence of one continued infection from the previous month (May 2017), and identified the number of infections reflect a "Downward trend". Additional data was not included to identify the previous trends or any pattern identified. The action plan identified staff education on aspiration pneumonia with hard copy learning as well as urinary tract infections, and skin/soft tissue education. Although requested, a Data Review Report was not provided for 6/17.

The Monthly Report dated July of 2017, identified four residents were treated with antibiotics for a total of four courses of antibiotic therapy. The categories of infection included the following: respiratory/lung infections - three residents; skin infections - one resident; and a urinary infection in one resident. The Monthly Infection Control Report identified a total of one nosocomial infection, and two community acquired infections. A hand written narrative note titled Trends, identified a resolved urinary tract infection upon admission, with identified negative lab work. However, the resident continued on prophylactic antibiotic use. One incident was identified as skin/soft tissue healing without antibiotics. The initial log reflected intravenous antibiotics were implemented for treatment. The action plan identified staff education on handwashing and infection prevention provided at a staff meeting in July. A Data Review Report was provided for the

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	00019	A. BUILDING: _____ B. WING _____	12/01/2017

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GOOD SAMARITAN SOCIETY - HOWARD LAKE	413 13TH AVENUE HOWARD LAKE, MN 55349

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month of 7/17. The positive findings identified one resident was treated for an upper respiratory tract infection, which was nosocomial. The infection remained isolated to one resident. The document additionally noted attempts to discontinue antibiotic therapy for a resident on a prophylactic antibiotic were successful. Although the review identified the data trending was positive, it did not provide a comparison to previous trends, nor did it identify a goal for the data measure, the goal was "to be determined". The document indicated the information had been reviewed by the QAPI (Quality Assurance Performance Improvement) group on 8/25/17, and no action was taken.

The report dated August 2017 identified three residents were treated with antibiotics for a total of three courses of antibiotic therapy. One resident was noted in each of the following categories: respiratory/lung infection, skin infection, and gastrointestinal. A document, titled Order Listing Report, dated 8/15/17, identified there was one resident being treated with antibiotic therapy through 8/18/17, and three individuals being treated with an antifungal powder. An Order Listing Report dated 9/1/17, identified one additional resident was treated with antibiotic therapy, and one resident continued to receive antifungal treatment. The Monthly Infection Control Report identified a total of two nosocomial infections, and one community acquired infection. A hand written narrative note, titled Trends, identified three infections of alternate sources with no trends noted. The note identified an episode of bronchitis was isolated with no spread of infection. The action plan identified staff re-education on isolation precautions related to recurrent problems with c. diff. A Data Review Report was provided for the

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month of 8/17. The positive findings identified one resident was treated for upper respiratory tract infection which was nosocomial, which remained isolated to one resident. The negative findings included prophylactic antibiotic treatment with risk versus benefit statement noted. It was also noted resident with c. diff positive culture will always test positive. The data review identified trending was positive, but no comparisons were provided. The data measure goal continued to indicate it was yet "to be determined". Although the review identified the data trending was positive, it did not provide a comparison to previous trends, nor did it identify a goal for the data measure. The information was noted to have been reviewed by the QAPI group on 9/20/17 with no action taken.

The Monthly Report for September of 2017 identified seven residents were treated with antibiotics for a total of eight courses of antibiotic therapy. Upon review of the entries, it was noted one entry was from 8/26/17. The categories of infection included the breakdown of infections as follows: skin infections - two residents, urinary infection in five residents, and c. diff. in one resident. An order listing report, dated 10/18/17, was provided for those receiving antibiotic and antifungal therapy. The Monthly Infection Control Report identified a total of three nosocomial infections, and five community acquired infections. A hand written narrative note, titled Trends, identified no trends were noted. A notation was also made identifying the c. diff. infection was isolated. It was noted three of five of the urinary tract infections were community acquired, one was nosocomial, and one was "procommunity admit." The action plan identified a "situation, background, assessment, recommendation (SBAR)" notification was provided to physicians, staff educated and

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interventions implemented. A note was written to monitor hand hygiene, however, it did identify how this would be done. A Data Review Report was requested but not provided for the month of 9/17.

The October 2017, report of resident infections in the center identified three residents with four courses of antibiotic therapy. The categories of infection included the breakdown of infections as follows: respiratory/lung - two residents, and gastrointestinal/colon - two residents. An order listing report, dated 11/13/17, was provided for those receiving antibiotic and antifungal therapy. The Monthly Infection Control Report identified a total of two nosocomial infections, and one community acquired infections. A hand written narrative note, titled Trends, identified no trends were noted. The action plan identified "flu [influenza]/pneumonia season approaching, noting reeducation was provided on precautions/vaccinations." A Data Review Report was provided for the month of October, 2017, and noted a positive data trending direction, however, the facility goal was yet to be determined. The information was noted to have been reviewed by the QAPI team on 11/17/17, and no action was taken.

The November 2017, report of resident infections in the center identified one resident, with only first name and first initial of the last name, with no additional documents provided. On three pink sticky notes there were four residents identified to have received antibiotic therapy on the following dates; 11/12/17, 11/17/17, 11/17/17, and 11/27/17. There were no additional documents provided when the Infection Control Log book was initially reviewed 11/28/17. Although requested, the Monthly Infection Control Report and Data Review report was not provided for

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21390	Continued From page 29 11/17. During the interview on 12/1/17, at 9:43 a.m. the director of nursing (DON) stated the information regarding infections was obtained on residents admitting to the facility, with lab results recorded if received. The DON stated tracking and trending was monitored through QAPI. The DON stated the information on the infection control log is compiled monthly. Staff relayed information regarding current infections via the Communication Book and shift reports. However, the DON further stated the log was not used day to day as it was used for monthly tracking and trending. In reviewing training needs identified, the DON stated staff education had been provided for handwashing in 7/17. The DON identified an increase in prevalence of urinary tract infections in 9/17. The DON stated staff was monitored for ongoing handwashing techniques through observation. Although an increase in UTI's was identified, audits and/or return demonstrations of handwashing had not been implemented. The DON stated the infection rate was compared to the previous month, however there was no documentation to reflect this. A table titled Resident Infection Control Report, dated 2017 was provided with data entered from January thorough June, however, no analysis was provided regarding trending or interventions implemented. A facility policy, titled Surveillance, reviewed 10/17 identified surveillance as an activity to "find, analyze, control and prevent nosocomial infections." The definition further outlined the process as date collection, analysis of data, establishment of trends, passing the information on to those who need to take action and documentation in conclusion.	21390		

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21390	Continued From page 30 SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could review and revise applicable infection control policies and procedures to ensure comprehensive surveillance and analysis of facility wide infection control systems which includes time, comprehensive tracking and trending. The director of nursing (DON) or designee could educate all appropriate staff. The director of nursing (DON) or designee could develop auditing systems to ensure ongoing compliance with infection control policies and procedures and report those results to the quality improvement group. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		