Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
May 9, 2023

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: CCN: 245441
Cycle Start Date: February 9, 2023

Dear Administrator:

On April 3, 2023, the Minnesota Departments of Health and Public Safety, completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 9, 2023

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Re: Reinspection Results
Event ID: N0L212

Dear Administrator:

On April 3, 2023 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on February 9, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2023

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

RE: CCN: 245441
Cycle Start Date: February 9, 2023

Dear Administrator:

On February 9, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 9, 2023 (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).

In addition, if substantial compliance with the regulations is not verified by August 9, 2023 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/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: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/6/23 through 2/9/23, a survey for compliance with Appendix Z, Emergency Preparedness Requirements for Long Term Care facilities, §483.73(b)(6) was conducted during a standard recertification survey. The facility was NOT in compliance. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulation has been attained	E 000		
E 041 SS=F	Hospital CAH and LTC Emergency Power CFR(s): 483.73(e) §482.15(e) Condition for Participation: (e) Emergency and standby power systems. The hospital must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section and in the policies and procedures plan set forth in paragraphs (b)(1)(i) and (ii) of this section. §483.73(e), §485.625(e), §485.542(e) (e) Emergency and standby power systems. The [LTC facility CAH and REH] must implement emergency and standby power systems based on the emergency plan set forth in paragraph (a) of this section. §482.15(e)(1), §483.73(e)(1), §485.542(e)(1),	E 041		3/24/23

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

Electronically Signed | 03/16/2023

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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E 041	Continued From page 1 §485.625(e)(1) Emergency generator location. The generator must be located in accordance with the location requirements found in the Health Care Facilities Code (NFPA 99 and Tentative Interim Amendments TIA 12-2, TIA 12-3, TIA 12-4, TIA 12-5, and TIA 12-6), Life Safety Code (NFPA 101 and Tentative Interim Amendments TIA 12-1, TIA 12-2, TIA 12-3, and TIA 12-4), and NFPA 110, when a new structure is built or when an existing structure or building is renovated. 482.15(e)(2), §483.73(e)(2), §485.625(e)(2), §485.542(e)(2) Emergency generator inspection and testing. The [hospital, CAH and LTC facility] must implement the emergency power system inspection, testing, and [maintenance] requirements found in the Health Care Facilities Code, NFPA 110, and Life Safety Code. 482.15(e)(3), §483.73(e)(3), §485.625(e)(3),§485.542(e)(2) Emergency generator fuel. [Hospitals, CAHs and LTC facilities] that maintain an onsite fuel source to power emergency generators must have a plan for how it will keep emergency power systems operational during the emergency, unless it evacuates. *[For hospitals at §482.15(h), LTC at §483.73(g), REHs at §485.542(g), and and CAHs §485.625(g):] The standards incorporated by reference in this section are approved for incorporation by reference by the Director of the Office of the Federal Register in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. You may obtain the	E 041		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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E 041	Continued From page 2 material from the sources listed below. You may inspect a copy at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202-741-6030, or go to: http://www.archives.gov/federal_register/code_of_federal_regulations/ibr_locations.html. If any changes in this edition of the Code are incorporated by reference, CMS will publish a document in the Federal Register to announce the changes. (1) National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02169, www.nfpa.org, 1.617.770.3000. (i) NFPA 99, Health Care Facilities Code, 2012 edition, issued August 11, 2011. (ii) Technical interim amendment (TIA) 12-2 to NFPA 99, issued August 11, 2011. (iii) TIA 12-3 to NFPA 99, issued August 9, 2012. (iv) TIA 12-4 to NFPA 99, issued March 7, 2013. (v) TIA 12-5 to NFPA 99, issued August 1, 2013. (vi) TIA 12-6 to NFPA 99, issued March 3, 2014. (vii) NFPA 101, Life Safety Code, 2012 edition, issued August 11, 2011. (viii) TIA 12-1 to NFPA 101, issued August 11, 2011. (ix) TIA 12-2 to NFPA 101, issued October 30, 2012. (x) TIA 12-3 to NFPA 101, issued October 22, 2013. (xi) TIA 12-4 to NFPA 101, issued October 22, 2013. (xiii) NFPA 110, Standard for Emergency and Standby Power Systems, 2010 edition, including TIAs to chapter 7, issued August 6, 2009..	E 041		

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E 041	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.6.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2. This deficient condition could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every 36 months - 4 hour continuous run of the emergency generators is being completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	E 041	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. 004- Hospital CAH and LTC Emergency Power: 1. The Environmental Services Director and/or designee will schedule the 36 month 4 hour load bank test normally required for Type I generators. Scheduled on 3/7/23. 2. The 36 month 4 hour load bank test will be completed on 3/24/23. Assurance of On-going Compliance: 1. The facility maintenance program will be updated to include the Type I 36 month 4 hour load bank test. Completed: 3/7/23 2. The facility preventative maintenance program will flag the Type I 36 month 4 hour load bank test one month prior to the due date for our inspection to follow up with our vendor for scheduling the test to ensure compliance with NFPA Electrical	

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E 041	Continued From page 4	E 041	System regulations. 3. This test will also be added to our vendor's automatic scheduling system. 4. This will be audited weekly x 4 and monthly x 3 to ensure compliance. Results will be brought to the quality assurance and performance committee for review and further recommendations.	
F 000	INITIAL COMMENTS On 2/6/23 through 2/9/23, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed with no deficiency issued; H54418291C (MN84052) H54418289C (MN84072) H54418290C (MN83326) H5441070C (MN81768) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 684	Quality of Care	F 684		3/22/23

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F 684 SS=D	Continued From page 5 CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to comprehensively assess and monitor bruises for 1 of 1 resident (R128) reviewed for non-pressure related skin conditions. Findings include: R128 was admitted to the facility on 1/26/23. Diagnosis listed on the Diagnosis Sheet dated 1/26/23, located in the medical record included: Parkinson's disease, (disorder of the central nervous system that affects movement), weakness, chronic kidney disease (when the kidneys fail to filter waste and excess fluid from the blood) and compression fracture of the lumbar vertebra (small breaks or fractures in the vertebrae). Observation and interview on 2/7/23, at 10:29 a.m. R126 noted to have several dark bluish bruises on the tops of both hands. The bruises ranged in sizes from 1/4 inch to 1 inch in diameter. R126 indicated he was not sure how he got the bruises, and unsure if they were improving or worsening.	F 684	F684: Plan of Correction: R128 has discharged from the facility. Nursing management will review all current residents to ensure that all bruises are documented. Further, nursing management will ensure the bruises are listed on the Weekly Skin Observation tracking tool to ensure the bruises are monitored weekly by licensed nursing staff. Nursing management will review care plans of all residents to ensure the include potential for skin concerns when applicable. Nursing staff will be educated on the process of thoroughly documented all bruises at the time of admission, including a description and measurements. Education will include adding bruises to the Weekly Skin Observation tracking tool at the time of admission and when new bruises are noted throughout a resident□s stay. Education will be provided to staff via a meeting to occur on 3/16/23. Random audits to ensure compliance will be conducted by nursing management for all residents in the facility who have	

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F 684	Continued From page 6 R126's admission Minimum Data Set (MDS) assessment dated 1/30/23, identified R126 as having a brief interview for mental status (BIMS) score of "15" indicating intact cognition. The MDS indicated R126 required extensive staff assistance with activities of daily living (ADL's). Review of the admit data collection tool dated 1/26/23, identified bruises on the back of R126's right and left hands. A bruise on the left wrist (from IV) and a bruise along the shin bone of the lower left leg. The tool did not include a description or size of the bruises. R126's skin assessment dated 2/3/23, did not identify or address the bruises to the hands or the lower left leg, that had been identified on 1/26/23. R126's current care plan dated 1/27/23, indicated R126 requires assistance with ADL's, with resident participation. The care plan identified R126 as having potential for impairment to skin integrity. Interventions included; avoid scratching skin and complete weekly skin observations by the licensed nurse. The care plan did not identify at risk for bruising or current bruises identified on the admission skin assessment. Review of the current physicians orders dated 1/26/23, included Aspirin 81 milligrams (mg) daily. Observation and interview on 2/7/23, at 10:29 a.m. R126 noted to have several dark bluish bruises on the tops of both hands. The bruises ranged in sizes from 1/4 inch to 1 inch in diameter. R126 indicated he was not sure how he got the bruises, and unsure if they were improving or worsening	F 684	bruises. Audits will be completed weekly x 4 and monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for review.	

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F 684	Continued From page 7 Interview on 2/7/23, at 1:00 p.m. nursing assistant (NA)-A indicated R126 has had the bruises on the tops of both hands and shin since admission. NA-A indicated she thought the bruises looked darker in color and thought they were worsening. NA-A indicated she had not reported her observations, because she though the licensed nursing staff monitor residents skin weekly. Interview on 2/7/23, at 2:00 p.m. the director of nursing (DON) confirmed staff had not been monitoring R126's bruises when identified. The DON further indicated all nursing staff had been trained on the importance of monitoring skin conditions, that includes bruising. Interview on 2/8/23, at 9:30 a.m. registered nurse (RN)-A indicated she was unsure if R126's bruises were healing or not. RN-A stated weekly skin checks and skin monitoring did not include bruises, rather pressure ulcers and lacerations. RN-A confirmed she had not been monitoring or assessing R126's identified bruises, to the hands or the lower leg for progress in healing. Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation, dated 4/26/22, indicated the purpose of the policy is to accurately document observations and assess residents skin. This included bruises, contusions, skin tears and abrasions. The policy indicated bruises should be monitored weekly and with any changes. Findings should be documented on the skin observation tool and the residents care plan.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii)	F 686		3/22/23

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F 686	Continued From page 8 §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on document review, observation, and interview, facility policy review, and review of manufacturer guidelines, the facility failed to ensure an assessment was completed for the use of a foam cushion placed on a pressure reducing mattress and failed to follow manufacturer guidelines for the use of a "Panacea Original Mattress (a pressure reducing)" for 1 of 3 residents (R10) reviewed for pressure ulcers. This increased the potential for R10, who was at risk for the development of pressure ulcers, to develop a pressure ulcer (area of skin breakdown due to unrelieved pressure). In addition, the facility failed to comprehensively assess and implement interventions to prevent worsening and prevent and/or additional pressure ulcers (PU)'s from developing for 1 of 3 residents (R124) reviewed for pressure ulcers. Findings include: Review of a document provided by the facility titled, "Pressure Ulcer/Wound Care Resource	F 686	F686: Plan of Correction Director of Nursing provided education to R10 and her daughter regarding the increased risk of pressure ulcer development related to using a foam mattress topper on 2/9/23. Daughter and resident have chosen to keep foam mattress topper. R10□s care plan has been updated to include assisting resident with repositioning every 2 hours and prn if resident has not done so individually. Nursing management reviewed all residents in facility and ensured there was documentation of education provided to those residents that do not have the facility issued pressure reducing mattress or additional padding on their pad. Residents who chose to not use the facility□s pressure reducing mattress or use extra padding on their mattress will be educated at least quarterly on the increased risk of development of pressure ulcers related to this choice. Care plans	

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	245441	A. BUILDING _____ B. WING _____	C 02/09/2023

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F 686	Continued From page 9 Packet," dated 05/26/22, indicated ". . .Based on the comprehensive assessment of a resident, the facility must ensure that. . .A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. . ." Review of a document provided by the facility titled, "Panacea Foam Mattress. . .Owner's Manual," indicated ". . .Never alter this product in any way. . .No part of component of a Panacea mattress should be used with non-Panacea parts or components. . ." Review of R10's electronic medical record (EMR) located under the "Profile" tab indicated the resident was admitted to the facility on 09/04/19, with a diagnosis of generalized muscle weakness. Review of R10's EMR "Care Plan," located under the "Care Plan" tab and dated 08/24/20, indicated the resident had the potential for impairment to skin integrity due to decreased mobility and urinary incontinence. The intervention was to provide R10 with a pressure reducing mattress. Review of R10's EMR "Braden Scale for Predicting Pressure Sore Risk," located under the "Assmts (Assessment)" tab and dated 09/30/22, indicated the resident scored 17 for the development of pressure ulcers. A score of under 18 indicated R10 was at risk for the development of pressure ulcers. Review of R10's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/23/22, indicated a "Brief Interview for	F 686	will be updated to include a turning and repositioning schedule per the resident□s individual needs. Nursing staff will be educated on the importance of educating residents on the increased risk of pressure ulcers when not using the facility□s pressure reducing mattress. Education will occur via a meeting to occur on 3/16/23. R124 has discharged from the facility. All residents at risk for pressure ulcers were reviewed to ensure that there were appropriate care planned interventions to promote the healing of current pressure ulcers and to prevent skin breakdown from occurring. Nursing staff will be educated on ensuring care planned interventions for the prevention and treatment of pressure ulcers are in place and the importance of providing ongoing education to residents via a meeting to occur on 3/16/23. Random audits to ensure compliance will be conducted by nursing management weekly x 4 and monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for Review.	

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F 686	Continued From page 10 Mental Status (BIMS)" score of 11 out of 15 which revealed R10 was moderately cognitively impaired. The assessment indicated R10 required extensive assistance of one staff for bed mobility and transfers and was at risk for the development of pressure ulcers. During an interview on 02/07/23 at 9:00 a.m. R10 pointed to her mattress and stated her back was in pain due to the poor mattress. R10 gave permission for the surveyor to examine the mattress. The covers were lifted and a foam cushion topper was observed on a pressure reducing mattress. The resident stated her family had brought the cushion in to attempt to make the mattress more comfortable. During an interview on 02/08/23 at 8:06 a.m., nursing assistant (NA)-K and NA H stated they were both familiar with R10. Both NA K and NA H stated they were aware of the foam cushion on the resident's bed and were aware the resident's family brought the foam cushion topper for the resident's bed. During an interview on 02/08/23 at 2:55 p.m., the director of nursing (DON) stated she was not aware R10 had a foam cushion topper to her mattress. DON N stated the resident was at risk for the development of pressure ulcers. A request was made for documentation in which risks versus benefits were discussed with the resident and/or her family. A subsequent interview conducted on 02/09/23 at 9:35 a.m., DON was asked if R10 and/or her family were provided information on risks verses benefits for the use of a foam cushion which potentially could lead to a pressure ulcer. DON	F 686		

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F 686	Continued From page 11 stated she needed to get in touch with the resident's family and review the clinical records. No information was provided by the end of the survey which addressed the risk versus benefits of the continued use of a foam cushion on R10's pressure reducing mattress. R124 R124 was admitted to the facility on 1/18/23, with diagnoses (identified on the active physician order sheet) dated 2/8/23, including; chronic kidney disease (the kidney fails to filter waste and excess fluid from the blood) altered mental status (change in average mental function) weakness and unstageable pressure ulcer (ulcer that has full thickness tissue loss but is either covered by necrotic tissue or eschar. Necrotic tissue is non-viable tissue and eschar is dead tissue that is hard, dry and leathery) of the right heel. R124's admission minimum data set (MDS) assessment dated 1/24/23, identified R124 as having a baseline interview for mental status (BIMS) of "14" (cognitively intact). R124 required assistance with activities of daily living (ADL's)	F 686		

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F 686	Continued From page 12 that included dressing, toileting, transfer, positioning and walking. The MDS identified R124 as being at risk for PU's and identified a unhealed unstageable pressure ulcer. Interventions included; a reduction mattress and PU care. Review of the admission data collection form dated 1/18/23, identified R124 as having a unstageable PU to the right heel. Review of a wound data collection tool dated 1/18/23, identified R124 as having a unstageable pressure ulcer on the right heel. The PU measured 3.7 centimeters (cm) length by 2.0 cm width. The resident had pain in the PU area. The PU has a minimum amount of serosanguinous drainage (thin pink watery fluid) and surrounding tissue is pink in color. A Mepilex dressing (absorbent dressing used for wound exudate) applied. Review of a wound data collection tool dated 1/21/23, identified R124 as having a PU on the right heel. The PU measured 4.2 centimeters (cm) length by 5.4 cm width and 0.1 cm depth. The PU has 30% granulation tissue (new connective tissue) and 70% slough tissue (referred to as necrotic/fibrotic tissue). The PU has a moderate amount of serosanguinous drainage and surrounding tissue is pink in color. A Mepilex dressing applied. Review of a wound data collection tool dated 1/27/23, identified R124 as having a PU on the right heel. R124 voiced complaints of pain in the PU area. The PU measured 4.0 centimeters (cm) length by 4.0 cm width by 0.1 cm depth. The PU has 90% granulation and 10% slough. The PU	F 686		

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F 686	Continued From page 13 has a moderate amount of purulent drainage (white, yellow or brown fluid and can be a sign of infection) and skin is macerated (softening and breaking down of skin) around the PU. Review of a wound data collection tool dated 1/30/23, identified R124 as having a PU on the right heel. The PU measured 4.0 cm length by 3.1 cm width. The assessment did not include the characteristics of the PU bed. The PU had drainage on the dressing and the tissue surrounding the PU was pink. Review of a wound date collection tool dated 2/1/23, identified R124 as having a PU on the right heel. The PU measured 4.0 cm length by 3.1 cm width. The PU was described as having 100% eschar tissue. The PU had a moderate amount of serosanguinous drainage and the skin margins were macerated with erythema (redness with possible infection). Treatment of Iodosorb dressing (absorbs wound fluids and kills bacteria) with foam and Kerlix covering. Review of a wound date collection tool dated 2/5/23, identified R124 as having a PU on the right heel. The PU measured 3.7 cm length by 5.4 cm width and 0.1 cm depth. The characteristics of the PU bed were not described. The PU had a minimum amount of serous drainage and surrounding tissue noted to be macerated.. Treatment of Iodosorb to wound base and cover with foam and Kerlix. Review of the current physicians orders dated 1/18/23, included orders to reduce and redistribute pressure to the right heel and do not lay or sit in one position for a long period of time. Avoid positions that can make the PU worsen.	F 686		

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F 686	Continued From page 14 Place cushions or pillows under legs to reduce pressure. Check wound daily for signs of infection, redness swelling and increased pain and administer Oxycodone (used for moderate to severe pain) 5 mg bid (twice daily) for PU pain. Review of a provider visit progress note dated 1/24/23, by certified nurse practitioner (CNP)-A, indicated R124 was seen related to a change in R124's PU of the right heel. The progress notes identified the PU to the heel as a stage 2 ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister) with some eschar and granulation tissue. Erythema around the PU edges. Treatment orders to apply Medihoney (aids in debridement, of which is the removal of damaged tissue and provides a moist healing environment) with foam dressing cover and wrap with kerlix. Change dressing daily and as needed (PRN). Review again in 2 days. Start Doxycycline (antibiotic) and continue offloading. The progress note further indicated the NH (nursing home) wound nurse will be following wound. Review of a physician order dated 1/27/23, included Iodosorb treatment to the PU on the right heel, due to no improvement from the current treatment. Review of the care plan revised on 1/31/23, identified R124 as having a PU on the right heel. R124 is at risk for further breakdown, due to decreased mobility and weakness. Interventions included; assess/record/monitor wound healing daily on the wound data form, facility RN to assess weekly with skin assessments, float heels in bed using blue foam boots and/or pillows,	F 686		

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F 686	Continued From page 15 remind the resident to change positions at least every 2-3 hours and to not stand up or transfer with the blue foam boot on. Staff to assist the resident with socks and shoes. R124 may use a sock aid or shoe horn to get her shoes on, but may be difficult for her due to her right heel PU. R124 has pain in the right heel ulcer and staff to evaluate the effectiveness of the pain medication given. Observation and interview on 2/7/23, at 9:30 a.m. R124 was sitting in her recliner with her feet dependent to the floor. The residents right lower leg and foot was slightly swollen. The right foot had a gripper sock on. Both heels were resting on the floor. R124 stated she had a PU on her heel. There was a protective heel boot sitting next to her bed. R124 stated she wears the protective boot to her right foot during the night, but does not wear during the day. R124 indicated she usually has her tennis shoe on but needed help to get it on. R124 further indicated she did not elevate her feet or have her feet off the floor during the day, rather just during the night when in bed. R124 stated it was too difficult to elevate the footrest herself. Observation on 2/7/23 at 10:30 a.m. R124's PU treatment was done by the director of nursing (DON). R124's right sock, tennis shoe and dressing was removed. The sock and shoe noted to be tight and difficult to remove due to the resident complaining of pain. The PU on the heel was covered with necrotic tissue and surrounding tissue was pink with some maceration and peeling skin. After a new dressing was applied, staff assisted with putting the residents sock and shoe back on. Pressure and friction was required to get the sock and shoe on and a metal shoe	F 686		

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F 686	Continued From page 16 horn was used on the heel to get the shoe on. The shoe horn was pressed against part of the pressure ulcer. Interview with the resident at this time, stated that she had been wearing her shoes for at least a week and she has been having a lot of pain when having her sock and shoes put on and taken off. Observation on 2/9/23, at 9:00 a.m. R124's PU treatment was done by registered nurse (RN)-B. R124's tennis shoe, sock and dressing was removed from the right foot. R124 clenched her teeth and complained of pain when this was done. There was a moderate amount of brownish colored drainage on the dressing (Isosorb has a brownish color) R124's PU was observed to be covered with necrotic tissue. When RN-B cleansed the PU, R124 flinched and complained of pain. The tissue around the PU noted to be macerated with peeling skin. There was also a 1.0 inch diameter discolored area in the skin above the PU on the right heel. RN-B indicated this was a change in the tissue. The PU measured 3.4 cm length by 4.6 cm depth. RN-B also indicated R124 received Oxycodone for pain prior to the dressing change at 5:30 a.m., but still had a lot of pain with treatment. Because R124 complained of increased pain when putting on and removing the sock and tennis shoe, R124 agreed to put on a gripper sock at this time. Observations over the course of the survey on 2/6/23 through 2/9/23, R124 was observed to be sitting in her recliner with both of her feet/heels on the floor. R124 was wearing tennis shoes during observations on 2/7/23 through 2/9/23. When interviewing R124 again on 2/8/23, at 2:00 p.m. she confirmed she did not elevate her legs or have her feet off the floor when up during the day.	F 686		

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F 686	Continued From page 17 R124 indicated she could not get the foot pedals of the recliner up herself and staff do not come in and offer to assist. R124 stated the staff did assist her with wearing protective boots at night. R124 indicated she wanted to go home and would do anything to help the PU heal, so that could happen. Interview on 2/7/23, at 1:30 p.m., nurse aide (NA)-A confirmed R124 sits in her recliner most of the day with her feet/heels touching the floor. NA-A indicated she was aware of R124's PU on the right heel, but was unsure of any interventions other than the nurse changing the dressing to the right heel. NA-A further verified R124 wears her tennis shoes throughout the day. Interview on 2/8/23, at 11:00 a.m., NA-B confirmed R124 spends a lot of the day sitting in her recliner with her feet down. NA-A indicated she was not aware of any interventions during the day, but was aware that R124 wears protective boots at night when in bed. NA-B further verified R124 wears tennis shoes throughout the day. Interview on 2/9/23, at 9:00 a.m. RN-B indicated R124's PU on the right heel has not improved. RN-B indicated R124 did not have necrotic tissue covering R124's entire PU on admission, but now the entire PU is covered with necrotic tissue. RN-B also confirmed it was difficult taking R124's sock and shoes on and off due to causing pressure and friction on the PU, that caused increased pain for the resident. RN-B further indicated when R124's PU was identified to become odorous, the provider was notified and a change in treatment had been done. Interview on 2/9/23, at 9:20 a.m. physical	F 686		

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F 686	Continued From page 18 therapist (PT)-A ,stated R124 has been wearing tennis shoes since admission, that she was aware of. PT-A indicated she had been aware of R124's shoes being tight and gave her a metal shoe horn, to assist with putting the shoe on and off. PT-A indicated she was unaware of exactly where the PU was located on the heel. PT-A indicated when R124 was given the ok to walk independently in her room, there should have been a interdisplinary discussion with nursing. Options and the condition of the PU could have been discussed to promote healing of the PU as well as safety of the resident with walking. PT-A indicated this had not been done. Interview on 2/9/23, at 9:30 a.m. with RN-C indicated R124 wanted to wear tennis shoes, even when encouraging her not to. RN-C indicated since therapy allowed R124 to walk independently (about a week ago) R124 started to wear her tennis shoes due to the risk of falling. RN-C indicated R124 thought it would be too difficult if she had to put on her shoes on, when walking to the bathroom and to meals. RN-C confirmed she did not review the risks with R124 or family related to wearing the tennis shoe throughout the day and not elevating her legs. RN-C verified no other options had been given for R124 related to footwear, that would promote less pressure on the heel. Interview on 2/9/23, at 10:00 a.m. the DON stated she was aware R124 wanted to wear tennis shoes, even when encouraged not to. The DON indicated staff had implemented interventions to prevent worsening of the PU, but R124 did not always comply. The DON did state PT-A should not have given the metal shoe horn to R124 to aid in putting her shoe on the right foot, and	F 686		

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F 686	Continued From page 19 confirmed the staff could have offered other options for R124 to use that would cause less pressure to the PU. Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation, dated 4/26/22, indicated the purpose of the policy is to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for PU. The policy indicated the interdisciplinary team should determine any modifications that are necessary to the residents plan of care. Interventions should focus on physical , emotional and psychosocial aspects that may be impacted. Treatments and interventions should be consistent with the residents goals. Education should be provided to the resident and/or family. If a pressure ulcer is not determine to be clinically unavoidable, the ulcer should show signs of improvement within two to 4 weeks. Signs of improvement might include decrease in size, decrease in exudate and improvement in tissue (from necrotic to slough to granulation to epithelial) If a resident makes an informed choice to refuse treatment or interventions, then education of what a PU is, what the risk of the refusal is, and the potential outcome should be provided to the resident and/or family. The education should be documented.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and	F 689		3/22/23

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F 689	Continued From page 20 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the recommended supervision during meals to prevent choking for 1 of 3 residents (R45) reviewed for accident hazards. Findings include: Review of R45's electronic medical record (EMR) titled "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on 08/25/22, with a diagnosis of dysphasia (difficulty swallowing). Review of a document provided by the facility titled, "Diet Notification Form," dated 08/26/22, indicated the level of supervision while eating was "Line of Sight." Review of a document provided by the facility titled, "Physician Orders," dated 08/26/22, indicated the resident could have "Distant Supervision During Meals/PO [oral] Intakes." Record review of a "Diet Notification Form," written by the Speech Therapist (ST) on 09/21/22, indicated a recommendation for the resident to receive ". . .line of sight. . ." supervision and be encouraged to eat in the dining room. Record review of R45's EMR "Care Plan," located under the tab "Care Plan" and dated 09/26/2022, indicated interventions for the resident's nutrition/hydration problems involved "line of	F 689	F689: Plan of Correction: R45□s care plan was reviewed and he continues to eat meals in main dining room with distant line of sight supervision. R45 was re-evaluated by speech therapy on 2/16/23 and his care plan was updated with her recommendations. The care plans, dietician assessments, and speech therapy assessments (when applicable) were reviewed for all residents to ensure all residents were eating in a location to provide the necessary supervision to meet their needs. All care plans were updated if applicable. The level of supervision needed for residents was added to their dining tray cards as an additional reminder to staff. Nursing staff will be educated on the importance of supervision for residents who are receiving altered diets and are at risk for choking via a meeting to be held on 3/16/23. Random audits to ensure compliance will be conducted by nursing management weekly x 4 and monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for Review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	C 02/09/2023

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F 689	Continued From page 21 sight" supervision. Record review of R45's "ST [speech therapist]-Therapist Progress & Discharge Summary" written by the ST on 10/20/2022, indicated a recommendation for the resident to ". . .continue to receive distant supervision and eat in main dining room for meals to ensure safety when consuming meal and monitor for increase of s/s [signs and symptoms]of aspiration or other swallowing difficulties. . ." Review of R45's EMR titled significant change "Minimum Data Sheet (MDS)" with an Assessment Reference Date (ARD) of 11/14/22, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of five out of 15 which revealed R45 was severely cognitively impaired. The assessment indicated the resident required supervision, such as oversight and cueing, after set-up of a meal. The Care Area Assessment (CAA), located under the assessment triggered nutrition and directed the staff to develop a care plan. During an observation on 02/06/23 at 6:43 p.m., R45 was observed in his room eating his evening meal. There were no staff present during this observation. During an observation on 02/07/23 at 8:13 a.m., R45 was observed eating his breakfast meal in his room and there were no staff present. During an observation on 02/07/23 at 8:39 a.m., R45 was observed eating his breakfast meal in his room and there were no staff present. During an interview on 02/09/23 at 7:26 a.m.,	F 689		

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F 689	Continued From page 22 nursing assistant (NA) H stated she was aware R45 was at risk of choking. NA H stated she props the resident's door open during mealtimes so she can keep an eye on him. NA H stated the resident was currently on contact precautions and did not go to the main dining room. During an interview on 02/09/23 at 7:32 a.m., NA-L stated R45 typically went to the main dining room for meals but was under contact precautions and did not. During an interview on 02/09/23 at 10:11 a.m., nurse manager (NM) D stated she was covering for the unit manager on the 300 unit and confirmed she was familiar with R45. NM D stated the resident typically ate in the main dining room but currently eats in his room due to being on contact precautions. NM D stated the resident gets frequent checks, outside of his room, during his mealtimes. During an interview on 02/09/23 at 10:15 a.m., speech therapist (ST) A stated R45 eating in his room with only intermittent "line of sight" supervision was not adequate. ST A stated her previous recommendations was for the resident to be in the dining room with direct "line of sight" supervision and was based upon her evaluation at the time of the resident's discharge from skilled therapy. ST A stated without a new evaluation or information from nursing that the resident improved, leaving the resident alone in his room, while eating, was not adequate. During an interview on 02/09/23 at 12:16 p.m., the director of nursing (DON) stated based on the ST A's recommendations, the resident required one person to sit in his room with him, while	F 689		

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F 689	Continued From page 23 under contact isolation precautions and this was not done by staff.	F 689		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 02/09/2023. At the time of this survey, GOOD SAMARITAN SOCIETY - ALBERT LEA was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/16/2023

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 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. GOOD SAMARITAN SOCIETY - ALBERT LEA is a 1 story building with no basement. The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II (111) construction. In 1968, an addition was constructed and was determined to be of Type II (111) construction. In 1975 an addition was constructed and was determined to be of Type II	K 000		

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K 000	Continued From page 2 (111) construction. In 1980 an addition was constructed and was determined to be of Type II (111) construction. In 1997 an addition was constructed and was determined to be of Type II (111) construction. In 1998 an addition was constructed and was determined to be of Type II (111) construction. Because the original building and the 5 additions are of the same type of construction allowed for existing buildings, the facility was surveyed as one building, Type II (111). The facility is fully protected throughout by an automatic sprinkler system and has a fire alarm system with smoke detection in corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 85 beds and had a census of 74 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidence by:	K 000		
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation the facility failed to	K 211	Preparation and execution of this	3/16/23

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K 211	Continued From page 3 maintain facility means of egress requirements per NFPA 101 (2012 edition), Life Safety Code sections 19.2.1, 7.1.6.4, and 7.1.10.1. These deficient findings could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation that the 500. 600, 700 Wing exit pathways exhibited coverage of snow and ice. An interview with the Maintenance Director verified these deficient findings at the time of discovery.	K 211	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. K211 Means of Egress – Paths of Egress It is the policy of the facility to maintain paths of egress in accordance with NFPA requirements. Corrective action will include the following: 1. All snow and ice were removed from the 500, 600, 700 wing exit pathways. 02/15/2023 2. All residents and staff have the potential to be affected by this practice. Snow removal of all sidewalks and means of egress will be cleared of snow to not hinder evacuation of residents in the event of emergencies. Removal of snow on all sidewalks and means of egress will start to be removed by maintenance director or designee after approximately 1 inch of snow accumulation. Snow shovels and ice melt will be placed at each facility exit for staff to have quick access for clearing egress doors. 3. Upon snow fall, both maintenance	

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K 211	Continued From page 4	K 211	director and facility administrator will monitor the amount of snow fall and the maintenance director will begin snow removal on all means of egress after approximately 1 inch of snow accumulation. If at any point the maintenance director is unavailable, the administrator or designee will complete the removal of snow to ensure safe egress for evacuations in the event of an emergency. 4. Compliance will be monitored by the facility administrator and QAPI committee by performing audits on days of snow accumulation of 1 inch or greater to ensure snow was removed for safe egress. Audits will be completed by the administrator or designee on days forecasted to have snow. Compliance will be met on or before 03/01/2023	
K 353 SS=E	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		3/16/23

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K 353	Continued From page 5 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the sprinkler system in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 9.7.5, and NFPA 25 (2011 edition) Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, sections 5.2.1.1.2, 5.2.2.2, and NFPA 13 (2010 edition), Standard for the Installation of Sprinkler Systems, section 8.5.6.1. These deficient findings could have a patterned impact on the residents within the facility. Findings include: 1. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, the sprinkler head located in the 100 Wing Janitor Closet, exhibited signs of being painted. 2. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, in the Physical Therapy Office closet, that items were stacked high in close proximity to the sprinkler head, closer than 18 inches. 3. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, in the 100 Wing, that outside of Rooms 1201, 1203, and 1207, sprinkler heads were loaded with foreign debris. An interview with the Maintenance Director	K 353	K353 NFPA Sprinkler Systems It is the policy of the facility to perform and assure sprinkler systems are tested in accordance with NFPA standards and requirements. And accept this facilities credible allocation of compliance and correct the citation K353 Corrective action will include MEASURES and changes used to prevent a recurrence: 1. Environmental Services and designees will schedule sprinkler head replacement for the sprinkler head in the 100 wing Janitor Closet. Scheduled to be Completed: 3/22/2023 2. Environmental Services and designee will remove items to maintain 18” clearance from the sprinkler deflector in the Physical Therapy Office Closet. To be completed by: 03/8/2023 3. Environmental Services and designee will remove foreign debris from sprinkler heads outside of Rooms 1201, 1203, and 1207. To be completed by: 02/18/2023 4. Preventative maintenance program and instructions will be updated to include Quarterly scheduled fire sprinkler systems inspections, maintenance and testing : Completed 03/01/2023 Assurance of On-Going Compliance The Environmental Services Director and/or designee will conduct quarterly	

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	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING _____	**02/09/2023**

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K 353	Continued From page 6 verified these deficient findings at the time of discovery.	K 353	inspections to ensure fire sprinkler systems meet this requirement and as identified in our preventative maintenance program. The facility safety committee will review and oversee documentation that shows that the aforementioned inspections are performed quarterly as required for a period of 12 months. Beginning 03/08/2023. The facility administrator will monitor and verify Quarterly fire sprinkler systems are not obstructed and inspected are completed and documented per assigned PM scheduling. Beginning 03/01/2023	
K 355 SS=F	Portable Fire Extinguishers CFR(s): NFPA 101 Portable Fire Extinguishers Portable fire extinguishers are selected, installed, inspected, and maintained in accordance with NFPA 10, Standard for Portable Fire Extinguishers. 18.3.5.12, 19.3.5.12, NFPA 10 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to properly inspect, and maintain documentation of portable fire extinguishers in accordance with NFPA 101 (2012 edition), Life Safety Code, sections 19.3.5.12, 9.7.4.1, and NFPA 10 (2010 edition), Standard for Portable Fire Extinguishers, section 7.2.4.1, 7.2.4.3, and 7.3.1.1.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include:	K 355	K355- Portable Fire Extinguishers It is the policy of the facility to maintain portable fire extinguishers in accordance with NFPA standards and requirements. Corrective action will include: 1. The Environmental Services Director and/or designee will schedule annual inspection of portable fire extinguishers. Completed 3/1/23. 2. The Environmental Services Director and/or designee will review current floor	3/16/23

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K 355	Continued From page 7 1. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed during a review of available documentation that no annual inspection and maintenance records were available for review 2. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, the fire extinguisher located in the Elevator Room had not been inspected, monthly or annually, since 2020. 3. On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, the fire extinguisher located in Wing 700 - Storage Room had no monthly dates recorded on the inspection tag An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 355	plans to include portable fire extinguishers location in the elevator room and the 700 Wing storage room for monthly/annual inspections. Completed 2/20/23. Assurance of On-going Compliance: 1. Environmental Services Director and/or designee as part of the monthly Fire Extinguisher inspections preventative maintenance program will verify that documentation is visible and accessible. 2. Portable fire extinguishers will be audited weekly x 4 and monthly x 3 to ensure compliance with NFPA standards. Audit results will be brought to the Quality Assurance and Performance Improvement Committee for review and further recommendations.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS.	K 372		3/31/23

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K 372	Continued From page 8 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test, and inspect the facility smoke dampers per NFPA 101 (2012 edition), Life Safety Code, sections 8.5.5.2, 8.5.5.4.2, and NFPA 105 (2010 edition), Standard for Smoke Door Assemblies and Other Opening Protectives, section 6.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed during documentation review, that the last documented that smoke damper inspection and testing was completed on 12/17/2018. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 372	K372: Subdivision of Building Spaces-Smoke Barriers/Smoke Damper Testing. It is the policy of the facility to continuously maintain in reliable operating condition Fire Alarm Systems and to ensure Fire Alarm Systems are inspected, tested and maintained periodically. Corrective action will include: 1. Environmental Services Director and/or designee will schedule smoke damper inspection and testing. Scheduled: 2/15/23 2. Testing scheduled to be completed on 3/31/23. Assurance of On-Going Compliance 1. To ensure system continues to meet NFPA requirements, the facility's preventative maintenance program will be updated to include all of the required inspections. This task was completed on 3/7/23. 2. This program will flag the smoke damper inspection one month prior to the inspection due date to ensure that the inspection is scheduled with our outside contractor. 3. This inspection has also been added to our contractor's automatic scheduling system. 4. Audits will be performed by the Environmental Services Director weekly x 4 and monthly x 3 to ensure compliance. Audit results will be brought to the Quality Assurance and Performance	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING _____	**02/09/2023**

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K 372	Continued From page 9	K 372	Improvement Committee for review and further recommendations.	
K 374 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Doors 2012 EXISTING Doors in smoke barriers are 1-3/4-inch thick solid bonded wood-core doors or of construction that resists fire for 20 minutes. Nonrated protective plates of unlimited height are permitted. Doors are permitted to have fixed fire window assemblies per 8.5. Doors are self-closing or automatic-closing, do not require latching, and are not required to swing in the direction of egress travel. Door opening provides a minimum clear width of 32 inches for swinging or horizontal doors. 19.3.7.6, 19.3.7.8, 19.3.7.9 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the smoke barrier doors per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.8 and 8.5.4.1. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation that the following smoke barrier door assemblies exhibited air-gap greater than 1/8" that would allow the passage of smoke: Wings 100, 300, and 600; adjacent to the Laundry; adjacent to Admin Office.	K 374	K374- NFA 101 Subdivision of Building Spaces- Smoke Barrier Doors Corrective action will include: 1. The Maintenance Director or designee will adjust or repair the smoke barrier doors on Wings 100, 300, and 600 to meet NFPA requirements. Completed on or before 03/27/2023 2. The Maintenance Director and or designee will conduct routine inspections and maintenance of smoke rated doors. Beginning 03/01/2023 3. The facilities preventative maintenance program will be verified to include annual Smoke Door Inspections. Completed 03/07/2023	3/16/23

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K 374	Continued From page 10 An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 374	Assurance of On-Going Compliance 1. It our policy to inspect and maintain smoke doors as part of our preventative maintenance program. The Maintenance Director will conduct at a minimum annual inspections and maintenance of fire and smoke rated doors. Completed 03/01/2023 2. The facility safety committee will review and oversee documentation that shows that the aforementioned inspections are performed annually as required for a period of 1 year. Beginning 03/01/2023 3. The facility administrator will monitor and verify annual smoke door inspections are completed and documented per assigned PM scheduling. Beginning 03/01/2023	
K 918 SS=F	Electrical Systems - Essential Electric Syste CFR(s): NFPA 101 Electrical Systems - Essential Electric System Maintenance and Testing The generator or other alternate power source and associated equipment is capable of supplying service within 10 seconds. If the 10-second criterion is not met during the monthly test, a process shall be provided to annually confirm this capability for the life safety and critical branches. Maintenance and testing of the generator and transfer switches are performed in accordance with NFPA 110. Generator sets are inspected weekly, exercised under load 30 minutes 12 times a year in 20-40 day intervals, and exercised once every 36 months for 4 continuous hours. Scheduled test under load conditions include a complete	K 918		3/24/23

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K 918	Continued From page 11 simulated cold start and automatic or manual transfer of all EES loads, and are conducted by competent personnel. Maintenance and testing of stored energy power sources (Type 3 EES) are in accordance with NFPA 111. Main and feeder circuit breakers are inspected annually, and a program for periodically exercising the components is established according to manufacturer requirements. Written records of maintenance and testing are maintained and readily available. EES electrical panels and circuits are marked, readily identifiable, and separate from normal power circuits. Minimizing the possibility of damage of the emergency power source is a design consideration for new installations. 6.4.4, 6.5.4, 6.6.4 (NFPA 99), NFPA 110, NFPA 111, 700.10 (NFPA 70) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test the on-site emergency generator system per NFPA 99 (2012 edition), Health Care Facilities Code, section 6.4.1.1.6.1, 6.4.4.1, 6.4.4.2 and NFPA 110 (2010 edition) 8.4.9, 8.4.9.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by a review of available documentation, that no documentation was presented to confirm that the required once every 36 months - 4 hour continuous run of the emergency generators is being completed. An interview with the Maintenance Director	K 918	K918: NFPA Electrical Systems-Essential Electrical Systems 1. The Environmental Services Director and/or designee will schedule the 36 month 4 hour load bank test normally required for Type I generators. Scheduled on 3/7/23. 2. The 36 month 4 hour load bank test will be completed on 3/24/23. Assurance of On-going Compliance: 1. The facility maintenance program will be updated to include the Type I 36 month 4 hour load bank test. Completed: 3/7/23 2. The facility preventative maintenance program will flag the Type I 36 month 4 hour load bank test one month prior to the due date for our inspection to follow up with our vendor for scheduling the test to	

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K 918	Continued From page 12 verified this deficient finding at the time of discovery.	K 918	ensure compliance with NFPA Electrical System regulations. 3. This test will also be added to our vendor's automatic scheduling system. 4. This will be audited weekly x 4 and monthly x 3 to ensure compliance. Results will be brought to the quality assurance and performance committee for review and further recommendations.	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by:	K 920		3/16/23

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K 920	Continued From page 13 Based on observation and staff interview, the facility failed to manage usage of flexible cords and cables in accordance with NFPA 99 (2012 edition), Health Care Facilities Code, section 10.2.3.6 and NFPA 70, (2011 edition), National Electrical Code, sections 400-8(1). This deficient condition could have an isolated impact on the residents within the facility. Findings include: On 02/09/2023 between 1000 AM and 0300 PM, it was revealed by observation, that at Nurses Station 4, a full-sized refrigerator was being powered by an extension cord. An interview with the Maintenance Director verified this deficient finding at the time of discovery.	K 920	K920 Electrical Equipment – Power Cords and Extension Cords It is the policy of the facility to maintain the usage of all Power/extension Cords and power strips in accordance with NFPA 101 standards and requirements. And accept this facilities credible allocation of compliance and correct the citation K920 Corrective action will include: 1. The Environmental Services Director and or designee will remove the extension cord in use at Nurse Station 4. on: 03/24/2023 2. Scheduled to have outlet installed with electrical contractor. Completed: 03/07/2023 3. Work will be completed 03/24/2023. Assurance of On-Going Compliance 1. The Environmental Services Director and/or designee will conduct ongoing power extension cords, power strips and power surge protector inspection to assure NFPA standards and requirements and as identified in our preventative maintenance program. 2. The facility safety committee will review and oversee documentation that shows that the aforementioned inspections are performed as required. The committee will monitor annual power cord inspections. Beginning on : 03/01/2023	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
March 6, 2023

Administrator
Good Samaritan Society - Albert Lea
75507 240th Street
Albert Lea, MN 56007

Re: State Nursing Home Licensing Orders
Event ID: N0L211

Dear Administrator:

The above facility was surveyed on February 6, 2023 through February 9, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

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

Please feel free to call me with any questions.

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: Melissa.Poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: _____ B. WING _____	C 02/09/2023

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 2/6/23 through 2/9/23, a licensing survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found to be NOT in compliance with MN State Licensure. The following licensing orders were issued. Please indicate in your electronic plan of correction that you have	2 000		

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2 000	Continued From page 1 reviewed these orders, and identify the date when they will be completed. The following complaints were reviewed during the survey; H54418291C (MN84052) H54418289C (MN84072) H54418290C (MN83326) H5441070C (MN81768) Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor ' s findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will	2 000		

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2 000	Continued From page 2 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on document review, observation, and interview, facility policy review, and review of manufacturer guidelines, the facility failed to ensure an assessment was completed for the use	2 900	F686: Plan of Correction Director of Nursing provided education to R10 and her daughter regarding the increased risk of pressure ulcer	3/22/23

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2 900	Continued From page 3 of a foam cushion placed on a pressure reducing mattress and failed to follow manufacturer guidelines for the use of a "Panacea Original Mattress (a pressure reducing)" for 1 of 3 residents (R10) reviewed for pressure ulcers. This increased the potential for R10, who was at risk for the development of pressure ulcers, to develop a pressure ulcer (area of skin breakdown due to unrelieved pressure). In addition, the facility failed to comprehensively assess and implement interventions to prevent worsening and prevent and/or additional pressure ulcers (PU)'s from developing for 1 of 3 residents (R124) reviewed for pressure ulcers. Findings include: Review of a document provided by the facility titled, "Pressure Ulcer/Wound Care Resource Packet," dated 05/26/22, indicated ". . .Based on the comprehensive assessment of a resident, the facility must ensure that. . .A resident who enters the facility without pressure ulcers does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable. . ." Review of a document provided by the facility titled, "Panacea Foam Mattress. . .Owner's Manual," indicated ". . .Never alter this product in any way. . .No part of component of a Panacea mattress should be used with non-Panacea parts or components. . ." Review of R10's electronic medical record (EMR) located under the "Profile" tab indicated the resident was admitted to the facility on 09/04/19, with a diagnosis of generalized muscle weakness.	2 900	development related to using a foam mattress topper on 2/9/23. Daughter and resident have chosen to keep foam mattress topper. R10□s care plan has been updated to include assisting resident with repositioning every 2 hours and prn if resident has not done so individually. Nursing management reviewed all residents in facility and ensured there was documentation of education provided to those residents that do not have the facility issued pressure reducing mattress or additional padding on their pad. Residents who chose to not use the facility□s pressure reducing mattress or use extra padding on their mattress will be educated at least quarterly on the increased risk of development of pressure ulcers related to this choice. Care plans will be updated to include a turning and repositioning schedule per the resident□s individual needs. Nursing staff will be educated on the importance of educating residents on the increased risk of pressure ulcers when not using the facility□s pressure reducing mattress. Education will occur via a meeting to occur on 3/16/23. R124 has discharged from the facility. All residents at risk for pressure ulcers were reviewed to ensure that there were appropriate care planned interventions to promote the healing of current pressure ulcers and to prevent skin breakdown from occurring. Nursing staff will be educated on ensuring care planned interventions for the prevention and treatment of pressure ulcers are in place and the importance of providing ongoing education to residents	

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2 900	Continued From page 4 Review of R10's EMR "Care Plan," located under the "Care Plan" tab and dated 08/24/20, indicated the resident had the potential for impairment to skin integrity due to decreased mobility and urinary incontinence. The intervention was to provide R10 with a pressure reducing mattress. Review of R10's EMR "Braden Scale for Predicting Pressure Sore Risk," located under the "Assmts (Assessment)" tab and dated 09/30/22, indicated the resident scored 17 for the development of pressure ulcers. A score of under 18 indicated R10 was at risk for the development of pressure ulcers. Review of R10's EMR quarterly "Minimum Data Set (MDS)" with an Assessment Reference Date (ARD) of 12/23/22, indicated a "Brief Interview for Mental Status (BIMS)" score of 11 out of 15 which revealed R10 was moderately cognitively impaired. The assessment indicated R10 required extensive assistance of one staff for bed mobility and transfers and was at risk for the development of pressure ulcers. During an interview on 02/07/23 at 9:00 a.m. R10 pointed to her mattress and stated her back was in pain due to the poor mattress. R10 gave permission for the surveyor to examine the mattress. The covers were lifted and a foam cushion topper was observed on a pressure reducing mattress. The resident stated her family had brought the cushion in to attempt to make the mattress more comfortable. During an interview on 02/08/23 at 8:06 a.m., nursing assistant (NA)-K and NA H stated they were both familiar with R10. Both NA K and NA H stated they were aware of the foam cushion on the resident's bed and were aware the resident's	2 900	via a meeting to occur on 3/16/23. Random audits to ensure compliance will be conducted by nursing management weekly x 4 and monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for Review.	

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2 900	Continued From page 5 family brought the foam cushion topper for the resident's bed. During an interview on 02/08/23 at 2:55 p.m., the director of nursing (DON) stated she was not aware R10 had a foam cushion topper to her mattress. DON N stated the resident was at risk for the development of pressure ulcers. A request was made for documentation in which risks versus benefits were discussed with the resident and/or her family. A subsequent interview conducted on 02/09/23 at 9:35 a.m., DON was asked if R10 and/or her family were provided information on risks verses benefits for the use of a foam cushion which potentially could lead to a pressure ulcer. DON stated she needed to get in touch with the resident's family and review the clinical records. No information was provided by the end of the survey which addressed the risk versus benefits of the continued use of a foam cushion on R10's pressure reducing mattress. R124 R124 was admitted to the facility on 1/18/23, with diagnoses (identified on the active physician order sheet) dated 2/8/23, including; chronic kidney disease (the kidney fails to filter waste and excess fluid from the blood) altered mental status (change in average mental function) weakness and unstageable pressure ulcer (ulcer that has full thickness tissue loss but is either covered by necrotic tissue or eschar. Necrotic tissue is non-viable tissue and eschar is dead tissue that is hard, dry and leathery) of the right heel. R124's admission minimum data set (MDS)	2 900		

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2 900	Continued From page 6 assessment dated 1/24/23, identified R124 as having a baseline interview for mental status (BIMS) of "14" (cognitively intact). R124 required assistance with activities of daily living (ADL's) that included dressing, toileting, transfer, positioning and walking. The MDS identified R124 as being at risk for PU's and identified a unhealed unstageable pressure ulcer. Interventions included; a reduction mattress and PU care. Review of the admission data collection form dated 1/18/23, identified R124 as having a unstageable PU to the right heel. Review of a wound data collection tool dated 1/18/23, identified R124 as having a unstageable pressure ulcer on the right heel. The PU measured 3.7 centimeters (cm) length by 2.0 cm width. The resident had pain in the PU area. The PU has a minimum amount of serosanguinous drainage (thin pink watery fluid) and surrounding tissue is pink in color. A Mepilex dressing (absorbent dressing used for wound exudate) applied. Review of a wound data collection tool dated 1/21/23, identified R124 as having a PU on the right heel. The PU measured 4.2 centimeters (cm) length by 5.4 cm width and 0.1 cm depth. The PU has 30% granulation tissue (new connective tissue) and 70% slough tissue (referred to as necrotic/fibrotic tissue). The PU has a moderate amount of serosanguinous drainage and surrounding tissue is pink in color. A Mepilex dressing applied. Review of a wound data collection tool dated 1/27/23, identified R124 as having a PU on the right heel. R124 voiced complaints of pain in the	2 900		

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2 900	Continued From page 7 PU area. The PU measured 4.0 centimeters (cm) length by 4.0 cm width by 0.1 cm depth. The PU has 90% granulation and 10% slough. The PU has a moderate amount of purulent drainage (white, yellow or brown fluid and can be a sign of infection) and skin is macerated (softening and breaking down of skin) around the PU. Review of a wound data collection tool dated 1/30/23, identified R124 as having a PU on the right heel. The PU measured 4.0 cm length by 3.1 cm width. The assessment did not include the characteristics of the PU bed. The PU had drainage on the dressing and the tissue surrounding the PU was pink. Review of a wound date collection tool dated 2/1/23, identified R124 as having a PU on the right heel. The PU measured 4.0 cm length by 3.1 cm width. The PU was described as having 100% eschar tissue. The PU had a moderate amount of serosanguinous drainage and the skin margins were macerated with erythema (redness with possible infection). Treatment of Iodosorb dressing (absorbs wound fluids and kills bacteria) with foam and Kerlix covering. Review of a wound date collection tool dated 2/5/23, identified R124 as having a PU on the right heel. The PU measured 3.7 cm length by 5.4 cm width and 0.1 cm depth. The characteristics of the PU bed were not described. The PU had a minimum amount of serous drainage and surrounding tissue noted to be macerated.. Treatment of Iodosorb to wound base and cover with foam and Kerlix. Review of the current physicians orders dated 1/18/23, included orders to reduce and redistribute pressure to the right heel and do not	2 900		

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2 900	Continued From page 8 lay or sit in one position for a long period of time. Avoid positions that can make the PU worsen. Place cushions or pillows under legs to reduce pressure. Check wound daily for signs of infection, redness swelling and increased pain and administer Oxycodone (used for moderate to severe pain) 5 mg bid (twice daily) for PU pain. Review of a provider visit progress note dated 1/24/23, by certified nurse practitioner (CNP)-A, indicated R124 was seen related to a change in R124's PU of the right heel. The progress notes identified the PU to the heel as a stage 2 ulcer (Partial thickness loss of dermis presenting as a shallow open ulcer with a red-pink wound bed, without slough. May also present as an intact or open/ ruptured blister) with some eschar and granulation tissue. Erythema around the PU edges. Treatment orders to apply Medihoney (aids in debridement, of which is the removal of damaged tissue and provides a moist healing environment) with foam dressing cover and wrap with kerlix. Change dressing daily and as needed (PRN). Review again in 2 days. Start Doxycycline (antibiotic) and continue offloading. The progress note further indicated the NH (nursing home) wound nurse will be following wound. Review of a physician order dated 1/27/23, included Iodosorb treatment to the PU on the right heel, due to no improvement from the current treatment. Review of the care plan revised on 1/31/23, identified R124 as having a PU on the right heel. R124 is at risk for further breakdown, due to decreased mobility and weakness. Interventions included; assess/record/monitor wound healing daily on the wound data form, facility RN to assess weekly with skin assessments, float heels	2 900		

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2 900	Continued From page 9 in bed using blue foam boots and/or pillows, remind the resident to change positions at least every 2-3 hours and to not stand up or transfer with the blue foam boot on. Staff to assist the resident with socks and shoes. R124 may use a sock aid or shoe horn to get her shoes on, but may be difficult for her due to her right heel PU. R124 has pain in the right heel ulcer and staff to evaluate the effectiveness of the pain medication given. Observation and interview on 2/7/23, at 9:30 a.m. R124 was sitting in her recliner with her feet dependent to the floor. The residents right lower leg and foot was slightly swollen. The right foot had a gripper sock on. Both heels were resting on the floor. R124 stated she had a PU on her heel. There was a protective heel boot sitting next to her bed. R124 stated she wears the protective boot to her right foot during the night, but does not wear during the day. R124 indicated she usually has her tennis shoe on but needed help to get it on. R124 further indicated she did not elevate her feet or have her feet off the floor during the day, rather just during the night when in bed. R124 stated it was too difficult to elevate the footrest herself. Observation on 2/7/23 at 10:30 a.m. R124's PU treatment was done by the director of nursing (DON). R124's right sock, tennis shoe and dressing was removed. The sock and shoe noted to be tight and difficult to remove due to the resident complaining of pain. The PU on the heel was covered with necrotic tissue and surrounding tissue was pink with some maceration and peeling skin. After a new dressing was applied, staff assisted with putting the residents sock and shoe back on. Pressure and friction was required to get the sock and shoe on and a metal shoe	2 900		

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2 900	Continued From page 10 horn was used on the heel to get the shoe on. The shoe horn was pressed against part of the pressure ulcer. Interview with the resident at this time, stated that she had been wearing her shoes for at least a week and she has been having a lot of pain when having her sock and shoes put on and taken off. Observation on 2/9/23, at 9:00 a.m. R124's PU treatment was done by registered nurse (RN)-B. R124's tennis shoe, sock and dressing was removed from the right foot. R124 clenched her teeth and complained of pain when this was done. There was a moderate amount of brownish colored drainage on the dressing (Isosorb has a brownish color) R124's PU was observed to be covered with necrotic tissue. When RN-B cleansed the PU, R124 flinched and complained of pain. The tissue around the PU noted to be macerated with peeling skin. There was also a 1.0 inch diameter discolored area in the skin above the PU on the right heel. RN-B indicated this was a change in the tissue. The PU measured 3.4 cm length by 4.6 cm depth. RN-B also indicated R124 received Oxycodone for pain prior to the dressing change at 5:30 a.m., but still had a lot of pain with treatment. Because R124 complained of increased pain when putting on and removing the sock and tennis shoe, R124 agreed to put on a gripper sock at this time. Observations over the course of the survey on 2/6/23 through 2/9/23, R124 was observed to be sitting in her recliner with both of her feet/heels on the floor. R124 was wearing tennis shoes during observations on 2/7/23 through 2/9/23. When interviewing R124 again on 2/8/23, at 2:00 p.m. she confirmed she did not elevate her legs or have her feet off the floor when up during the day. R124 indicated she could not get the foot pedals	2 900		

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2 900	Continued From page 11 of the recliner up herself and staff do not come in and offer to assist. R124 stated the staff did assist her with wearing protective boots at night. R124 indicated she wanted to go home and would do anything to help the PU heal, so that could happen. Interview on 2/7/23, at 1:30 p.m., nurse aide (NA)-A confirmed R124 sits in her recliner most of the day with her feet/heels touching the floor. NA-A indicated she was aware of R124's PU on the right heel, but was unsure of any interventions other than the nurse changing the dressing to the right heel. NA-A further verified R124 wears her tennis shoes throughout the day. Interview on 2/8/23, at 11:00 a.m., NA-B confirmed R124 spends a lot of the day sitting in her recliner with her feet down. NA-A indicated she was not aware of any interventions during the day, but was aware that R124 wears protective boots at night when in bed. NA-B further verified R124 wears tennis shoes throughout the day. Interview on 2/9/23, at 9:00 a.m., RN-B indicated R124's PU on the right heel has not improved. RN-B indicated R124 did not have necrotic tissue covering R124's entire PU on admission, but now the entire PU is covered with necrotic tissue. RN-B also confirmed it was difficult taking R124's sock and shoes on and off due to causing pressure and friction on the PU, that caused increased pain for the resident. RN-B further indicated when R124's PU was identified to become odorous, the provider was notified and a change in treatment had been done. Interview on 2/9/23, at 9:20 a.m. physical therapist (PT)-A ,stated R124 has been wearing tennis shoes since admission, that she was	2 900		

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2 900	Continued From page 12 aware of. PT-A indicated she had been aware of R124's shoes being tight and gave her a metal shoe horn, to assist with putting the shoe on and off. PT-A indicated she was unaware of exactly where the PU was located on the heel. PT-A indicated when R124 was given the ok to walk independently in her room, there should have been a interdisplinary discussion with nursing. Options and the condition of the PU could have been discussed to promote healing of the PU as well as safety of the resident with walking. PT-A indicated this had not been done. Interview on 2/9/23, at 9:30 a.m. with RN-C indicated R124 wanted to wear tennis shoes, even when encouraging her not to. RN-C indicated since therapy allowed R124 to walk independently (about a week ago) R124 started to wear her tennis shoes due to the risk of falling. RN-C indicated R124 thought it would be too difficult if she had to put on her shoes on, when walking to the bathroom and to meals. RN-C confirmed she did not review the risks with R124 or family related to wearing the tennis shoe throughout the day and not elevating her legs. RN-C verified no other options had been given for R124 related to footwear, that would promote less pressure on the heel. Interview on 2/9/23, at 10:00 a.m. the DON stated she was aware R124 wanted to wear tennis shoes, even when encouraged not to. The DON indicated staff had implemented interventions to prevent worsening of the PU, but R124 did not always comply. The DON did state PT-A should not have given the metal shoe horn to R124 to aid in putting her shoe on the right foot, and confirmed the staff could have offered other options for R124 to use that would cause less pressure to the PU.	2 900		

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2 900	Continued From page 13 Facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation, dated 4/26/22, indicated the purpose of the policy is to appropriately use prevention techniques and pressure redistribution surfaces on those residents at risk for PU. The policy indicated the interdisciplinary team should determine any modifications that are necessary to the residents plan of care. Interventions should focus on physical , emotional and psychosocial aspects that may be impacted. Treatments and interventions should be consistent with the residents goals. Education should be provided to the resident and/or family. If a pressure ulcer is not determine to be clinically unavoidable, the ulcer should show signs of improvement within two to 4 weeks. Signs of improvement might include decrease in size, decrease in exudate and improvement in tissue (from necrotic to slough to granulation to epithelial) If a resident makes an informed choice to refuse treatment or interventions, then education of what a PU is, what the risk of the refusal is, and the potential outcome should be provided to the resident and/or family. The education should be documented. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care and services are implemented and reduce the risk for pressure	2 900		

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2 900	Continued From page 14 ulcer development. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		
21665	MN Rule 4658.1400 Physical Environment A nursing home must provide a safe, clean, functional, comfortable, and homelike physical environment, allowing the resident to use personal belongings to the extent possible. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to provide the recommended supervision during meals to prevent choking for 1 of 3 residents (R45) reviewed for accident hazards. Findings include: Review of R45's electronic medical record (EMR) titled "Admission Record," located under the "Profile" tab, indicated the resident was admitted to the facility on 08/25/22, with a diagnosis of dysphasia (difficulty swallowing). Review of a document provided by the facility titled, "Diet Notification Form," dated 08/26/22, indicated the level of supervision while eating was "Line of Sight." Review of a document provided by the facility	21665	F689: Plan of Correction: R45□s care plan was reviewed and he continues to eat meals in main dining room with distant line of sight supervision. R45 was re-evaluated by speech therapy on 2/16/23 and his care plan was updated with her recommendations. The care plans, dietician assessments, and speech therapy assessments (when applicable) were reviewed for all residents to ensure all residents were eating in a location to provide the necessary supervision to meet their needs. All care plans were updated if applicable. The level of supervision needed for residents was added to their dining tray cards as an additional reminder to staff. Nursing staff will be educated on the importance of supervision for residents who are receiving altered diets and are at	3/22/23

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21665	Continued From page 15 titled, "Physician Orders," dated 08/26/22, indicated the resident could have "Distant Supervision During Meals/PO [oral] Intakes." Record review of a "Diet Notification Form," written by the Speech Therapist (ST) on 09/21/22, indicated a recommendation for the resident to receive ". . .line of sight. . ." supervision and be encouraged to eat in the dining room. Record review of R45's EMR "Care Plan," located under the tab "Care Plan" and dated 09/26/2022, indicated interventions for the resident's nutrition/hydration problems involved "line of sight" supervision. Record review of R45's "ST [speech therapist]-Therapist Progress & Discharge Summary" written by the ST on 10/20/2022, indicated a recommendation for the resident to ". . .continue to receive distant supervision and eat in main dining room for meals to ensure safety when consuming meal and monitor for increase of s/s [signs and symptoms]of aspiration or other swallowing difficulties. . ." Review of R45's EMR titled significant change "Minimum Data Sheet (MDS)" with an Assessment Reference Date (ARD) of 11/14/22, indicated the resident had a "Brief Interview for Mental Status (BIMS)" score of five out of 15 which revealed R45 was severely cognitively impaired. The assessment indicated the resident required supervision, such as oversight and cueing, after set-up of a meal. The Care Area Assessment (CAA), located under the assessment triggered nutrition and directed the staff to develop a care plan. During an observation on 02/06/23 at 6:43 p.m.,	21665	risk for choking via a meeting to be held on 3/16/23. Random audits to ensure compliance will be conducted by nursing management weekly x 4 and monthly x 3. Audit results will be brought to the Quality Assurance Performance Improvement Committee for Review.	

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21665	Continued From page 16 R45 was observed in his room eating his evening meal. There were no staff present during this observation. During an observation on 02/07/23 at 8:13 a.m., R45 was observed eating his breakfast meal in his room and there were no staff present. During an observation on 02/07/23 at 8:39 a.m., R45 was observed eating his breakfast meal in his room and there were no staff present. During an interview on 02/09/23 at 7:26 a.m., nursing assistant (NA) H stated she was aware R45 was at risk of choking. NA H stated she props the resident's door open during mealtimes so she can keep an eye on him. NA H stated the resident was currently on contact precautions and did not go to the main dining room. During an interview on 02/09/23 at 7:32 a.m., NA-L stated R45 typically went to the main dining room for meals but was under contact precautions and did not. During an interview on 02/09/23 at 10:11 a.m., nurse manager (NM) D stated she was covering for the unit manager on the 300 unit and confirmed she was familiar with R45. NM D stated the resident typically ate in the main dining room but currently eats in his room due to being on contact precautions. NM D stated the resident gets frequent checks, outside of his room, during his mealtimes. During an interview on 02/09/23 at 10:15 a.m., speech therapist (ST) A stated R45 eating in his room with only intermittent "line of sight" supervision was not adequate. ST A stated her previous recommendations was for the resident	21665		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: _____ B. WING _____	C 02/09/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21665	Continued From page 17 to be in the dining room with direct "line of sight" supervision and was based upon her evaluation at the time of the resident's discharge from skilled therapy. ST A stated without a new evaluation or information from nursing that the resident improved, leaving the resident alone in his room, while eating, was not adequate. During an interview on 02/09/23 at 12:16 p.m., the director of nursing (DON) stated based on the ST A's recommendations, the resident required one person to sit in his room with him, while under contact isolation precautions and this was not done by staff. SUGGESTED METHODS OF CORRECTION: The director of nursing or designee could review and assess residents who are at risk for choking/aspirating and ensure safety and supervision while eating. Educate staff on the importance of supervision for residents who are receiving altered diets and are at risk for choking/aspirating. The DON or designee should conduct measurable audits for a specific amount of time of the delivery of care to residents affected and those who have the potential to be affected to ensure appropriate care, services, and supervision are implemented. The DON or designee should bring all audit information to the Quality Assurance Performance Improvement (QAPI) committee to determine compliance or the need for further monitoring TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21665		