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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: M112

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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 **12/09/2015** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With
B. Not in Compliance with Program

Program Requirements Compliance Based On:
___1. Acceptable POC

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

Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(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 :
Debra Vincent, HFE NEII 12/28/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/28/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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
12/04/2015
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5550

Good Samaritan Society Warren has been designated as a Special Focus Facility (SFF)

On December 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2015, the Department of Public Safety completed a PCR to verify the facility achieved and maintained compliance with Federal certification Regulations. We presume based on the plan of correction that the facilty corrected the deficiencies as of November 29, 2015. Based on our visit, we have determined the facility has corrected the deficiencies issued pursuant to the October 15, 2015 standard survey, effective November 29, 2015. As a result of our findings, this Department discontinued the Category 1 remedy of State monitoring as of November 29, 2015.

In addition, the Department recommended to the CMS Region V Office, the following action related to the remedies imposed in the CMS letter of November 13, 2015:

• Federal Civil Money Penalty of $1,600.00 per instance for the instance of noncompliance at F353 (S/S: F) identified in the CMS-2567 for the survey ending October 15, 2015, remain in effect.

• Discretionary Denial of Payment for New Medicare and Medicaid Admissions, (DPNA), effective December15, 2015, be rescinded.

Since the primary trigger for NATCEP loss is DPNA, the facility's two year loss of NATCEP to begin December 15, 2015, would also be rescinded.

Refer to the CMS 2567b for both health and life safety code for the results of the revisits.

Effective November 29, 2015, the facility is certified for 52 skilled nursing facility beds.

MDH
Minnesota Department of Health

CMS Certification Number (CCN): 245550

December 28, 2015

Ms. Michelle Garrey, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

Dear Ms. Garrey:

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 November 29, 2015 the above facility is certified for:

52 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 52 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

Minnesota Department of Health

Electronically delivered
December 28, 2015

Ms. Michelle Garrey, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550026

Dear Ms. Garrey:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On November 3, 2015, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective November 8, 2015. (42 CFR 488.422)

On November 13, 2015, the Centers for Medicare and Medicaid Services (CMS) informed you that the following enforcement remedies were being imposed:

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions effective December 15, 2015
- Federal Civil Money Penalty of $1,600.00 per instance for the instance of noncompliance at F353 (S/S: F) identified in the CMS-2567 for the survey ending October 15, 2015

This was based on the deficiencies cited by this Department for a standard survey completed on October 15, 2015. The most serious deficiency was found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On December 9, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on December 16, 2015, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 15, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 29, 2015. We have determined, based on our visit, that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 15, 2015, as of November 29, 2015.

As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective November 29, 2015.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in their letter of November 13, 2015:

- Federal Civil Money Penalty of $1,600.00 per instance for the instance of noncompliance at F353 (S/S: F) identified in the CMS-2567 for the survey ending October 15, 2015, remain in effect.
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions effective December 15, 2015, be rescinded.

Further, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 15, 2015, due to discretionary denial of payment for new admissions. Since your facility attained substantial compliance on November 29, 2015, the original triggering remedy, discretionary denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us

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

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing	12/9/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **11/29/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **11/29/2015**	ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **11/29/2015**
ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **11/29/2015**	ID Prefix **F0318** Reg. # **483.25(e)(2)** LSC	Correction Completed **11/29/2015**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **11/29/2015**
ID Prefix **F0353** Reg. # **483.30(a)** LSC	Correction Completed **11/29/2015**	ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **11/29/2015**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **11/29/2015**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	12/28/2015	32981	12/09/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
10/15/2015			

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing 01 - MAIN BUILDING 01	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	11/24/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	TL/mm	12/28/2015	27200	12/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/21/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245550	A. Building B. Wing 02 - KITCHEN ADDTION	12/16/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0067	11/24/2015	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By TL/mm	Date: 12/28/2015	Signature of Surveyor: 27200	Date: 12/16/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on: 10/21/2015

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: M112

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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 **10/15/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **52** (L18)

13.Total Certified Beds **52** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	52			
(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 :
Vienna Andresen, HFE NEII — 11/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath
Enforcement Specialist — 12/02/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(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

CCN: 24 5550

Good Samaritan Society Warren has been designated as a Special Focus Facility (SFF)

On October 15, 2015 a standard survey was completed at this facility and found to not be in compliance with Federal participation requirements. The survey found the most serious deficiencies to be widespread deficiencies that contitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F). Since the facility is a SFF, the facility is subject to progressive enforcement. As a result the Department imposed the Category 1 remedy of State monitoring, effective November 8, 2015.

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

- Civil Money Penalty for deficiency cited at F353, effective October 15, 2015 (42 CFR 488.430 through 488.444
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 15, 2015

If Discretionary Denial of payment goes in effect, the facility would be subject to a two year loss of NATCEP begnning, December 15, 2105. Post Certification Revisit (PCR) to follow.

Refer to the CMS 2567 for both health and life safety code along with the facilitys plan of correction.

Minnesota Department of Health

Electronically delivered
November 3, 2015

Ms. Michelle Garrey, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550026

Dear Ms. Garrey:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On October 15, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567, whereby significant corrections are required. A copy of the Statement of Deficiencies (CMS-2567 and/or Form A) is enclosed.
This letter provides important information regarding your response to these deficiencies and addresses the following issues:

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);

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.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us

Phone: (218) 308-2104
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective November 8, 2015. (42 CFR 488.422)

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

- Civil Money Penalty for deficiency cited at F353, effective October 15, 2015 (42 CFR 488.430 through 488.444)

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 15, 2015.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore Good Samaritan Society - Warren is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective December 15, 2015. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

The CMS Region V Office will notify you of their determination regarding our recommendations, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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 PoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your 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 **December 15, 2015** (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by April 15, 2016 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Phone: (651) 430-3012 Fax: (651) 215-0525

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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 Good Samaritan Society, Warren is a Special Focus Facility (SFF) and a certification survey was conducted on 10/15/15. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under	F 279		11/29/15

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		11/13/2015

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

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F 279	Continued From page 1 §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a care plan to identify the use of coumadin (anitcoagulant) medication and interventions to monitor the side effects of the medication such as bruising and / or bleeding for 1 of 1 resident (R21) reviewed who received Coumadin daily. Findings include: R21's Diagnosis Report dated 10/15/2015, indicated R21 was diagnosed with atrial fibrillation (irregular heart rate), hypertension (high blood pressure) and dementia. R21's quarterly Minimum Data Set (MDS) dated 7/9/2015, indicated R21 received anticoagulant therapy. R21's current Medication Review Report, directed staff to administer Coumadin 1.5 milligrams (mg) to R21 daily. R21's care plan dated 10/14/15, failed to identify R22's diagnosis of atrial fibrillation, coumadin use and corresponding interventions to direct staff to observe for side effects of anticoagulation therapy usage, such as excessive bleeding, bruising and	F 279	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. F279 1. R21's care plan was updated 10/15/2015 to identify the use of anticoagulant therapy and interventions to monitor side effects of Coumadin. 2. All current and future residents who receive anticoagulant therapy will have the use of the medication and interventions reflected in their care plan. 3. Licensed staff was educated on 10/23/2015 regarding the system for anticoagulant therapy being addressed in the care plan. 4. Care plans of residents who received	

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F 279	Continued From page 2 international normalized ration monitoring (INR-lab work to identify blood clotting levels). On 10/15/2015, at 11:55 a.m. the director of nursing (DON) stated R21 received Coumadin daily for atrial fibrillation. The DON verified R21's care plan lacked focus areas and interventions with regards to anticoagulation management. The DON stated Coumadin was a high risk medication and should have been identified on the care plan. The facility policy titled, Care Plan, dated 9/2012, indicated, "Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs.	F 279	anticoagulant therapy will be audited by DNS, or designee, to assure care plan interventions are in place 2x/month x 2 months, monthly x 1. Reports of audits will be forwarded to QAPI committee for review and further recommendations. 5. 11/29/2015	
F 282 SS=E	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure turning and repositioning assistance was provided and / or utilized safe repositioning devices and / or apply pressure relieving boots as directed by the care	F 282	F282 1. R37 will not be up in wheel chair longer than indicated by physician order. The resident's preference to be up in wheelchair longer than the physician order	11/29/15

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F 282	Continued From page 3 plan for 4 of 4 residents (R37, R20, R10, R9) observed for timely positioning and pressure ulcer care. In addition, the facility failed to provided incontinence care and services as directed by the care plan for 2 of 2 residents (R20, R10) observed for timely toileting. The facility failed to ensure a brace used for contractures was implemented as directed by the care plan for 1 of 3 residents (R10) observed who had a contracture and failed to ensure oral care was provided as directed by the care plan for 1 of 2 residents (R20) observed during evening cares. Findings include: R37 had a healing stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer, and was not provided bedrest as directed by the care plan. R37's care plan dated 8/9/15, indicated R37 had a pressure ulcer on the coccyx. The interventions directed staff to turn and reposition R37 every two hours, encourage off loading (pressure relief) while sitting and provide wound care as ordered. R37 was to be up in wheelchair for meals only for a maximum of 45 minutes. On 10/13/15, at 9:14 a.m. the director of nursing (DON) stated R37 had developed the stage IV pressure ulcer while hospitalized and was first noted when R37 was readmitted to the nursing home on 3/5/15. On 10/14/15, from 1:15 p.m. until 8:17 p.m. R37	F 282	will have a risk/benefit discussion documented. R20 and R10 will be reevaluated utilizing the positioning assessment and evaluation tool and the care plan will be updated to reflect the resident's assessed need. Residents will receive repositioning as indicated in the plan of care. R20 will be provided oral care. R20 and R10 will receive incontinence care as directed by the care plan. R10 will be referred to OT for reevaluation of brace. Nursing staff will apply brace as directed by OT as indicated in care plan. R9 will have pressure relief boots and will be repositioned as indicated by care plan and will be reassessed using the position assessment and evaluation tool. 2. All current residents dependent for turning/repositioning, requiring application of devices and dependent for toileting will be assessed for these areas quarterly, annually and upon significant change and care plans updated as needed. All future residents will be assessed for dependence on turning/ repositioning, require application of devices, oral care, and toileting needs upon admissions and reviewed for appropriate care plan interventions assessed quarterly, annually and upon significant change with care plan updated as needed. Residents with low Braden scores will be reassessed using the position assessment and evaluation tool. 3. On November 19th and 20th all nursing staff will be educated on the policy and procedure for routine daily practices, and the importance to follow care plans	

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F 282	Continued From page 4 was continuously observed. -At 1:15 p.m. R37 was assisted into bed and provided wound care to the stage IV pressure ulcer on the coccyx. The wound bed was observed pink with new tissue granulation. R37 remained in bed. -At 2:00 p.m. R37 was assisted into the wheelchair and assisted to the birthday party. R37 was observed to remain seated in the wheelchair until 8:17 p.m. (seven hours and two minutes). On 10/14/15, at 7:53 p.m. nursing assistant (NA)-C verified she was responsible for R37's cares. NA-C stated R37 was not on bedrest, however, R37 should not be up in the wheelchair for over three hours at a time and ideally, should be in bed. NA-C stated she usually tried to reposition R37 in bed and when in the wheelchair and had not. On 10/14/15, at 5:07 p.m., the DON stated R37's care plan for bedrest with the exception of being up for 45 minutes during meals should have been followed. R20 was at risk for pressure ulcer development and was not provided assistance with repositioning as directed by the care plan. R20's care plan dated 7/20/15, indicated pressure ulcer risk and directed staff to turn and reposition R20 every two hours, use body pillow to prevent knees from reaching the wall and causing injury, provide pressure reducing mattress in bed and cushion in wheelchair and to notify nurse immediately for skin breakdown.	F 282	on turning and repositioning, application of devices, oral care, and toileting. Licensed nurses will also be reeducated regarding resident refusal and risk benefit education and documentation. A formal root cause analysis will be initiated through the QAPI process to identify barriers to the provision of care according to the care plan. Upon results of the root cause analysis the PDSA cycle will be initiated. This process will continue until an intervention demonstrates sustainability. Interdisciplinary team will review EHR dashboard which includes point of care tasks documentation for task completion. A checklist will be developed and implemented with the licensed nurses for monitoring to ensure daily care has been completed per care plan every shift. 4. Personal cares and adherence to care plans will be audited by observation and documented on all shifts by licensed nurses daily, licensed nurses will provide immediate correction to staff if plan of care is not followed. All findings will be forwarded to DNS for further action and analysis for trends and patterns. DNS will report findings and action plans weekly to leadership staff. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

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F 282	Continued From page 5 On 10/14/15, from 4:43 p.m. until 7:48 p.m. R20 was continuously observed seated in a wheelchair without repositioning / offloading assistance (three hours and five minutes). During this observation, R20 was noted to be unable to verbally communicate or make needs known. -At 7:48 p.m. Na-C was observed to assist R20 into bed and provide evening cares. R20's buttocks were observed to be red with no open areas. On 10/14/15, at 7:55 p.m. NA-C stated she had just started her shift and was unaware of when the last time R20 was repositioned / offloaded. On 10/14/15, at 8:00 p.m. NA-G stated she had answered call lights on R20's wing, but had not been assigned to provide resident care, therefore, had not provided R20 repositioning assistance. On 10/14/15, at 7:13 p.m. registered nurse (RN)-A stated she had not provided R20 with repositioning of off-loading. On 10/15/15, at 9:10 a.m. the DON confirmed R20 should have been repositioned every 2 hours as directed by R20's care plan. ORAL CARE R20 was not provided oral care during observation of evening care on 10/14/15. R20's care plan dated 10/14/15, indicated R20 required total staff assistance with all personal	F 282		

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F 282	Continued From page 6 cares including oral cares. On 10/13/15, at 11:22 a.m. R20's teeth were observed with a build up of white tarter like substance. On 10/14/15, at 7:48 p.m. NA-C was observed providing R20 evening cares. R20's teeth were observed to have a large amount of white debris covering her front teeth. NA-C had not provided R20 oral care. On 10/15/15, at 9:10 a.m. the DON stated it was her expectation oral care would be provided with both morning and evening cares according to R20's care plan. TOILETING R20 was incontinent of urine and was not provided assistance with incontinence care as directed by the care plan. R20's care plan dated 10/14/15, indicated R20 was incontinent of bowel and bladder and directed staff to check and change R20's incontinent brief every two hours. On 10/14/15, from 4:43 p.m. until 7:48 p.m. R20 was continuously observed and was not provided incontinence care (three hours and five minutes). -At 7:48 p.m. NA-C assisted R20 to bed. When NA-C provided incontinence care, R20's incontinent brief was observed saturated with urine which had a strong, foul odor. NA-C verified R20 was incontinent of a large amount of foul	F 282		

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smelling urine.
-At 7:55 p.m. NA-C stated she had just started her shift and did not know who was responsible to provide R20 cares and was not aware if R20 had been assisted with incontinence needs from the time the day shift NA left at 2:30 p.m. until NA-C had provided R20 cares.

On 10/15/15, at 9:10 a.m. the DON confirmed R20 should have been provided incontinence care and services every two hours as directed by R20's care plan.

R10 was not provided repositioning assistance, application of a right hand brace nor provided timely incontinence care as directed by R10's care plan.

R10's care plan dated 6/24/15, indicated R10 was at risk for pressure ulcer development, was incontinent of bowel and bladder and had left sided paralysis with a decreased range of motion. The care plan directed staff to turn and reposition R10 at least every two hours and as needed and also provide toileting and incontinence care (as noted below per the DON). The plan also directed staff to apply a brace to R10's right hand for two hours when in bed, three times a day, after meals.

On 10/14/15, at 12:49 p.m. R10 was observed in bed, eating lunch. At 1:12 p.m. R10's lunch tray had been removed and R10 remained in bed. A brace had not been applied to R10's right arm/wrist.

On 10/15/15, at 5:00 p.m. R10 was observed

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seated in her wheelchair in the dining room, with other residents, as the activity staff member was reading to them.
-At 5:28 p.m. R10 remained seated in her wheelchair at the dining room table. R10 proceeded to be served and consume her evening meal.
- At 6:41 p.m. licensed practical nurse (LPN)-A transported R10 back to R10's room. LPN-A positioned R10's wheelchair in front of the television set and adjusted R10's bed side stand. LPN-A lacked placing R10's hand brace on R10's right hand/wrist. In addition, LPN-A lacked offering R10 an opportunity to be repositioned or toileted.
-At 7:02 p.m. RN-A was observed to enter R10's room and administered R10's medication. RN-A lacked offering R10 an opportunity to be repositioned or toileted.
-At 8:10 p.m. (3 hours and 10 minutes since R10 had last been repositioned) the surveyor intervened and interviewed the DON.
-At 8:15 p.m. NA-B and NA-C entered R10's room and was observed to assist RN-B with R10's evening cares.
-At 8:20 p.m. (3 hours and 20 minutes since R10 had been repositioned) NA-B, NA-C and RN-B utilized a mechanical lift and transferred R10 from the wheelchair to bed. R10 was positioned in bed; RN-B and NA-C checked and removed R10's soiled brief. R10 had been incontinent of a large amount of urine and bowel. R10's perineal area was covered in bowel movement from the front to the back. R10's coccyx area was reddened. RN-B confirmed R10 had been incontinent of bowel and bladder.
On 10/14/15, at 8:10 p.m. the DON confirmed she expected staff to follow R10's care plan with regards to R10's every two hour turning and

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repositioning program.
On 10/15/15, at 8:25 a.m. the DON stated even if R10's care plan had not specifically directed staff to toilet R10 every two hours, this was the standard of practice for a resident who was incontinent.
On 10/15/15, at 8:30 p.m. RN-B confirmed R10's hand brace was not applied and remained on the bedside stand in a basket, near R10's bed.

R9 was not repositioned in bed using the positioning lift, and pressure relief boots were not on at all times as directed by R9's plan of care.

R9's care plan dated 10/15/15, indicated R9 had a deep pressure ulcer to the right heel and was at risk for further breakdown and was incontinent of bladder. The care plan directed staff to ensure R9's blue pressure (Prevalon) relief boots were on at all times and heels were free from pressure, two staff total assist to turn and reposition with a mechanica lift and a repositioning sling at least every 2 hours and two staff to check and provide incontinent care every 2 hours and change as needed.

On 10/15/15, at 8:04 a.m. R9 was observed seated in her wheelchair in the dining room. R9 was not wearing the Prevalon boots.

On 10/15/15, at 9:04 a.m. NA-E and NA-D transferred R9 from her wheelchair to bed via a mechanical lift. Once in bed, the NAs detached the lift sling and proceeded to physically turn R10 side to side during the provision of cares. R9's body and head were observed rigid with R9's head up off the bed. After completing cares, NA-E applied R9's Prevalon boots.

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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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F 282	Continued From page 10 On 10/15/15, at 9:15 a.m. NA-E confirmed R9 was to wear the boots at all times. NA-E stated staff did not use the mechanical lift to reposition R10 in bed because they don't have time to use it. A bed positioning lift sheet was observed on the bed under R9 and the lift was positioned at R9's bedside, however, the lift was not used for repositioning R9 in bed. On 10/15/15, at 11:38 a.m. RN-B confirmed R9 required total assistance and stated the facility had a no lift policy so staff would not injury themselves or the resident during transfers. RN-B stated If a resident was unable to turn themselves, staff were directed to use the lift to reposition them. RN-B verified R9 was unable to independently move in bed therefore staff were expected to use the lift to reposition R9. RN-B stated the lift was for repositioning a resident in bed in order to keep the resident from getting harmed during transfers or positioning. Additionally, RN-B confirmed R9 was to wear the Prevalon boots at all times. On 10/15/15, at 12:02 p.m. the DON confirmed R9 was very rigid with movement and it was her expectation staff implemented safe resident handling which directed staff to use the mechanical lift for transferring and positioning a dependent resident as it really reduced the risk of injury to the resident and staff. the DON stated staff should have used the lift when repositioning R9 in bed and providing cares. The DON also verified R9 was to wear the Prevalon boots at all times as directed by the care plan. The DON stated it was her expectation that staff follow and implement the residents care plans. The facility Care Plan policy dated 9/2012,	F 282		

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F 282	Continued From page 11 indicated residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. In addition, the care plan would emphasize the care of the resident ensuring the resident received appropriate care and services.	F 282		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility to ensure oral care was provided for 1 of 2 residents (R20) observed during evening cares and was dependent of staff for the service and failed to ensure timely assistance for bowel and bladder incontinence was provided for 2 of 2 residents (R20, R10) observed who were dependent on staff for assistance with incontinence care. Findings include: R20 was not provided incontinence care nor oral care as directed by the care plan. R20's quarterly Minimum Data Set (MDS) dated	F 312	F312 1. R20 will receive oral care. R20 and R10 will receive bowel and bladder incontinence care according to care plan. 2. All current residents dependent for toileting will be assessed quarterly, annually and upon significant change and care plans updated as needed. Residents will be assessed for oral needs annually and upon significant change. All future residents will be assessed for oral needs, and toileting needs upon admissions. Toileting will be reviewed for appropriate care plan interventions quarterly, annually and upon significant change with care plan updated as needed. Residents will be assessed for oral needs annually and upon significant change.	11/29/15

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F 312	Continued From page 12 7/15/15, indicated R20 had memory impairment, was non ambulatory, required full physical assistance with personal hygiene including oral care, was always incontinent of bowel and bladder, was not on a scheduled toileting plan and required extensive assistance of two or more persons for toileting needs, transfers and mobility. R20's care plan dated 10/14/15, indicated R20 required total assistance with oral care. The plan also indicated R20 required incontinent care and directed staff to check and change R20's incontinent brief every two hours. R20's Diagnosis Report dated 10/15/15, indicated R20 was diagnosed with Alzheimer's disease, adult failure to thrive and unspecified psychosis. Review of R20's medical record revealed a dentist had assessed R20's oral cavity and teeth on 9/26/14, and indicated R20 had periodontal disease and gingivitis. On 10/13/15, at 11:22 a.m. R20's teeth were observed with a build up of white tarter like substance. On 10/14/15, from 4:43 p.m. until 7:48 p.m. R20 was continuously observed and was not provided incontinence care (three hours and five minutes). During this observation, R20 was noted to be unable to express needs. At 7:48 p.m. NA-C assisted R20 to bed to provide evening cares. R20's front teeth were observed to have a large amount of white debris covering the teeth. When NA-C provided incontinence care, R20's incontinent brief was observed saturated with urine which had a strong, foul odor. NA-C verified R20 was incontinent of a large amount of foul	F 312	3. On November 19th and 20th all nursing staff will be educated on the policy and procedure for routine daily practices, and the importance to follow care plans on toileting. Staff will be reeducated regarding expectations for resident oral care. A formal root cause analysis will be initiated through the QAPI process to identify barriers to the provision of care according to the care plan. Upon results of the root cause analysis the PDSA cycle will be initiated. This process will continue until an intervention demonstrates sustainability. Interdisciplinary team will review EHR dashboard which includes point of care tasks documentation for task completion. A checklist will be developed and implemented with the licensed nurses for monitoring to ensure daily care has been completed per care plan every shift. 4. Provision of toileting per plan of care and oral care will be audited by observation and documented on all shifts by licensed nurses daily, licensed nurses will provide immediate correction to staff if plan of care is not followed. All findings will be forwarded to DNS for further action and analysis for trends and patterns. DNS will report findings and action plans weekly to leadership staff. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

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smelling urine. NA-C completed evening cares and had not provided R20 oral cares.
-At 7:13 p.m. registered nurse (RN)-A verified she was responsible for the oversight of resident care on R20's unit and stated she had not provided R20 incontinence care.
-At 7:55 p.m. NA-C stated she had just started her shift and did not know who was responsible to provide R20 cares and was not aware if R20 had been assisted with incontinence needs from the time the day shift NA left at 2:30 p.m. until NA-C had provided R20 cares.
-At 8:00 p.m. NA-G stated she had answered call lights on R20's wing (600 wing) but had not been assigned to provide resident care therefore she had not provided R20 with any assistance related to incontinence needs.

On 10/15/15, at 9;10 a.m. the director of nursing (DON) stated that it was her expectation oral care be provided with both morning and evening cares and R20 should have been provided oral care during evening cares on 10/14/15. The DON also stated R20 should have been provided incontinence care and services every two hours as directed by the care plan.

A facility policy related to providing oral care / evening cares and incontinence care was requested but not provided.

R10 was not provided incontinence care for 3 hours and 20 minutes on the evening of 10/14/15.

R10's care plan dated 6/24/15, indicated R10 had bowel and bladder incontinence and directed staff to turn and reposition R10 at least every two hours and as needed (DON had confirmed this included toileting / incontinence care as noted

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below). Perineal care was to be provided with each incontinent episode.

R10's quarterly MDS dated 8/11/15, indicated R10 had severe cognitive impairment and required extensive assist with personal hygiene and toileting, was incontinent of bowel and bladder, had limited upper extremity range of motion (ROM) on one side and limited ROM on both lower extremities.

R10's Diagnosis Report printed on 10/15/15, indicated R10 was diagnosed with hemiplegia (paralysis on one side of the body) and hemiparesis (weakness) from a stroke, history of urinary tract infections, acute kidney failure and dementia.

R10's Care Area Assessment (CAA) dated 3/2/15, indicated R10 required total assistance with toileting.

On 10/15/15, at 5:00 p.m. R10 was observed seated in her wheelchair in the dining room, with other residents, as the activity staff member was reading to them.
-At 5:28 p.m. R10 remained seated in her wheelchair at the dining room table. R10 proceeded to be served and consume her evening meal.
- At 6:41 p.m. licensed practical nurse (LPN)-A transported R10 back to R10's room. LPN-A positioned R10's wheelchair in front of the television set and adjusted R10's bed side stand. LPN-A lacked offering R10 an opportunity to be toileted.
-At 7:02 p.m. RN-A was observed to enter R10's room and administered R10's medication. RN-A lacked offering R10 an opportunity to be toileted.

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F 312	Continued From page 15 -At 8:10 p.m. (3 hours and 10 minutes since R10 had last been repositioned) the surveyor intervened and interviewed the DON. -At 8:15 p.m. NA-B and NA-C entered R10's room and was observed to assist RN-B with R10's evening cares. -At 8:20 p.m. (3 hours and 20 minutes since R10 had been repositioned) NA-B, NA-C and RN-B utilized a mechanical lift and transferred R10 from the wheelchair to bed. R10 was positioned in bed. RN-B and NA-C checked and removed R10's soiled brief. R10 had been incontinent of a large amount of urine and bowel. R10's perineal area was covered in bowel movement from the front to the back. R10's coccyx area was reddened. RN-B confirmed R10 had been incontinent of bowel and bladder. On 10/15/15, at 8:25 a.m. the DON stated even if R10's care plan had not specifically directed the staff to toilet R10 every two hours, this was the standard of practice for a resident who was incontinent. On 10/15/15, at 11:39 a.m. NA-D stated R10 should have the incontinent brief checked / changed every two hours. On 10/15/15, at 11:47 a.m. NA-E stated she thought R10 should have had her brief checked and changed if needed, every two hours. Care Plan policy dated 9/2012, indicated residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. In addition, the care plan would emphasize the care of the resident ensuring the resident received	F 312		

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F 312	Continued From page 16 appropriate care and services. No policy related to incontinence care was provided.	F 312		
F 314 SS=E	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement interventions in order to promote wound healing and / or prevent the development of pressure ulcers according to the individual assessed need for 4 of 4 residents (R37, R20, R10, R9) in the sample observed for pressure ulcer care and services. Findings include: R37 had a healing stage IV (Full thickness tissue loss with exposed bone, tendon or muscle. Slough or eschar may be present on some parts of the wound bed. Often includes undermining and tunneling) pressure ulcer and was not provided bedrest according to the physician order	F 314	F314 1. R37 will not be up in wheel chair longer than indicated by physician order. The resident's preference to be up in wheelchair longer than the physician order will have a risk/benefit discussion documented. R10 and R20 will be reevaluated utilizing the positioning assessment and evaluation tool and care plan will be updated to reflect the resident's assessed need. Residents will receive repositioning as indicated by plan of care. R9 will have pressure relief boots and will be repositioned as indicated by care plan and will be reassessed using the position assessment and evaluation tool 2. All current and future residents will be	11/29/15

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F 314	Continued From page 17 and as directed by the care plan. R37's Diagnosis Report dated 10/15/15, indicated R37 diagnoses included pressure ulcer of sacral (buttock) region, anemia and low back pain. R37's quarterly Minimum Data Set (MDS) dated 8/25/15, indicated R37 had memory impairment, required extensive assistance of two or more persons for transfers and bed mobility, was unable to ambulate, had a urinary catheter, was occasionally incontinent of bowel and had one unhealed stage IV pressure ulcer which measured 1.8 centimeter (cm) in length by 2.0 cm in width and 0.3 cm in depth. R37's physicians order dated 5/8/15, directed bedrest with complete offload-up (pressure relief) and up for meals for 45 minutes maximum. R37's care plan dated dated 8/9/15, indicated R37 had a pressure ulcer on the coccyx and directed staff to assist R37 with turning and repositioning every two hours, encourage off loading while sitting, provide wound care as ordered, provide a pressure relief mattress, follow physician order for bedrest and up in wheelchair only for meals for 45 minute maximum amount of time, provide cushion while in wheelchair. The plan also directed staff to provide supplemental protein, amino acids, vitamins and minerals to promote wound healing and four ounces Arginaid (a dietary supplement that is high in protein) extra twice a day and Ensure Plus four ounces four times a day. The plan directed staff to notify	F 314	assessed using the Braden scale. Current or future residents with a Braden score of 18 or below will have the positioning assessment and evaluation tool completed and care planned as appropriate. 3. On November 19th and 20th all nursing staff will be reeducated on the importance to follow the care plan and document appropriately on turning/repositioning and application of devices. Licensed nurses will also be reeducated regarding resident refusal and risk benefit education and documentation. A consultation with a TENA representative will be scheduled A formal root cause analysis will be initiated through the QAPI process to identify barriers to the provision of care according to the care plan. Upon results of the root cause analysis the PDSA cycle will be initiated. This process will continue until an intervention demonstrates sustainability. Interdisciplinary team will review EHR dashboard which includes point of care tasks documentation for task completion. A checklist will be developed and implemented with the licensed nurses for monitoring to ensure daily care has been completed per care plan every shift. 4. Turning/repositioning, application of devices, and adherence to care plans will be audited by observation and documented on all shifts by licensed nurses daily, licensed nurses will provide immediate correction to staff if plan of care is not followed. All findings will be forwarded to DNS for further action and	

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F 314	Continued From page 18 nurse immediately of any new areas of skin breakdown such as redness, blisters, bruises, discoloration, etc. and to reinforce to R37 the importance of adequate intake. On 10/13/15, at 9:14 a.m. the director of nursing (DON) stated R37 had developed the stage IV pressure ulcer while hospitalized and the pressure ulcer was first noted when R37 was readmitted to the nursing home on 3/5/15. On 10/14/15, from 1:15 p.m. until 8:17 p.m. the following continuous observations were made: -At 1:15 p.m. R37 was assisted into bed and provided wound care to the stage IV pressure ulcer on the coccyx. The wound bed appeared pink with new tissue granulation. Following the wound care, R37 remained in bed. -At 2:00 p.m. R37 was assisted into the wheelchair and assisted to the facility monthly birthday party. R37 was observed to remain up in the wheelchair until the observation ended at 8:17 p.m. On 10/14/15, at 4:44 p.m. licensed practical nurse (LPN)-B was asked if R37's physician order for bedrest with the exception of being up 45 minutes for meals was still a current order and was to be followed. LPN-B stated she was unaware of a physician order for R37's bedrest and stated R37 preferred to be up in her wheelchair rather than in bed. LPN-B stated the facility's practice was to provide off-loading and repositioning at a minimum of every two hours and had off-loaded R37 while assisting R37 to the toilet twice between 2:00 p.m. and 4:44 p.m.	F 314	analysis for trends and patterns. DNS will report findings and action plans weekly to leadership staff. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

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On 10/14/15, at 5:07 p.m. the DON was asked if R37's physician order for bedrest except for 45 minutes for meals was still supposed to be followed or if the care plan interventions which directed staff to turn and reposition R37 every two hours was what staff were supposed to follow. The DON confirmed R37's care plan directives for repositioning needs were conflicting and she did not know if the physician wanted R37 to be on bedrest or not. The DON stated she would call the physician in the morning to clarify R37's repositioning needs.

On 10/14/15, at 7:01 p.m. R37 stated when the pressure ulcers first developed she was told she needed to be on bedrest at all times except for 45 minutes during meals when she could be up in the wheel chair. R37 stated when the ulcers started to heal she was able to stay up out of bed more and more. R37 stated she had made the decision to be up in the chair more and more. R37 further stated she had asked a few of the facility staff if it was OK to stay up longer than the 45 minutes and they stated yes that this was OK. When R37 was asked if any of the nursing staff had explained to her what could happen if she did not follow the physician orders for bedrest she stated no, but I suppose the sores might not heal, but they are healing so I'm O.K.'D

R37's interdisciplinary progress notes were reviewed from 3/5/15-10/14/15, and there was no documentation found that indicated R37 had been explained the risk and benefits of following the physicians order for bedrest to promote wound healing.

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On 11/14/15, at 7:53 p.m. nursing assistant (NA)-C who was responsible for R37's care, stated that R37 was not on bedrest and she usually tried to rotate R37 when in bed and the wheelchair, however, R37 should not be up in the wheelchair for over 3 hours at one time. NA-C stated ideally, R37 should be in bed. NA-C stated R37 preferred to stay up in the wheelchair in the evening watching television until about 9:00 p.m.

On 10/16/15, at 12:12 p.m. the DON was interviewed vie telephone. The DON stated the staff from the wound clinic had called and informed her the physician order for R37's bedrest had not been discontinued and the physician wanted R37 to continue with bedrest except for the 45 minute time allowance to be up for meals.

R20 was at risk for pressure ulcer development and was not provided assistance with repositioning according to the assessed need.

R20's Diagnosis Report dated 10/15/15, indicated R20 was diagnosed with Alzheimer's disease, adult failure to thrive and unspecified psychosis.

R20's quarterly Minimum Data Set (MDS) dated 7/15/15, indicated R20 had memory impairment, required extensive assistance of two or more persons for transfers and bed mobility, was unable to ambulate, was always incontinent of bowel and bladder and was at risk for pressure

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F 314	Continued From page 21 ulcer development. R20's care plan dated 7/20/15, indicated R20 was at risk for pressure ulcers and directed staff to turn and reposition R20 every two hours, use body pillow to prevent knees from reaching the wall and causing injury, provide pressure reducing mattress and cushion for wheelchair and to notify the nurse immediately for skin breakdown. The Positioning Assessment & Evaluation dated 10/7/15, indicated R20 was completely dependent on staff for repositioning needs, was incontinent of bowel and bladder, required two staff and a total lift for all transfers, required assistance of one staff and repositioning sling with lift for positioning, and needed to be turned and repositioned every two hours to promote healing of pressure ulcers and other skin integrity issues. R20's Skin Observation form completed 10/9/15, identified R20 had no skin conditions observed. On 10/14/15, from 4:43 p.m. until 7:48 p.m. R20 was continuously observed seated in a wheelchair without repositioning / offloading assistance (three hours and five minutes). During this observation, R20 was noted to be unable to verbally communicate or make needs known. -At 7:13 p.m. registered nurse (RN)-A stated she had not provided R20 with repositioning or off-loading needs. -At 7:48 p.m. R20 was assisted to bed and NA-C provided evening cares. R20's buttocks were	F 314		

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observed to be red with no open areas.
-At 7:55 p.m. NA-C stated she had just started her shift and did not know who was responsible to provide R20 cares and was not aware if R20 had been assisted with incontinence needs from the time the day shift NA left at 2:30 p.m. until now, when she had provided R20 cares because there wasn't a NA assigned to R20's wing after 2:30 p.m. until she arrived at 7:30 p.m.
-At 8:00 p.m. NA-G stated she had answered call lights on R20's wing but was not assigned to provide any resident care therefore she had not assisted R20 in any way.

On 10/15/15, at 9:10 a.m. the DON confirmed R20 should have been repositioned every two hours according to the assessed needs.

R10 was identified at risk for the development of a pressure ulcer and was not repositioned for 3 hours and 20 minutes on the evening of 10/14/15.

R10's care plan dated 6/24/15, indicated R10 was at risk for pressure ulcer development related to R10's limited mobility and bowel and bladder incontinence. The interventions directed staff to turn and reposition R10 at least every two hours and as needed.

R10's quarterly MDS dated 8/11/15, indicated R10 had severe cognitive impairment and required total assist with bed mobility and transferring, required extensive assist with personal hygiene, toileting and dressing. was at risk for the development of a pressure ulcer which included an intervention for a turning and repositioning program, incontinent of bowel and bladder; had limited upper extremity range of

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motion (ROM) on one side and limited ROM on both lower extremities. R10's Pressure Ulcer Care Area Assessment (CAA) dated 3/2/15, indicated R10 was at risk for the development of a pressure ulcer and required a scheduled turning program. Care plan considerations included continuation of the current care plan with repositioning, off-loading, and perineal care after each incontinence episode to prevent pressure ulcer/skin breakdown.

R10's Mobilization Support Data Collection Tool dated 8/11/15, indicated R10 used a total lift for bed mobility and transfers. R10 had limited ROM and a loss of voluntary movement in lower extremities and upper left extremity.

R10's Braden Scale for Predicting Pressure Sore Risk dated 8/19/15, identified R10 to be at risk for the development of a pressure ulcer and the intervention guide recommended R10 be turned frequently and moisture managed.

R10's Skin Observation dated 9/14/15, indicated no skin conditions.

R10's Diagnosis Report dated 10/15/15, indicated R10's diagnoses included hemiplegia (paralysis on one side of the body) and hemiparesis (weakness) from a stroke, acute kidney failure, dementia, and diabetes.

On 10/15/15, at 5:00 p.m. R10 was observed seated in her wheelchair in the dining room, with other residents, as the activity staff member was reading to them.
-At 5:28 p.m. R10 remained seated in her wheelchair at the dining room table. R10 proceeded to be served and consume her

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evening meal.
- At 6:41 p.m. licensed practical nurse (LPN)-A transported R10 back to R10's room. LPN-A positioned R10's wheelchair in front of the television set and adjusted R10's bed side stand. LPN-A lacked offering R10 an opportunity to be repositioned.
-At 7:02 p.m. RN-A was observed to enter R10's room and administered R10's medication. RN-A lacked offering R10 an opportunity to be repositioned.
-At 8:10 p.m. (3 hours and 10 minutes since R10 had last been repositioned) the surveyor intervened and interviewed the DON.
-At 8:15 p.m. NA-B and NA-C entered R10's room and was observed to assist RN-B with R10's evening cares.
-At 8:20 p.m. (3 hours and 20 minutes since R10 had been repositioned) NA-B, NA-C and RN-B utilized a mechanical lift and transferred R10 from the wheelchair to bed. R10 was positioned in bed; RN-B and NA-C checked and removed R10's soiled brief. R10 had been incontinent of a large amount of urine and bowel. R10's perineal area was covered in bowel movement from the front to the back. R10's coccyx area was reddened.

On 10/14/15, at 8:10 p.m. the DON confirmed she expected staff to follow R10's care plan with regards to R10's every two hour turning and repositioning program.

On 10/15/15, at 11:39 a.m. NA-D stated R10 should be turned and repositioned every two hours.

On 10/15/15, at 11:47 a.m. NA-E stated she thought R10 should have been repositioned every

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F 314	Continued From page 25 two hours. R9 had a heel pressure ulcer and staff failed to apply Prevalon pressure relieving boots as directed by the care plan. R9's Wound Assessment dated 9/28/15, indicated R9 had a deep tissue pressure ulcer to right heel. Interventions included repositioning / turning, support surfaces, wound treatment, pain management and moisture/incontinence protection. R9's Positioning Assessment dated 9/29/15, indicated R9 was at risk for pressure ulcer development, was dependent on staff for all mobility, was unable to make major changes in body position per self, Braden score indicated risk for pressure ulcer development and had a current deep tissue pressure ulcer to right heel. The assessment also indicated bilateral Prevalon boots were to be worn at all times and staff to reposition R9 every two hours. R9's quarterly Minimum Data Set (MDS) dated 9/29/2015, indicated R9 had severe cognitive impairment, had a deep tissue pressure ulcer, was totally dependent on staff for bed mobility, transfers, toileting and hygiene and was on a turning and repositioning schedule. R9's Activities of Daily Living Care Area Assessment (CAA) dated 1/23/15, indicated R9 was at risk for pressure ulcers, was always incontinent of bowel and bladder and required regular turning scheduled.	F 314		

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R9's Diagnosis Report dated 10/15/2015, indicated R9 was diagnosed with Alzheimer's Disease, pressure ulcer right ankle and foot and anemia.

R9's care plan dated 10/15/15, indicated R9 had a deep tissue pressure ulcer to the right heel and was at risk for further breakdown. The plan directed staff to ensure blue pressure relief boots (Prevalon) were on at all times and heels were free from pressure.

On 10/15/15, at 8:04 a.m. R9 was observed seated in her wheelchair in the dining room. R9 was not wearing the Prevalon boots. R9's heels were resting on the foot rest cushion.

On 10/15/15, at 9:04 a.m. NA-E and NA-D we observed to transfer R9 from her wheelchair to bed via a mechanical lift. Following the provision of cares and positioning, NA-E applied R9's Prevalon boots as directed.

On 10/15/15, at 9:15 a.m. NA-E confirmed staff were to keep R9's Prevalon boots on at all times including when in bed.

On 10/15/15, at 11:38 a.m. RN-B confirmed R9 was to wear the Prevalon boots at all times and stated she should have had them on.

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F 314	Continued From page 27 On 10/15/15, at 12:02 p.m. the DON stated R9 should have had the Prevalon boots on at all times and she expected staff to follow R9's care plan. Pressure Ulcers policy dated 9/2012, indicated staff would utilize prevention and assessment interventions to ensure a resident without a pressure ulcer would not develop a pressure ulcer. In addition, residents would receive appropriate assessments and services to promote and maintain skin integrity. Care Plan policy dated 9/2012, indicated residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. In addition, the care plan would emphasize the care of the resident ensuring the resident received appropriate care and services.	F 314		
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 318	F318	11/29/15

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F 318	Continued From page 28 review, the facility failed to ensure range of motion (ROM) ability had been assessed and services provided for 1 of 2 residents (R20) who had an identified limitation in bilateral upper and lower extremities; and failed to apply adaptive equipment for 1 of 2 residents (R10) reviewed who had a contracture. Findings include: R20 had bilateral upper and lower extremity limitations in range of motion (ROM) and was not provided ROM services as directed. R20's quarterly Minimum Data Set (MDS) dated 7/15/15, indicated R20 had memory impairment, had limitations in upper and lower extremity range of motion on both sides of the body, was unable to ambulate and required extensive assistance of 2 or more persons for transfers & bed mobility. The MDS also indicated R20 had not participated in formal physical therapy or an individualized restorative nursing rehabilitation program. in further review of previous MDSs a decline in ROM ability was not determined. R20's Diagnosis Report dated 10/15/15, indicated R20 was diagnosed with Alzheimer's disease, adult failure to thrive and unspecified psychosis. R20 was observed on 10/13/2015, at 11:12 a.m. and was noted to have contractures on bilateral shoulders, elbows, wrists, knees and ankles.	F 318	1. PT/OT to evaluation and treat R20 for limitation to upper and lower extremities and the need for adaptive equipment. R10 will be referred to OT for reevaluation of brace. Nursing staff will apply brace as directed by OT as indicated in care plan. 2. All current and future residents with limitations or decline identified by the MDS assessment and RAI process. This process will happen upon admission, quarterly, annually and upon significant change. 3. Education provided on 11/20/15 with interim MDS nurse on the need for PT/OT involvement when limitations or decline in ROM is noted during the RAI process and the MDS assessment. On November 19th and 20th nursing staff will be educated regarding the process for reporting resident decline. 4. Care watch report for ADL decline will be audited by DNS or designee weekly x4 weeks and 2x per month x 2 months to identify if OT/PT notification occurred and recommendations care planned and implemented to assure solutions are sustained. Results of audits will be reported to QAPI for further evaluation and further recommendations. 5. 11/29/2015	

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R20's care plan dated 10/14/15, had not identified R20 had limitations in bilateral upper and lower extremity ROM.

R20's medical record revealed a lack of an assessment that identified R20's contractures had been assessed and whether a restorative nursing rehabilitation program had been considered in order to maintain and or improve R20's ROM ability. The following documents in the record were reviewed:

-A document titled Therapy Documentation Notes dated 4/29/11, (over 5 years ago), written by a registered nurse indicated R20 had limited ROM in all extremities and a nursing rehabilitation program was not in place due to R20's resistance in participating.
-A document titled Therapy Documentation Notes dated 12/10/13, written by a registered nurse indicated R20 had bilateral palm splints initiated due to increased contractures and R20's refusal to participate in passive range of motion. The progress note indicated the palm splints were to be applied upon rising and removed twice a day to check skin integrity and cleansing.

There was no further information in the record that indicated the splints were either successful or unsuccessful and the care plan had not indicated palm splints were part of R20's plan of care. The RN who wrote the aforementioned therapy documentation notes could not be interviewed because she was no longer employed by the facility.

On 10/14/15, at 5:23 p.m. the director of nursing

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F 318	Continued From page 30 (DON) verified R20 had contractures and did not have a restorative program in place. The DON stated when ROM was provided, R20 had become more agitated and resistive but would look in R20's record for more information as to why ROM ability was not reassessed and a ROM program was not implemented. Following record review, the DON stated she could not find R20's last physical therapy ROM assessment. The DON stated the facility did not have a process in place to screen all the residents ROM abilities. The DON confirmed R20's contractures were not comprehensively assessed and a restorative ROM program was not attempted since prior to 4/29/11. The DON stated R20's contractures should have been assessed and interventions implemented / attempted in order to restore ROM or minimize further loss of ROM. R10 was observed not wearing a right hand splint as directed by the care plan / occupational therapy. R10's care plan dated 3/2/15, indicated a deficit for self-care performance related to R10's stroke and left sided paralysis and decreased ROM. The interventions directed staff to apply a brace to R10's right hand two hours in bed, three times a day, after meals. R10's quarterly MDS dated 8/11/15, indicated R10 had severe cognitive impairment and required total assist with bed mobility and transferring; required extensive assist with personal hygiene, toileting and dressing and had limited upper extremity ROM on one side and limited ROM on both lower extremities.	F 318		

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R10's Mobilization Support Data Collection Tool dated 8/11/15, indicated R10 had limited ROM and a loss of voluntary movement in lower extremities and upper left extremity.

R10's Therapy Daily documentation note dated 8/18/14, directed staff to apply a right hand splint for two hour intervals three times a day (after breakfast, lunch and supper).

On 10/14/15, at 12:49 p.m. R10 was observed lying in bed, eating lunch. At 1:12 p.m. R10's lunch tray had been removed and R10 remained in bed. A hand brace had not been applied to R10's right arm/wrist.

R10's Diagnosis Report printed on 10/15/15, identified R10's diagnoses as hemiplegia (paralysis on one side of the body) and hemiparesis (weakness) from a stroke, hand contracture and dementia.

On 10/15/15, at 6:41 p.m. licensed practical nurse (LPN)-A transported R10 back to R10's room following the evening meal. LPN-A positioned R10's wheelchair in front of the television set and adjusted R10's bed side stand. However, LPN-A failed to place R10's hand brace on R10's right arm/wrist.

On 10/15/15, at 8:30 p.m. registered nurse (RN)-B confirmed R10 was to wear the hand brace as directed and stated the brace remained on the bedside stand in a basket, near R10's bed.

On 10/14/15, at 8:10 p.m. the DON confirmed she expected staff to follow R10's care plan.

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F 318	Continued From page 32 On 10/15/15, at 11:47 a.m. NA-E stated she was unsure of when R10 was to wear the hand brace. NA-E stated she thought it was to be worn at night and in fact, had never seen R10 wear the hand brace. Care Plan policy dated 9/2012, indicated residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. In addition, the care plan would emphasize the care of the resident ensuring the resident received appropriate care and services. Arm Sling policy dated 9/2012, directed staff to apply the sling according to physician orders or the therapist's instructions.	F 318		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and 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 ensure safe resident handling equipment was utlized as directed for 1 of 1 resident (R9) reviewed for bed mobility and repositioning safety.	F 323	F323 1. Staff will utilize turning and repositioning slings per SRHP for R9. 2. All current and future residents requiring safe resident handling equipment for bed mobility and	11/29/15

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F 323	Continued From page 33 Findings include: R9's quarterly Minimum Data Set (MDS) dated 9/29/2015, indicated R9 had severe cognitive impairment, had a deep tissue pressure ulcer, was totally dependent on staff for bed mobility, transfers, toileting and hygiene and was on a turning and repositioning schedule. R9's Activities of Daily Living Care Area Assessment (CAA) dated 1/23/15, indicated R9 was at risk for pressure ulcers, was always incontinent of bowel and bladder and required regular turning scheduled. R9's positioning assessment dated 9/29/15 indicated R9 was dependent on staff for all mobility, was unable to make major changes in body positioning and staff were to reposition every two hours. R9's Diagnosis Report dated 10/15/2015, indicated R9 was diagnosed with osteoarthritis, Alzheimer's Disease, pressure ulcer and anemia. R9's care plan dated 10/15/15, indicated R9 limited physical mobility and directed staff to turn and reposition R9 every two hours in bed with a total mechanical lift and repositioning sling. On 10/15/15, at 9:04 a.m. nursing assistant (NA)-E and NA-D transferred R9 from her wheelchair to bed using the mechanical lift and high back sling. Once in bed, NA-E and NA-D	F 323	repositioning have the potential to be affected. All current residents be assessed with the bed mobilization support data tool quarterly, annually and upon significant change and care plans updated as needed. All future residents will be assessed with the bed mobilization support data tool upon admission, quarterly, annually and upon significant change with care plan updated as needed. 3. On November 19th and 20th nursing staff will be reeducated on expectations regarding the facility's SRHP and mechanical lift competency demonstration. A checklist will be developed and implemented with the licensed nurses for monitoring of proper use of SRHP every shift. 4. Utilization of SRHP program will be audited by observation and documented on all shifts by licensed nurses daily, licensed nurses will provide immediate correction to staff if plan of care is not followed. All findings will be forwarded to DNS for further action and analysis for trends and patterns. DNS will report findings and action plans weekly to leadership staff. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

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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 323	Continued From page 34 removed the sling and proceeded to provide R9 incontinence cares. The NA's were observed to physically turn R9 from side to side while cleansing peri area and applying new incontinent brief and clothing. R9's body and head were observed to be rigid. R9's head remained off of the bed. NA-E and NA-D had not utilized the mechanical lift or positioning sling during the observation. A positioning sling / sheet was observed under R9. On 10/15/15, at 9:15 a.m. NA-E stated "we" do not use the lift to reposition R9 in bed and we have told staff we do not use it because we don't have time to do that. At this time, a positioning sling was observed on R9's bed, positioned under her. On 10/15/15, at 11:38 a.m. registered nurse (RN)-B confirmed R9 required staff assistance to turn and reposition. RN-B stated the facility had a "no lift policy" so staff did not injure themselves or a resident. RN-B stated if a resident could not turn themselves, staff were to supposed to use the lift. RN-B verified R9 could not turn herself therefore staff were expected to use the lift for repositioning. RN-B stated the lift was to be used for repositioning in bed which kept the resident from getting harmed during movement as they were not being tugged on or hurt. On 10/15/15, at 12:02 p.m. the director of nursing (DON) verified R9 was very rigid and it was her expectation staff implemented safe resident handling in which staff were expected to utilize a mechanical lift for any resident that required total	F 323		

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F 323	Continued From page 35 assistance with transferring and positioning. The DON also stated the shearing risk was eliminated too and it reduced the risk of injury to the resident and staff. The DON stated staff should have used the lift when repositioning R9 in bed and when they provided cares. The facility "Mobility Support and Positioning" guide dated 10/2013, indicated: A total lift should be used for those residents who are unable to provide weight-bearing assistance, impaired sitting balance, are uncooperative, rigid, difficult to turn or unable to follow verbal cue. This is to support the resident's ability to change position which promotes comfort, support and proper body alignment, to assist the resident who has decreased functional ability to change position and reduce the risk of pressure ulcers, skin tears and shearing. The facility policy "Safe Resident Handling Program" dated 12/2008, indicated, this program was intended to minimize resident and employee injuries.	F 323		
F 353 SS=F	483.30(a) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. The facility must provide services by sufficient numbers of each of the following types of	F 353		11/29/15

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F 353	Continued From page 36 personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: Except when waived under paragraph (c) of this section, licensed nurses and other nursing personnel. Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate nurse staffing was provided in order to provide the cares and services for all 34 residents residing in the facility. Findings include: Refer to F282: the facility failed to ensure turning and repositioning assistance was provided and / or utilized safe repositioning devices and / or apply pressure relieving boots as directed by the care plan for 4 of 4 residents (R37, R20, R10, R9) observed for timely positioning and pressure ulcer care. In addition, the facility failed to provided incontinence care and services as directed by the care plan for 2 of 2 residents (R20, R10) observed for timely toileting. The facility failed to ensure a brace used for contractures was implemented as directed by the care plan for 1 of 3 residents (R10) observed who had a contracture and failed to ensure oral care was provided as directed by the care plan for 1 of	F 353	F353 1. The residents identified in F282, F312, F314, F318, and F323 will receive cares as in indicated by care plan. 2. All current and future residents will receive care related assistance as directed by plan of care. 3. All nursing staff will be educated on 11/24/15 in the follow areas: Mandated process for staff to remain ensuring care will be provided. How to locate the identification of their assigned group at the beginning of their shifts. Expectation regarding that anytime a resident is in the East wing there will be staff assigned to provide oversight. Formal SWOT analysis for staff recruitment was completed on 11/12/15. A formal recruitment plan is currently in development based on results of SWOT. Facility is currently in contract with ProStat staffing agency for supplemental staffing.	

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F 353	Continued From page 37 2 residents (R20) observed during evening cares. Refer to F312: the facility to ensure oral care was provided for 1 of 2 residents (R20) observed during evening cares and was dependent of staff for the service and failed to ensure timely assistance for bowel and bladder incontinence was provided for 1 of 2 residents (R10) observed who were dependent on staff for assistance with incontinence care. Refer to F314: the facility failed to implement interventions in order to promote wound healing and / or prevent the development of pressure ulcers according to the individual assessed need for 4 of 4 residents (R37, R20, R10, R9) in the sample observed for pressure ulcer care and services. Refer to F318: the facility failed to ensure range of motion (ROM) services had been provided for 1 of 2 residents (R20) who had an identified limitation in bilateral upper and lower extremities; and failed to provide adaptive equipment for 1 of 2 residents (R10) reviewed who had a contracture. Refer to F323: the facility failed to ensure safe resident handling equipment was utilized as directed for 1 of 1 resident (R9) reviewed for bed mobility and repositioning safety. On 10/13/2015, at 12:01 p.m. family member (FM)-A was interviewed and stated he was at the facility 2-3 times every day. FM-A stated there was not sufficient staff during the evening and approximately six weeks ago when at the facility	F 353	Admissions to facility have been suspended. Facility will utilize the 16 hour non-certified training program A checklist will be developed and implemented with the licensed nurses for monitoring of F282, F312, F314, F318 and F323. Facility Social Worker will interview residents and/or family members on an ongoing basis to assure care related needs are met. Facility will continue to utilize and review current suggestion/concern process. Facility administrator will provide education to family members regarding suggestion/concern process by mail. During quarterly care conference resident and/or family will be asked about their satisfaction of services provided and reminded of the suggestion/concern process. 4. Care related audits, as indicated in F282, F312, F314, F318, and F323. Call light audits will be performed 3 times per week x 4 weeks, weekly x 4 weeks, 2 times per month x 2 months on all shifts. Process for mandating will be audited by DNS or designee for compliance 3x/wk x 8 weeks, weekly x4. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

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at 9:00 p.m. he had found there was only one nursing assistant who came to work and was responsible for the care of all 34 residents. FM-A stated he was upset when he learned his family member had not been washed up or assisted to bed yet at 9:00 p.m. FM-A stated that he had reported the incident to the director of nursing.

On 10/14/2015, at 4:07 p.m. nursing assistant (NA)-F stated the evening shift always struggled for staff.

On 10/14/15, from 7:03 p.m. until 7:36 p.m. R24 was observed on the 500/600 wings crying and sobbing looking for her husband, wandering throughout the 500 wing going into and out of other resident rooms. R24 was distraught in the belief her husband had left her and she no longer wanted to live in the nursing home and did not know where to go. There were no staff on the 500/600 wing to provide R24 any type of reassurance or redirection in order to console her emotions.

Review of R24's medical record revealed R24's comprehensive diagnoses list dated 10/15/15, indicated R24 had unspecified psychosis, anxiety disorder and adult failure to thrive.

R24's quarterly Minimum Data Set (MDS) dated 8/4/15, indicated R24 had severe cognitive impairment, had wandering behavior and required extensive assistance of one staff for all cares.

R24's care plan dated 5/11/15, indicated R24 had a mood problem evidenced by episodes of high

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anxiety wheeling up and down halls searching for husband. The plan directed staff to anticipate R24's needs, ask R24 if she needed to use the bathroom. Provide encouragement / reassurance / assistance / redirection during episodes of anxiety. Offer resident her teddy bear wrapped in a blanket. Reassure resident that husband will be back shortly. 1:1 visits to provide reassurance. None of these interventions were attempted for R24 when observed during the observation.

On 10/14/15, at 7:13 p.m. the lights above room 505 (R27's) room and 507 (R8's room) were noticed to be on which indicated the residents in these rooms on the 500 and 600 wing had requested assistance. At this time there were no nursing staff observed on either the 500 or 600 wing area.
- At 7:21 p.m. these call lights remained on with staff observed in the area.
- At 7:24 p.m. registered nurse (RN)-A briefly entered room 505 and told R27 that someone would be there to help in a few minutes. RN-A exited the room and left the call light on.
- At 7:25 p.m. NA-G entered room 507 and shut the call light off (call light had been on for 12 minutes plus). Room 505's call light remained on.
- At 7:30 p.m. NA-G entered and answered room 505's call light (call light had been on for 17 minutes plus).

On 10/14/15, at 7:20 p.m. R30 was observed to propel herself in her wheelchair out to the east wing nursing station. R30 was dressed in her pajamas which she stated she had changed into herself. R30 stated she had been waiting for her evening medications and for someone to help her

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F 353	Continued From page 40 to bed. At 7:23 p.m. RN-A stopped by the nursing station and instructed R30 that she would be in to assist her shortly. RN-A followed R30 to R30's room. On 10/14/15, at 7:52 p.m. NA-G stated she had come in early to help with resident cares. NA-G stated she usually worked 10:00 p.m. until 6:30 a.m. and in the past she had been called in to switch from working overnights to evenings. NA-G stated the normal facility staffing pattern for nights was two NAs and one RN; on evenings the staffing pattern was three NAs and two RNs. NA-G confirmed it was busy on the evening shift because everyone wanted to get ready for bed at the same time. On 10/15/15, at 8:35 a.m. the call light above room 502 (R37's room) on the 500/600 wing was on. At this time there were no staff observed on the 500/600 wing. - At 8:40 a.m. the light above room 502 remained lit with no staff in sight. - At 8:50 a.m. the light above room 502 remained lit. At this time, NA-E was observed to wheel R20 in her wheelchair into the east wing common area. NA-E turned around and proceeded to walk back towards the 400 wing without addressing the call light above R37's door. - At 8:53 a.m. room 502's call light remained on with no staff observed on the 500/600 wing. - At 8:56 RN-C entered the 500/600 wing, acknowledged the call light had been on for room 502, entered room 502 and canceled the call light (call light had been on for 21 minutes plus).	F 353		

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F 353	Continued From page 41 On 10/14/15, at 7:13 p.m. RN-A confirmed she was responsible for the care of the residents who resided on the 500 and 600 wings of the facility (11 residents). RN-A stated that between 6:00 p.m. and 7:30 p.m. there was not a nursing assistant assigned to the 500 and 600 wings of the facility. RN-A stated she was responsible for answering the call lights and providing the care residents immediately requested. RN-A confirmed there were staffing challenges and stated she had to prioritize her work to ensure the safety of the residents and explained she usually answered the call lights first for those residents who had frequent falls and were impulsive and had to wait until the nursing assistant came in at 7:30 p.m. to assist the other residents who just wanted to get ready for bed. RN-A confirmed the facility had a lack of staff to answer call lights and provide evening cares to the residents. On 10/14/15, at 7:55 p.m. NA-C stated the residents who resided on the 500 and 600 wings (11 residents) of the facility didn't have a nursing assistant assigned to their care until NA-C started work at 7:30 p.m. NA-C stated sometimes a nursing assistant from another wing of the building answered the call lights but not always. NA-C stated she was unable to provide all of the resident cares according to their care plans like toileting every two hours, and turning and repositioning residents every two hours because there was not enough time to do those things as well as get all of the residents ready for bed. NA-C stated residents on the 500 and 600 wings had not received the assistance they needed in a timely manner.	F 353		

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F 353	Continued From page 42 On 10/15/2015, at 7:14 a.m. NA-E stated she only worked the 200 and 400 wings. NA-E stated the evening and night shifts were always short, everyday they are short. NA-E stated providing toileting and positioning cares was a problem. On 10/14/2015, at 4:07 p.m. the scheduler stated there had been a lot of changes at the facility in which staff needed to adjust to. The scheduler confirmed the evening shift struggled for staff, however, stated the facility had always made sure enough staff were available, everyone pitches in. The scheduler stated the facility was not short of staff every day. The scheduler confirmed the following scheduling information: -facility census was 34. -the AM shift had three NAs, one bath person Monday through Thursday and assist on the floor on Fridays. Two licensed nurses, one nurse manager and the DON who all assist with feeding the residents at meal time. -the PM shift has two nurses working from 2-10:30 p.m. and three NAs -the night shift had one nurse and two NAs The scheduler stated the facility utilized the "star" system which meant when a staff member had a star by their name they would have to stay overtime until the next staff member came in to work. The scheduler stated this system was very doable and worked well a covering shifts. On 10/14/2015, at 7:48 p.m. NA-C stated she provided cares to 9-10 residents on the east wing and was actually tossed all over the building to work.	F 353		

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On 10/14/15, at 8:01 p.m. the DON stated in order to cover the NA shortages,they just started obtaining one to two NAs per week from a staffing agency to cover the nursing assistant shifts. The DON stated the licensed nurse shifts were OK. The DON also stated the facility had hired new staff, however, they had not yet completed the NA program therefore could not work just yet.

On 10/15/15, at 7:25 a.m. NA-D stated when the facility was short staffed, one NA was on the 500 / 600 wing and one was on the 200 wing and the two of them divided the 400 wing. The nurses can reassign staff to ensure all wings are covered. NA-D confirmed the facility utilized the star system in which staff were not happy about, but did received five dollars more an hour for staying.

The staffing schedule for the weeks of 9/13/15-9/26/15, were reviewed and revealed the following:
-short a NA on 9/13/15, a 10 a.m. to 2 p.m. shift
-short a NA on 9/18/15, a 4-9 p.m. shift
-short a NA on 9/19/15, a 10 a.m. to 2 p.m. shift

The staffing schedule was reviewed for the weeks of 9/27-10/10/2015, which revealed the following:
-short a NA on 9/29/15, for a 4-9 p.m. shift
-short a NA on 10/5/15, a 4-9 p.m. shift
-short 10/8/15, a 4-9 p.m. shift.

On 10/15/15, at 9:24 a.m. NA- A stated at this

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F 353	Continued From page 44 time the facility was short staffed. NA-A stated the facility was unable to hire staff. NA-A stated she worked on the 500 / 600 wings in which 12 residents resided. She stated 3 of the residents (R8, R24, R20) required two staff for transfers and R20 required a mechanical lift to transfer. NA-A stated in order to find another staff member to assist her, she had to leave the wings in order to find help. NA-A stated the NAs attempted to do the best they could, but they were not able to perform resident cares timely as directed by the care plan because the facility was short staffed. On 10/15/15, at 1:00 p.m. the administrator stated the facility had been working on the staffing concerns at the facility. She stated the quality assurance and assessment (QAA) team had met in regards to staffing concerns but had not compared the staffing concerns in relationship to how the facility could ensure resident care plans were being implemented. In addition, she stated the facility had not developed a formal action plan to further address the staffing shortage. On 10/15/15, at 1:06 p.m. the DON verified the facility had not identified a concern with patient care since they had experienced short staffing concerns. A nurse staffing policy was requested but was not provided.	F 353		

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F 441	Continued From page 45	F 441		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441		11/29/15

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F 441	Continued From page 46 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure hand hygiene was performed following the provision of personal cares for 2 of 4 residents (R37, R9) observed during personal cares. Findings include: R20 was provided pericare and the facility failed to perform adequate hand hygiene. On 10/14/15, at 7:48 p.m. nursing assistant (NA)-C was observed providing R20 evening cares. NA-C donned gloves and removed R20's urine soaked incontinent product and performed pericare. With the same gloved hands, NA-C was observed to apply a new incontinent product while touching / moving R20's bed linen, nightgown and lift sling. NA-C had not removed her gloves or washed her hands. On 10/15/15, at 9:10 a.m. the director of nursing (DON) stated NA-C should have removed the gloves after providing R20 pericare / incontinence care and before putting a new incontinent product on R20. R9 was provided personal cares and the facility failed to perform adequate hand hygiene. On 10/15/15, at 9:05 a.m. NA-E and NA-D were observed to transfer R9 to bed via a mechanical	F 441	F441 1. Proper hand hygiene will be utilized when caring for R37, R9, and R20. 2. All residents have the potential to be affected by improper hand hygiene. 3. A skill fair will be conducted on 11/19/2015 and 11/20/2015 where nursing staff will be required to demonstrate proper hand hygiene. A checklist will be developed and implemented with the licensed nurses for monitoring to ensure daily care has been completed per care plan every shift. 4. Hand hygiene observation audits will be completed on all shifts by licensed nurses daily, licensed nurses will provide immediate correction to staff if hand hygiene is not followed. All findings will be forwarded to DNS for further action and analysis for trends and patterns. DNS will report findings and action plans weekly to leadership staff. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	10/15/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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F 441	Continued From page 47	F 441		

lift. Both NAs washed their hands and donned gloves. NA-E removed R9's incontinent product which was soiled with urine and feces, cleansed R9's rectal area, removed her soiled right glove and placed it in her left gloved hand. Using her ungloved hand, NA-E placed a clean incontinent product under R9 and threw the soiled glove she was holding in her left hand, into the trash can. NA-E applied a clean glove to her right hand and repositioned R9 in which R9 was observed to have feces on her front peri-area. NA-E proceeded to cleanse the area, throw the cleansing wipe into the trash and adjust R9's incontinent brief and clothing. NA-E was not observed to wash her hands after removing the soiled glove or after providing frontal peri-care.

On 10/15/15, at 9:18 a.m. NA-E stated, "I don't have time to remove my gloves and go to the sink and wash my hands." When asked about hand sanitizer use, NA-E stated, "I don't have time to do that either." NA-E stated she should have washed her hands and had not.

On 10/15/15, at 9:20 a.m. the DON stated staff had received hand washing training and should have removed their gloves and washed their hands after dirty to clean peri area cleansing. The DON further stated is was the expectation staff washed their hands as directed.

The facility policy, "Perineal Care" dated 9/2012, indicated staff were to use hand sanitizer or wash their hands with soap and water to cleanse hands after removing soiled gloves and to apply clean gloves to put on clean incontinent product and/or clothing.

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	245550	A. BUILDING _____ B. WING _____	10/15/2015

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F 441	Continued From page 48 The facility Infection Control Plan policy dated June 2012, indicated: The center will maintain an infection control plan/program to provide a safe, sanitary and comfortable environment for residents, families, visitors and employees and to help prevent the development and transmission of disease and infection.	F 441		
F 465 SS=D	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide wheelchair cleaning for 3 of 3 residents (R10, R20, R23) who were observed to have a soiled wheelchair. Findings include: On 10/13/15, at 10:36 a.m. R10 was observed seated in her wheelchair in her room. The spokes and underside metal bars of R10's wheelchair were covered with dust and dried dirt particles. In addition, the fabric covered side panels had splatters of a beige stained material. On 10/13/15, at 11:02 a.m. R23 was observed seated in her wheelchair in her room. R23's wheelchair had a layer of dust, dirt and grime adhered to the metal bars on the underside of	F 465	F465 1. The wheelchairs for residents R10, R20 and R23 were cleaned 10/14/2015. 2. All residents who utilize wheelchairs have the potential to be affected. 3. All staff will be educated on the expectation that if there is a soiled wheelchair they need to resolve the issue. A procedure for routine deep cleaning will be established and implemented by the Environmental Services Director. The DNS will reestablish a procedure for weekly surface cleaning on bath day. 4. Observation for wheelchair cleanliness and documentation audits will be completed by maintenance director or designee on every resident in a wheelchair 1 time per week for 2 months.	11/29/15

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F 465	Continued From page 49 R23's wheelchair. On 10/14/15, from 12:12 p.m. until 12:54 p.m. an environmental tour was conducted with the environmental service director (ESD), which the administrator joined during the middle of the tour. The ESD and administrator confirmed the following: - R10's wheelchair had dust and dirt particles adhered to the metal rungs underneath and on the side wheel panels - R20's wheelchair had dried food debris, dust and dirt adhered to the metal rungs and the purple fabric covered side panels had a dried, stained beige material spattered on to the fabric - In addition, R23's wheelchair was observed to have dust and dirt adhered to the metal rungs on the understructure The ESD stated it was the responsibility of both the nursing and maintenance staff to keep the wheelchairs clean. The ESD thought the wheelchairs were scheduled to be cleaned once a month and when needed. On 10/14/15, at 4:53 p.m. the director of nursing (DON) and the ESD confirmed the facility did not have a policy on wheelchair cleaning; however it was the practice of the bath aide to wash the wheelchairs when the resident was taking their bath. The DON stated the facility was in the process of developing a system to have maintenance do a deep cleaning of wheelchairs once a month, in addition to the weekly cleaning conducted by the bath aide. The DON and/or ESD were unable to verify the last time R10, R20, and R23's wheelchairs had been cleaned. The ESD confirmed R10, R20 and R23's wheelchairs	F 465	Every resident in a wheelchair will then be audited for wheelchair cleanliness and documentation monthly for 2 month. A formal report of audits will be forwarded to QAPI committee for review, reports indicating negative patterns and trends will trigger a formal root cause analysis. 5. 11/29/2015	

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F 465	Continued From page 50 were soiled when observed during the tour and had not appeared to have been cleaned within the past week. The DON confirmed the night time duty list which was located in a binder at the nursing station was incorrect as the nursing assistants who worked on the night shift were no longer responsible for cleaning the wheelchairs. On 10/15/15, at 9:00 a.m. nursing assistant (NA)-F, bath aide, stated she placed the resident's wheelchairs in the shower and washed them down while the resident was bathing. NA-F stated she also thought the night NA washed the wheelchairs down during the night, however, also stated in the past, the facility had been short of staff on the night shift. NA-F confirmed she had not washed R10's and R20's wheelchairs. The Night Duties for West End form directed staff to wash wheelchairs and mark the calendar when completed.	F 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPCC	

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

Electronically Signed | 11/13/2015

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2015**

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or 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 The Facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.	K 000		

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	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/21/2015**

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K 000	Continued From page 2 The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 33 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom	K 067	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	11/24/15

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K 067	Continued From page 3 exhaust, throughout the building which is not in accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 2:30 PM and 5:30 PM on 10/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Environmental Services (EL), that the facility's fire and smoke dampers were not tested/inspected within the last 4 years. The last documented test date for the fire and smoke damper tests is 06/24/2011. This was confirmed by the Director of Environmental Services (EL).	K 067	alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K067 The facility's fire and smoke damper test/inspection was completed on 10/02/2015. The Environmental Services Director is responsible to insure that the fire and smoke damper test/inspection is completed annually.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **02 - KITCHEN ADDTION** B. WING _____	**10/21/2015**

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GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145	K 000	EPOC	

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

Electronically Signed | 11/13/2015

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

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K 000	Continued From page 1 St. Paul, MN 55101 Or by e-mail to: Marian.Whitney@state.mn.us or 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 The Facility was inspected as 2 buildings: Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.	K 000		

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K 000	Continued From page 2 The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 52 beds and had a census of 33 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 067 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A This STANDARD is not met as evidenced by: Based on observations and an interview, it was revealed that the facility is using the corridors as part of the air distribution system to provide make-up air for the sleeping rooms' bathroom exhaust, throughout the building which is not in	K 067	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the	11/24/15

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K 067	Continued From page 3 accordance with NFPA 90A. This deficient practice could allow the products of combustion to travel far from the fire origin and negatively affect all residents, staff and visitors by restricting their means of egress in a fire situation.. Findings include: On facility tour between 2:30 PM and 5:30 PM on 10/21/2015, it was revealed during the review of the facility's fire and smoke damper test/inspection documentation and was confirmed by interview with the Environmental Services (EL), that the facility's fire and smoke dampers were not tested/inspected within the last 4 years. The last documented test date for the fire and smoke damper tests is 06/24/2011. This was confirmed by the Director of Environmental Services (EL).	K 067	statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. K067 The facility's fire and smoke damper test/inspection was completed on 10/02/2015. The Environmental Services Director is responsible to insure that the fire and smoke damper test/inspection is completed annually.	