Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
October 3, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: CCN: 245221
Cycle Start Date: August 22, 2024

Dear Administrator:

On September 24, 2024, 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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

October 3, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: Reinspection Results
Event ID: N22C12

Dear Administrator:

On September 24, 2024 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 August 22, 2024. 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

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September 3, 2024

Administrator
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550 Roselawn Avenue East
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RE: CCN: 245221
Cycle Start Date: August 22, 2024

Dear Administrator:

On August 22, 2024, 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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 November 22, 2024 (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 February 22, 2025 (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:

Travis Z. Ahrens
State Fire Safety Supervisor
Health Care & Correctional Facilities
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
Email: travis.ahrens@state.mn.us
Web: www.sfm.dps.mn.gov
Cell: 1-507-308-4189

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
	245221	A. BUILDING _____ B. WING _____	C 08/22/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 8/19/24-8/22/24, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73 was conducted during a standard recertification survey. The facility was in compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 8/19/24-8/22/24, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was 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 deficiencies cited: H5221708C (MN00099435). 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 substantial compliance with the regulations has been attained.	F 000		
F 584	Safe/Clean/Comfortable/Homelike Environment	F 584		9/20/24

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

Electronically Signed | 09/10/2024

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

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F 584 SS=E	Continued From page 1 CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and	F 584		

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F 584	Continued From page 2 §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure reclining foot rests functioned appropriately for 1 of 1 resident (R212) and failed to ensure a clean communal shower room which had the potential to affect all residents who used the shower room. Findings include, R212's comprehensive Minimum Data Set (MDS) in progress dated 8/15/24, indicated intact cognition, had coronary artery disease and hypertension (high blood pressure), acute myocardial infarction (heart attack), presence of an aortocoronary bypass graft, and had an encounter for surgical after care following surgery on the circulatory system. R212's physician orders form indicated the following order: 8/16/24, bumetanide 1 milligram (MG) by mouth daily for edema (fluid collecting in body tissues) and shortness of breath. R212's care plan dated 8/12/24, identified R212 took a diuretic. During interview on 8/19/24, at 1:13 p.m., R212 stated she mentioned to a few staff that the recliner chair did not work when trying to put her feet up, the foot rest would not stay in the upright position. R212 stated she mentioned the concern on 8/18/24, and again the morning of 8/19/24.	F 584	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 centers allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident #212 recliner spring tension was adjusted on 8/22/24 so that the reclining foot rest functioned appropriately. The shower room identified by Resident #13 on the lower-level odd numbered hallway was deep cleaned mechanically the last week of August. The shower room on the lower level even numbered hallway was mechanically cleaned the first week of September. 2. How will other residents, having the	

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F 584	Continued From page 3 During interview on 8/21/24 at 7:18 a.m., the manager of ancillary services (MOAS)-A stated he becomes aware of repairs thru the use of a maintenance slip or if there is something more severe or if something was urgent, a direct phone call was completed. MOAS-A further stated maintenance slips were used for everything to make him aware. A list of maintenance slips were requested from the past three weeks including completed orders and uncompleted work orders. During interview on 8/21/24 at 7:43 a.m., the MOAS-A provided the maintenance slips and further stated if in a hurry, instructs to fill out a slip, but if it is something like a remote not working, MOAS-A will look at the remote and not necessarily fill out a slip, but if a slip is not filled out, will look at the issue immediately or the same day. The work orders lacked information regarding R212's reclining chair. During interview and observation on 8/21/24 at 11:39 a.m., nursing assistant (NA)-B answered R212's call light and pulled the lever to recline R212 in the recliner chair. The foot rest would not stay in the elevated position. NA-B stated when the back of the chair is pulled back, the chair wouldn't stay in a reclined position and stated a lot of the chairs this style have been doing this since they got them and stated R212 had been wanting a new chair and stated somebody told R212 on 8/20/24, that they could not interchange the chairs, but did not know who told R212 the chairs could not be changed. NA-B further stated R212 mentioned the chair issue to her 8/20/24, but did not talk to maintenance. R212 stated she had swelling in her feet.	F 584	potential to be affected by the same deficient practice, be identified All residents with the recliners that have adjustable spring tensions will be checked to ensure the reclining footrest functions properly. All shower rooms were checked on 9/2/24 and a deep cleaning schedule was initiated the last week of August to deep clean all shower rooms on a monthly basis and as needed. 3. What measure will be put into place, or systematic changes will be made, to ensure that the deficient practice does not recur? All staff will be re-educated on the Policy for Common Area Cleaning and submission of maintenance slips for any equipment or furniture that is not functioning correctly as well as notifying maintenance supervisor with any concerns regarding cleanliness of resident private or shared care areas. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The maintenance supervisor will audit all recliners with adjustable spring tension to ensure the footrest functions properly and all shower rooms will be checked for cleanliness 1 x per week for one month, every month after for 3 months and then quarterly. Audit results will be brought to the QAPI committee for further review. 5. What is the date of completion? 9/20/24	

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F 584	Continued From page 4 During interview on 8/21/24, at 11:45 a.m., and 11:47 a.m., registered nurse (RN)-B stated if a recliner chair wasn't functioning, they contacted maintenance who will repair or replace a chair. RN-B stated she was not aware R212's leg rest on the chair was not functioning. RN-B stated MOAS-A was pretty quick and usually came up on the same day of any requests. RN-B further stated R212 had heart surgery and it would be important to elevate her legs for the swelling and edema. At 11:47 a.m., RN-B called and notified MOAS-A that R212's recliner chair was not working and would come up to look at the chair. During interview on 8/21/24 at 2:21 p.m., NA-B stated R212 was able to respond appropriately and could make her needs known. During interview on 8/22/24 at 7:33 a.m., MOAS-A stated the recliners had two springs that held the leg rest up and the manufacturer provided springs in three different tensions and stated the stiffness of the springs were used based on a resident's weight and residents used their legs and the lever to put their legs down, but if they don't have the strength, adjustments are made with a different tension spring. MOAS-A stated he did not know how long R212 had the problem and was first made aware of it around 12:00 p.m., on 8/21/24. During interview and observation 8/22/24 at 10:51 a.m., R212 was able to recline herself in the reclining chair and put the foot rest down and stated it was much better. During interview on 8/22/24 at 12:00 p.m., the director of nursing (DON) stated she expected	F 584		

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F 584	Continued From page 5 staff to complete a slip to notify maintenance and further stated she expected staff to contact maintenance and stated she would contact MOAS-A to see if there was a schedule for the shower room and expected housekeepers keep a schedule. R13's quarterly MDS dated 5/14/24, indicated R13 was cognitively intact and had diagnoses of heart failure and diabetes. Furthermore, R13's MDS indicated R13 required partial/moderate assistance to shower. When interviewed on 8/19/24 at 12:18 p.m., R13 was seated in their wheelchair in the room. R13 stated there was mold growing in the shower room. R13 stated she had reported it before about a year ago and it was cleaned up and looked great however it was returning. R13 stated it was between the tiles and along the edges of the floor. An observation on 8/19/24 at 12:26 p.m., the lower-level shower room for the odd number hallway was observed. The room had a small ivory/white tiled floor. Grout in between the tiles were whit/light colored in most of the areas.	F 584		

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F 584	Continued From page 6 However, several areas of the floor had darker black grout between the tiles. An observation on 8/21/24 at 12:28 p.m., the lower-level shower room for the even number hallway was observed. The room had a small ivory/white tiled floor. There was dark grout in between the tiles under the shower and along the shower floor and wall. When interviewed on 8/21/24 at 12:11 p.m., housekeeper (HSK)-A stated shower rooms were cleaned daily, and maintenance completed any deep cleaning and was not aware of any schedule for deep cleaning. HSK-A stated the shower room on the odd hallways did not get used much and most residents used the even hall shower. HSK-A was aware of the black grout between the tiles and along the wall and stated the mop used did not get in deep and mostly cleaned the surface of the tiles. HSK- stated they have tried to use their fingernail over the mop sponge to try to dig in between the tiles some, but it was hard to get it removed. When interviewed on 8/21/24 at 12:28 p.m., the MOAS-A verified the dark grout on the tile floor in the even number shower room and stated they needed to have a deep clean. MOAS-A further stated there was not a routine deep cleaning schedule and it was just as needed. MOAS-A was not aware of them needing cleaning and was not sure when the last time it was done. MOAS-A was able to confirm the shower rooms have not been deep cleaned in the past 8 months since their return. A policy, Resident Environment, dated 2/2/24, indicated the facility will provide a safe, clean,	F 584		

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F 584	Continued From page 7 comfortable environment that allows the residents use of some personal belongings. Resident rooms will be designed and equipped for adequate nursing care, safety and comfort and will ensure full visual privacy for each resident as well as the following, housekeeping and maintenance services and functional furniture appropriate to resident needs.	F 584		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the	F 656		9/20/24

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F 656	Continued From page 8 resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure comprehensive care plans were developed for 1 of 1 resident (R50) and failed to ensure non-pharmacological interventions were developed and implemented for 1 of 1 resident (R110) reviewed for psychotropic drug use. Findings include: R50's admission Minimum Data Set dated 7/9/24, indicated severe cognitive impairment, did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless, did not have physical, verbal, or other behaviors, had diagnoses of dementia and depression and took an antipsychotic and antidepressant medication. R50's care area assessment (CAA) worksheet dated 7/16/24, indicated R50 took duloxetine (an	F 656	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R50 has been discharged (8/21/2024). 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All current residents have been reviewed to ensure proper non-pharmacological interventions were developed and implemented for psychotropic drug use. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or designee will provide re-education	

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	245221	A. BUILDING _____ B. WING _____	C 08/22/2024

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F 656	Continued From page 9 antidepressant) and aripiprazole (an antipsychotic) for depression and psychotropic drug use would be addressed in the care plan in order to minimize risks. R50's physician orders indicated the following orders: 7/4/24, aripiprazole 20 milligrams (MG) by mouth once daily. 7/4/24, duloxetine 30 mg by mouth every evening, and 60 mg by mouth every morning. R50's orders lacked any monitoring for side effects of duloxetine and aripiprazole. R50's care plan was reviewed and lacked information R50 had a specific care plan for depression, and further lacked any monitoring for side effects of duloxetine and aripiprazole. R50's Pharmacist Medication Review form dated 8/15/24, indicated R50 was on Aspirin 325 mg daily indicated Aspirin was indicated for the prevention and or treatment of a wide variety of cardiovascular condition, and there was general consensus across guidelines that when used for primary or secondary cardiovascular prevention, lower doses of Aspirin have similar efficacy to higher doses, but carry less risk for significant bleeds. Please consider lowering this patient's Aspirin to 81 mg daily. The review lacked information for monitoring for side effects of aripiprazole or duloxetine. R50's Pharmacist Consultant review dated 7/19/24 indicated R50 was on aripiprazole 20 mg daily, please order monthly orthostatic blood pressure monitoring. R50's Pharmacist Consultant review dated 7/4/24	F 656	to all nurses responsible for completion of the care plan for proper development and implementation of non-pharmacological interventions for psychotropic drug use. Re-education will be completed by 9/18/2024.Care Plan Policy/Procedure Reviewed to see that systemic changes are sustained. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will conduct audits to ensure proper development and implementation of non-pharmacological interventions for psychotropic drug use. Audits will be completed weekly time one month, completed monthly x 1 quarter and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed. We will audit 10% of the affected census. 5. What is the date of completion? 9/20/2024	

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F 656	Continued From page 10	F 656		

indicated no potential clinically significant medication issues identified at this time.

During interview on 8/21/24 at 11:15 a.m., the consulting pharmacist (CP)-A stated antidepressant side effect monitoring included monitoring for central nervous system changes, whether a resident starts falling, weight loss and weight gain and further stated specific manifestations can take a few weeks and did not see any specific orders for R50.

During interview on 8/21/24 at 12:03 p.m., registered nurse (RN)-C stated if a resident was on a psychotropic medication, it was added to the careplan and any monitoring for side effects showed up in the medication administration records. RN-C viewed the orders and stated R50 should have monitoring because R50 was on aripiprazole and duloxetine and verified the orders lacked monitoring and further RN-C viewed R50's care plan and verified R50 did not have a care plan related to psychotropics. RN-C also viewed R50's discontinued orders and verified there were no orders for monitoring and stated it should be there and would have to follow up with the director of nursing.

During interview on 8/21/24 at 11:49 a.m., nursing assistant (NA)-B stated she would have to ask the nurse to see what kind of medications a resident was on and could also look in the Kardex to see if there were any behaviors to watch for.

During interview on 8/22/24 at 12:13 p.m., the director of nursing (DON) stated monitoring was completed weekly and should be part of the documentation and whether the medications are effective and stated monitoring was supposed to

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F 656	Continued From page 11 be in the nursing orders and checked the care plan and verified the care plan lacked information R50 was on aripiprazole and duloxetine or had any kind of monitoring in place. R110's admission Minimum Data Set (MDS) dated 8/7/24, indicated intact cognition, diagnosis of Bipolar disorders, was independent to supervision with ADL's and received an antispsychotic on a routine basis. R110's care area assessment (CAA) worksheet for psychotropic drug use dated 8/7/24, indicated: R110 received an antipsychotic, antidepressant, and hypnotic medication. Resident for drug induced Parkinsonism, multiple falls, chronic back pain, and myelofibrosis for diagnosis of bipolar disorder. Resident appears to tolerate medication without adverse reaction. Nursing staff observe for mood and behavior, and potential adverse reaction with administration of medication. R110's physician's orders dated 8/1/24, indicated olanzapine oral tablet 15 milligrams (mg). Give 15 mg by mouth at bedtime for psychosis. R110's care plan dated 8/5/24, indicated R110 was on antipsychotic medication therapy related to bipolar and psychosis. It further contained the following interventions: -R110 will be free of any discomfort or adverse side effects from antipsychotic medication use	F 656		

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F 656	Continued From page 12 through the review date. -monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (olanzapine). -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. -WARNINGS #1: Refer to boxed warnings in the orders or eMAR, or medication reference of choice R110's care plan lacked any indication of non-pharmacological interventions. During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated when a resident comes in as a new admission a baseline care plan was initiated by the admitting nurse, MDS nurse or the DON. After that they continue to develop a more comprehensive care plan which was driven by the admission assessment. As things change, the care plan was continuously updated and the MDS nurse had a huge part in that but all departments are included. RN-A further stated staff should be developing and impletmenting non-pharmacological interventions on the care plan for residents who receive an antipsychotic medication and verified R110's care plan lacked individualized non pharmacological interventions. During interview on 8/22/24 at 2:19 p.m. the director of nursing (DON) stated non pharmacologic interventions should be developed, monitored, care planned and documented for residents who receive an antipsychotic medication. A policy, Care Plan-R/S, LTC, Therapy & Rehab, dated 11/1/23, indicated the purpose was to	F 656		

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F 656	Continued From page 13 develop a comprehensive care plan using an interdisciplinary team approach, to provide guidance to the interdisciplinary team (IDT) in developing the initial care plan. The comprehensive care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders.	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure routine incontinent care was provided for 1 of 3 residents (R18) reviewed for dependent activities of daily living (ADL's). Findings include: R18's quarterly Minimum Data Set (MDS) dated	F 677	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R18 reviewed to ensure routine incontinent care was provided. 2. How will other residents, having the potential to be affected by the same	9/20/24

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F 677	Continued From page 14 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was always incontinent of bladder and bowel and required maximal assistance from staff for incontinent cares. R18's care plan revised 4/3/24, indicated R18 had incontinence related to impaired mobility, weakness, and use of a diuretic. Interventions included to monitor for signs of urinary tract infection, use incontinence products, check for incontinence frequently and provide brief change and incontinence cares as needed. R18's Kardex printed 8/20/24, indicated R18 required frequent checks for incontinence and assistance with incontinence cares. A continuous observation on 8/20/24 at 10:58 a.m., R18 was in their room seated in a broada wheelchair. R18 was slightly reclined, and the feet were not elevated. In front of R18 was the bedside table. At 11:58 a.m., the resident remained in the same position and no staff had entered the room. At 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. T NA-A obtained a chair and assisted R18 with lunch. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. NA-A had left R18's room without providing repositioning or checking for incontinence. At 12:55 p.m., housekeeper (HSK)-A entered R18's room for room cleaning. A At 1:10 p.m., hsk-A had completed cleaning R18's room. At 1:28 p.m., no other staff had entered R18's room to offer repositioning or check for incontinence care. At 1:35 p.m., NA-B	F 677	deficient practice, be identified? All current residents who are dependent with incontinence care have been reviewed to ensure routine incontinent care was provided. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or designee will provide re-education to all nurses and direct care staff to ensure routine incontinent care is provided to dependent residents. Re-education will be completed by 9/18/2024.. The policy that was reviewed to see that systemic changes will be sustained is Bowel and Bladder; Evaluation, Assessment, Toileting Programs Rehab/Skilled, Therapy & Rehab. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will conduct audits to ensure routine incontinent care is provided to dependent residents. Audits will be completed weekly x one month, monthly x 1 quarter and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed 5. What is the date of completion? 9/20/2024	

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F 677	Continued From page 15	F 677		

had entered R18's room and removed the pillow and reclined R18 all the way back in the broada chair. R18's feet were now elevated. NA-B had not asked or offered R18 incontinent cares.

When interviewed on 8/20/24 at 1:40 p.m., NA-B stated the Kardex, and care plan gave information about the cares residents need. NA-B was not sure if R18 had any skin concerns or was at risk for breakdown but knew R18 was usually reclined after lunch and should be repositioned every 2 hours. NA-B further stated NA-A usually did not work on this unit and they understood R18's routine a little better. NA-B verified they did not check or ask R18 about incontinence.

When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 was incontinent and required total assistance with repositioning and ADLs. R18 required a hoyer lift to get in and out of bed and should be repositioned and checked for incontinence about every 2 hours. NA-A verified they had not offered repositioning after lunch as she appeared to be resting comfortably. NA-A further stated R18 had not been checked for incontinence or changed since before lunch and stated was going to go do that now.

An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. Hand hygiene was performed upon entrance and gloves were donned however NA-A and LPN-A had not donned a gown. R18 was lifted with the Hoyer lift and placed in bed. NA-A removed R18's slippers. R18 had knee high nylon stockings in place and was wearing a nightgown/dress. NA-A unfastened R18's brief and tucked it down. NA-A provided cares from

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F 677	Continued From page 16 the front before LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. R18 cleaned R18 from the back side and removed gloves. NA-A applied barrier cream before placing a clean brief and assisted R18 to roll on their back. LPN-A pulled the brief through and secured. NA-A adjusted R18 to tilt to their right side and covered up. When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-B stated R18 was dependent with ADLs and was incontinent. LPN-B sated incontinent cares or checks should be completed every couple hours, or when R18 was repositioned. When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated repositioning and incontinent cares should happen frequently for R18 as R18 was at risk for skin breakdown. RN-A stated there wasn't a specific time frame, but multiple times a shift. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) stated incontinence cares were not completed on a specific timeframe but generally residents should check in the morning, after breakfast, before lunch, etc. The checks are individualized to the resident and should be included on the care plan. A facility policy for incontinent/ADL cares was requested however was not recieved.	F 677		
F 684 SS=E	Quality of Care CFR(s): 483.25	F 684		9/20/24

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F 684	Continued From page 17 § 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 record review the facility failed to ensure 3 of 4 residents (R18, R4, R12) reviewed for skin alterations had weekly skin observations completed. Furthermore, the facility failed to ensure bruising was assessed and monitored for 1 of 3 resident (R12) reviewed for bruising and a skin tear was assessed and monitored for 1 of 2 residents (R18) reviewed for pressure injury. Findings include: R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was at risk for pressure injury, was always incontinent of bladder and bowel, and was dependent on staff for mobility. R18's care plan revised 4/3/24, indicated R18 had potential for pressure ulcer development related to impaired mobility, weakness, history of falls, and use of a diuretic. R18 further had a known pressure insult of suspected deep tissue injury to both feels. Interventions included to assist to turn/reposition with a goal of every 2 hours, float	F 684	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R18, R4, R12 have been reviewed for skin alterations and weekly skin observations have been completed. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All current residents have been reviewed to ensure weekly skin observations have been completed. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or designee will provide re-education to all nurses to ensure weekly skin observations are completed. Re-education will be completed by 9/18/2024. The policy that was reviewed to see that systemic changes will be sustained is Skin Assessment Pressure Ulcer Prevention and Documentation	

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F 684	Continued From page 18 heels off bed, provide pressure reducing mattress and gel cushion in wheelchair, and notify the nurse immediately of any new skin breakdown. R18's Kardex printed 8/20/24, indicated R18 was a high risk for skin injury and had history of previous skin breakdowns. Staff were directed to notify the nurse of any new areas, redness, blisters, or bruises noted during care activities. R18's medical record lacked indication R18 had a weekly skin observation completed since 7/25/24. R18's nursing and provider orders lacked indication R18 required monitoring or treatment to the right lower extremity skin alteration on the skin. R18's medical record lacked evidence R18's skin tear had been assessed until 8/20/24 (after entrance). An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. R18 had knee high nylon stockings in place and was wearing a nightgown/dress. Under the stockings on R18's right shin, steri-strips were in place to close a skin alteration. LPN-A was not sure what the wound on R18's right shin was from and would check with LPN-B. When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-A stated skin observations were completed on shower days and verified R18 had not had a skin observation documented since 7/25/24. LPN-A was not sure	F 684	Requirements-Rehab/Skilled. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will conduct audits to ensure completion of weekly skin observations. Audits will be completed weekly for one month, monthly x 1 quarter and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed 5. What is the date of completion? 9/20/2024	

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F 684	Continued From page 19 why R18 had steri-strips on the right shin and was not able to find any documentation in R18's record of when or how it happened. There should be an incident report and documentation. LPN-B reviewed the 24-hour nurse book and verified there was not anything listed there either. When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated staff should be completing skin observations and reporting any new skin altercations so the correct follow up was in place. RN-A stated it appeared to be a skin tear and treatment was provided and was following up with staff to find out more details. RN-A verified there was no skin observations completed by staff since 7/25/24 and they should have been completed or documentation of refusal. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to complete weekly skin observations weekly with bathing. Nurses should also assess and document any skin alterations when they occur. R4's admission Minimum Data Set (MDS) dated 6/23/24, indicated intact cognition and diagnoses of encounter for orthopedic aftercare following surgical amputation, acquired absence of right leg below the knee, and type II diabetes mellitus with diabetic chronic kidney disease. It further indicated, impairment on one side of lower extremity, required staff assistance with most activities of daily living (ADL) and mobility, had a surgical wound, and no rejection of care behaviors were noted. R4's physician's order dated 6/20/24, indicated to	F 684		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 20 complete skin user data assessment (UDA) or daily skilled note regarding skin condition on bath day-Thursday morning. Please check entire body for any skin insults or new skin injury and report to nurse manager or wound team every day shift every Thursday for skin care. In addition, another physician's order dated 8/13/24, indicated wound care right leg: cleanse the wound using wound cleanser. Apply Vashe-moistened gauze, let sit 10 minutes, then remove and pat dry. Protect the skin around the wound with Cavilon barrier film. Apply medihoney alginate, cut to fit the size of the wound and place directly over wound followed by 4X4 silicone foam adhesive (zetuvit border) is covered for daily dressings. Moisturize legs daily with thick, hypoallergenic, high quality moisturizer (CeraVe, Eucerin, Cetaphil, Vanicream). Apply every day shift every other day for wound care R4's care plan dated 6/18/24, indicated R4 had an amputation of right below knee with the following interventions: -check and document on wound daily for signs/symptoms of infection, drainage, bleeding, any breakdown of skin and impaired circulation (edema or pain). -monitor/document pain management. Document frequency, duration, intensity of pain, phantom pain. Report to health care provider if medications are not effective. -monitor for excessive wound drainage, swelling, redness, etc. -monitor for bleeding and document. R4's medical record lacked any indication of weekly skin assessments. R4's progress notes for July and August 2024, lacked documentation of weekly skin	F 684		

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F 684	Continued From page 21 assessments. During interview on 8/21/24 at 2:06 p.m., registered nurse (RN)-C verified there was no documentaton of weekly skin assessments for the surgical incision on R4's right leg and there should have been. The skin assessment should include (at a minimum) a description of the wound in a progress note. R12 R12's significant change Minimum Data Set (MDS) dated 6/8/24, indicated, intact cognition and diagnoses of displaced bicondylar fracture of right tibia, atrial fibrillation, and chronic kidney disease (CKD). It further indicated R12 required assistance from staff with most activities of daily living (ADL), mobility, and received an anticoagulant on a routine basis. R12's physician's order dated 5/10/24, indicared please complete skin assessment UDA or daily skilled note regarding skin condition on this bath day-Friday PM. Please check entire body for any skin insults or new skin injury and report to nurse manager or wound team every evening shift every Friday for skin care. R12's care plan dated 5/6/24, indicated R12 was on anticoagulant therapy. Report to nurse observations of blood tinged or frank blood in urine, black tarry stools, dark or bright red blood in stools, sudden severe headaches, nausea, vomiting, diarrhea, muscle joint pain, lethargy, bruising, blurred vision, shortness of breath, loss of appetite, sudden changes in mental status, significant or sudden changes in vital signs, etc. It further indicated the following interventions:	F 684		

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F 684	Continued From page 22 -monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (apixaban). -Teaching: Resident/family/caregiver teaching to include the following: take/give medication at the same time each day; use soft toothbrush; use electric razor; avoid activities that could result in injury; take precautions to avoid falls; s/s of bleeding; avoid foods high in Vitamin K (includes greens such as spinach and turnips, asparagus, broccoli, cabbage, Brussel sprouts, milk, and cheese). -WARNINGS #1: Refer to boxed warnings in the orders or electronic medication administration record (eMAR), or medication reference of choice. R12's medical record lacked any indication of weekly skin assessments. R12's progress notes for July and August 2024, lacked documentation of weekly skin assessments. During observation and interview on 8/19/24 at 1:37 p.m., R12 stated her wheelchair was too narrow and the arm rests were too high. She then showed surveyor a bruise on the inside of her upper right arm which was dark purple in color and appeared to line up with height of arm rest. R12 further stated she was on a blood thinner (Eliquis) and she had reported it to "the lady at the front desk." During observation and interview on 8/20/24 at 7:59 a.m., R12 was sitting in her wheelchair in her room. She had a large purple bruise on her inner arm by the elbow (from a hospital blood draw) and another smaller purple bruise next to it	F 684		

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F 684	Continued From page 23 that she stated she had bumped on the arm rest of her wheelchair and demonstrated where it matched up. RN-D verified the bruise and stated she wasn't aware of it and it should have been documented in R4's chart and monitored until it was resolved. During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated the nurses were responsible to document and monitor skin alterations such as bruises and scratches. They also need to try to identify where they came from and depending on the answer, may need to fill out an incident report or a progress noted. RN-A further stated skin assessments should be completed weekly and documented in a UDA or progress note stating "I would like to see them follow it until it has resolved. RN-A verified R4 had a surgical incision on her right leg and didn't see any weekly skin assessments with a description of the incision which was important because it was hard to monitor what was going on without a description. She also verified R12's last skin assessment was on 8/9/24 and there haven't been any skin assessments since then. During interview on 8/22/24 at 2:19 p.m., the director of nursing (DON) stated skin assessments should be completed by nurses weekly and as needed and documented until resolved. If the skin alteration was a surgical incision, she would expect the nurse to monitor for healing, signs/symptoms of infection, drainage, proper closure, etc. and simply documenting the dressing was intact was not enough to be considered proper documentation.. A facility policy titled Skin Assessment Pressure	F 684		

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F 684	Continued From page 24 Ulcer Prevention and Documentation revised 4/26/24, directed staff notify the nurse immediately about monitor any bruise, contusion, abrasion, or skin tear noted during cares. Furthermore, the policy directed staff to monitor any bruise, contusion or skin tear weekly and update the resident's care plan.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 2 residents (R18) who were at risk for pressure ulcers were repositioned in a timely manner to prevent pressure injury. Findings include: R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also	F 686	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R18 has been reviewed for proper repositioning in a timely manner to prevent pressure injury. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All current residents have been reviewed	9/20/24

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F 686	Continued From page 25 indicated R18 was at risk for pressure injury and was dependent on staff for mobility. R18's skin Care Area Assessment (CAA) indicated R18 was at risk for pressure injury due to immobility and weakness. A review of R18's nursing and provider orders showed: -on 3/21/24, R18 required cleansing and barrier cream to be applied to wounds on the right buttock and posterior thigh. -on 7/24/24, R18 required cleaning and skin prep applied to the right heel daily. R18's weekly skin observation dated 7/25/24, indicated R18 had a healing right heel wound and no other skin concerns. R18's medical record lacked evidence weekly skin observations had been completed since 7/25/24. R18's care plan revised 4/3/24, indicated R18 had potential for pressure ulcer development related to impaired mobility, weakness, history of falls, and use of a diuretic. R18 further had a known pressure insult of suspected deep tissue injury to both feels. Interventions included to assist to turn/reposition with a goal of every 2 hours, float heels off bed, provide pressure reducing mattress and gel cushion in wheelchair, and notify the nurse immediately of any new skin breakdown. R18's Kardex printed 8/20/24, indicated R18 was a high risk for skin injury and had history of previous skin breakdowns. Staff were directed to notify the nurse of any new areas, redness, blisters, or bruises noted during care activities. When interviewed on 8/19/24, at 1:13 p.m., R18	F 686	to ensure proper repositioning in a timely manner to prevent pressure injury. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or designee will provide re-education to all nurses and direct care staff to ensure proper repositioning in a timely manner to prevent pressure injury. Re-education will be completed by 9/18/2024. The policy reviewed to see that systemic changes are sustained is Skin Assessment Pressure Ulcer Prevention and Documentation Requirements-Rehab/Skilled. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will conduct audits to ensure proper repositioning in a timely manner to prevent pressure injury. Audits will be completed weekly time one month, monthly x 1 quarter and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed 5. What is the date of completion? 9/20/24	

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F 686	Continued From page 26 was in a manual wheelchair with the legs elevated straight out. Pillows were positioned under R18's legs. R18's lunch was sitting in front on the bedside table. R18 stated "I have been sitting here for so long it hurts". At 1:20 p.m., health information management (HIM) came in to assist. R18 told HIM "Sitting up too long and it hurts". A continuous observation on 8/20/24 at 10:58 a.m., R18 was in their room seated in a broada wheelchair. R18 was slightly reclined, and the feet were not elevated. In front of R18 was the bedside table. At 11:58 a.m., R18 remained in the same position and no staff had entered the room. At 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. The lunch tray was set down on the bedside table and a pillow was placed behind R18's shoulders/back to help R18 sit up a bit more. R18's broada chair had not been adjusted. NA-A obtained a chair and assisted R18 with lunch. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. NA-A had left R18's room without providing repositioning or checking for incontinence. At 12:55 p.m., housekeeper (HSK)-A entered R18's room for room cleaning. At 1:10 p.m., hsk-A had completed cleaning R18's room. At 1:28 p.m., no other staff had entered R18's room to offer repositioning or check for incontinence care. At 1:35 p.m., NA-B had entered R18's room and removed the pillow and reclined R18 all the way back in the broada chair. R18's feet were now elevated. R18 had not been repositioned for 2 hours and 40 minutes. When interviewed on 8/20/24 at 1:40 p.m., NA-E stated the Kardex, and care plan gave	F 686		

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F 686	Continued From page 27 information about the cares residents need. NA-E was not sure if R18 had any skin concerns or was at risk for breakdown but knew R18 was usually reclined after lunch and should be repositioned every 2 hours. R18 did not like too many pillows and was repositioned by tilting the wheelchair back. NA-E verified R18 required to be reclined so their feet were then elevated for it to be considered a change in position. NA-E further stated NA-E usually did not work on this unit and they understood R18's routine a little better. When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 required total assistance with repositioning and ADLs. R18 required a hoyer lift to get in and out of bed and should be repositioned about every 2 hours. NA-A verified they had not offered R18 to be repositioned after lunch as she appeared to be comfortable. An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. NA-A and LPN-A finished cares and then tilted R18 to her right side and covered her up. When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-B did not think R18 was in the same position for long periods of time. LPN-B stated skin observations were completed on shower days and verified R18 had not had a skin observation documented since 7/25/24. LPN-B was going to complete a skin observation today.	F 686		

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F 686	Continued From page 28 When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated staff should be completing skin observations and reporting any new skin altercations so the correct follow up was in place. RN-A stated repositioning and incontinent cares should happen frequently for R18 and wasn't sure about an exact time frame, but multiple times a shift. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to complete weekly skin observations weekly with bathing. Nurses should also assess and document any skin alterations when they occur. DON further stated residents should not be in one position for long periods of time and repositioning frequency should be on the care plan and Kardex. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/24, directed staff to develop an individualized repositioning schedule for residents unable to position themselves. This positioning placed should be communicated to the nursing assistants using the Kardex.	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 §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.	F 689		9/20/24

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F 689	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure speech therapy recommendations were followed for 1 of 3 residents (R18) reviewed for nutrition. Findings include: R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 had no signs or symptoms of a swallowing disorder and required set up and clean up for meals. R18's diagnoses list printed on 8/20/24, indicated R18 had a secondary diagnosis of dysphagia (impaired swallowing). R18's hospital discharge summary dated 6/14/21, indicated R18 had been hospitalized for an ankle fracture. R18 was assessed by speech therapy for dysphagia and had recently advanced to thin liquids and no straws. R18's hospital discharge orders dated 6/14/21, indicated R18 required a regular diet with thin liquids and no straws. R18's discharge orders also indicated R18 to follow speech therapy. R18's provider order dated 6/14/21, indicated R18 required a regular diet thin liquids and no straws. R18's food and nutrition data collection dated 8/3/24, indicated R18 had a regular diet and	F 689	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R18 has been reviewed to ensure speech therapy recommendations are followed and orders are in place. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All current residents have been reviewed to ensure speech therapy recommendations are followed. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? DNS or designee will provide re-education to all nurses and direct care staff to ensure speech therapy recommendations are followed. Re-education will be completed by 9/18/2024. The policy that was reviewed to see that systemic changes are sustained is Diet Orders Food and Nutrition. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? DNS or designee will conduct audits to ensure speech therapy recommendations are followed. Audits will be completed weekly x one month, monthly x 1 quarter and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for	

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F 689	Continued From page 30 required a cup with lid, but had no direction of straw use. R18's Kardex printed 8/20/24, directed staff to provide R18 with a cup and lid for hot beverage safety. R18's Kardex lacked indication R18 should not use straws. R18's care plan revised 4/3/24, indicated R18 had a nutritional problem related to inadequate oral intake. Interventions include to use adaptive cup with covers and indicated R18 declined adaptive silverware. R18's care plan lacked indication R18 should not use straws. An observation on 8/20/24 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. The lunch tray was set down on the bedside table and a pillow was placed behind R18's shoulders/back to help R18 sit up a bit more. NA-A obtained a chair and assisted R18 with lunch. R18 had red juice and water in a handled cup with a spout lid. NA-A placed a straw in both cups and assisted R18 with drinking out of them. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. At 12:58 p.m., R18 reached and drank some water through the cup and straw. When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 was incontinent and required total assistance with repositioning and ADLs. NA-A verified R18 had been using straws had been told in report straws were ok to use. When interviewed on 8/20/24 at 2:20 p.m., licensed practical nurse (LPN)-B stated R18 required assistance and encouragement with	F 689	further review as needed 5. What is the date of completion? 9/20/2024	

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F 689	Continued From page 31 meals and was able to use straws with beverages. LPN-B acknowledged R18's diet order instructing no straws and stated they had not been aware of that before. LPN-B thought it was an old order that had not been changed. When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A was not sure why R18's diet order indicated no straws and verified it was initially written in 2021. Upon review, RN-A stated R18 had discharged from the hospital with that order and had initially signed onto hospice. Speech therapy had not seen her as initially ordered due to hospice. R18 had graduated from hospice in 12/2021 due to improvements and had not been seen by speech since then. RN-A stated staff should be following the order for no straws or following up with the provider. When interviewed on 8/21/24 at 2:22 p.m., speech therapist (ST) verified has not evaluated R18 since return from the hospital. ST stated there could be a re-evaluation for use of straws or a risk-benefits signed to ok the use, but otherwise the order for use of straws should be followed. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to be following instructions on the dietary card. If there were questions or conflicting information about what was needed, staff should be asking and get the information clarified. A facility policy titled Diet Orders revised 4/19/224, directed staff to monthly, the diet roster should be compared to the provider orders to ensure compliance with the provider order.	F 689		
F 700 SS=D	Bedrails	F 700		9/20/24

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 700	Continued From page 32 CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to assess 1 of 1 residents (R12) reviewed for bedrails. R4's significant change Minimum Data Set (MDS) dated 6/8/24, indicated, intact cognition and diagnoses of displaced bicondylar fracture of right tibia, atrial fibrillation, and chronic kidney disease (CKD). It further indicated R4 required assistance from staff with most activities of daily living (ADL) and mobility. R4's physician's order dated 5/7/24, indicated	F 700	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R12 did have an MD order for the Assist Bar, she did sign a consent to have the assist bar and an assessment was placed in the medical record. R12 has discharged. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified?	

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F 700	Continued From page 33 okay to install assist bar. Follow manufacturers recommendations and specifications to promote independence with bed mobility. Risk vs benefit have been reviewed and consent form signed. No directions specified for order. R4's Informed Consent for Bed Rails, was signed by R4 on 5/13/24. During observation and inteview on 8/19/24 7:59 a.m., R4 was sitting in her room, registered nurse (RN)-D verified the bilateral side rails on her bed and stated "all the residents have them for positioning." RN-D stated the resident needs to have a consent signed but wasn't sure about whether or not they need to have an assessment. During interview on 8/22/24 at 7:35 a.m., registered nurse (RN)-E stated in order for a resident to have bed rails they need a doctor's order, consent, and a safety assessment. RN-E was not not sure who was responsible for completing the assessment. During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated residents need to have a doctor's order, signed consent, assessment, care planned, and a desire to have them. . That is important for the possibility of restrait RN-A also verifed R12 did not have an assessment and it was important for the resident to be assessed for the possibility of it being a restraint. During interview on 8/22/24 at 2:19 p.m., the director of nursing (DON) stated in order for a resident to use side rails they would need to have a desire to want them up/on, a consent form would need to be filled out, enusre there was a	F 700	All residents who have assist bars have been audited and found to have the MD order, the assessment for use and the signed consent in the medical record. All residents will be assessed with admission, readmission, quarterly, annually and with change of condition to determine continued appropriateness of the assist bar. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Re-education for all nurses regarding all that needs to be in place including, the consent form that is signed upon admission, the assessment for use and the MD order to install per manufacturer's instruction. Re-education will be completed 9/18/2024. The policy reviewed to see that systemic changes are sustained is Bed Safety Including Bed Rails, Side Rails, Assist Bars-R/S/LTC, Therapy and Rehab. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The Director of Nursing and Nurse Managers will conduct audits to ensure appropriate completion of all needed items for the use of the Assist Bar. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality Assurance Performance Improvement committee for further review as needed.	

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F 700	Continued From page 34 benefit to the resident to have them installed, and a safety assessment. The facility's policy regarding bed rails dated 9/8/23, indicated: bed rail/side rail/assist bar usage will occur only when: a. Medical necessity is supported by resident assessment and data collection documentation allowing resident to assist or be independent with bed mobility and/or transfer. b. When the total bed environment i.e. bed frame, mattress bed rail/assist bar device and overlays) have been inspected and verified to be free of entrapment risk. c. Informed consent is obtained from resident and/or responsible party and then documented in the medical record, may use the Informed Consent for	F 700	5. What is the date of completion? 9/20/2024	
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a	F 756		9/20/24

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F 756	Continued From page 35 separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the consulting pharmacist (CP) failed to address an appropriate indication for an antidepressant for 1 of 1 resident (R212) reviewed for psychotropic medications. Findings include: R212's comprehensive Minimum Data Set (MDS) in progress dated 8/15/24, indicated intact cognition, had coronary artery disease and hypertension (high blood pressure), acute myocardial infarction (heart attack), presence of an aortocoronary bypass graft, and had an encounter for surgical after care following surgery on the circulatory system. Further, R212 did not have little interest or pleasure in doing things, and	F 756	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R212□s Drug Regimen Reviews were completed and documented in the Medical Record including an appropriate indication for the antidepressant that was ordered. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents have been reviewed to ensure that proper follow up was completed with each Drug Regimen Review, that each psychotropic	

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F 756	Continued From page 36 did not feel down, depressed, or hopeless. R212's physician orders dated 8/9/24, indicated R212 took bupropion (an antidepressant) HCL ER (extended release) 150 mg by mouth two times a day for status post CABG (coronary artery bypass grafting). R212's Medical Diagnosis form dated 8/21/24 at 1:39 p.m., indicated the following diagnoses: encounter for surgical aftercare following surgery on the circulatory system, presence of aortocoronary bypass graft, non-ST elevation myocardial infarction (heart attack), atherosclerotic heart disease of native coronary artery, essential hypertension. The form lacked information R212 had depression. R212's hospital discharge summary dated 8/9/24, indicated R212 was to continue taking the following medication: bupropion 150 mg take 1 tablet twice a day for S/P CABG. R212's nurse practitioner (NP) progress note dated 8/15/24, indicated R212 took bupropion 150 mg twice daily, further R212's mood and affect was normal. R212's pharmacist medication review dated 8/15/24, indicated the following recommendations: R212 was prescribed quetiapine (an antipsychotic) 25 mg tablet daily at bedtime with an associated diagnosis of "S/P CABG" listed with it in the electronic medical record (EMR). Per CMS (Centers for Medicare and Medicaid Services) guidelines, this may not be a sufficient diagnosis to warrant the use of an antipsychotic. Antipsychotics should be reserved for situations	F 756	medication has a clear and appropriate indication for the medication. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Re-education for all nurses with instructions for completing Nursing recommendations and/or routing Physician recommendations to the MD for all Drug Regimen reviews that are put in place by the Consultant Pharmacist. The policy reviewed to see that systemic changes are sustained is Psychotropic Medications-Rehab/Skilled. Re-education will be completed by 9/18/2024. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? The Director of Nursing and/or Nurse Managers will conduct audits to ensure appropriate completion of each Drug Regimen Review as they occur and are monthly and as needed. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the Quality Assurance Performance Improvement committee for further review as needed 5. What is the date of completion? 9/20/2024	

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F 756	Continued From page 37 where psychosis/delusions are present or situations where the patient poses an acute risk for harm to self or other. Please clarify the diagnosis for the Seroquel and update the EMR-if an adequate diagnosis is not present, consider tapering off of this medication. The pharmacist medication review lacked information regarding bupropion and an associated diagnosis of S/P CABG. During interview on 8/21/24 at 11:09 a.m., the consulting pharmacist (CP)-A stated bupropion was an antidepressant medication and a diagnosis of CABG was not a correct indication for bupropion and stated he wrote the recommendation for the quetiapine and stated the rationale would hold true for any psychotropic R212 was on. During interview on 8/22/24 at 12:00 p.m., the director of nursing (DON) stated CP-A completed pharmacy reviews and sends them over, they are printed and reviews for the physician are provided to the medical director and if a review is for nursing, the review is provided to the nurses. DON further stated the pharmacist should have identified the incorrect indication on the first initial review for the bupropion and further, it was important to have the correct diagnosis to track R212's depressive mood. A policy, Psychotropic Medications Rehab/Skilled dated 12/6/23, indicated the resident will be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without	F 756		

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F 756	Continued From page 38 adequate indications for its use.	F 756		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in	F 758		9/20/24

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F 758	Continued From page 39 §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure residents that were prescribed psychotropic medications were monitored for side effects, for 1 of 5 residents (R50) and failed to develop and implement non-pharmacological interventions for 1 of 5 residents (R110) reviewed for unnecessary medications. Findings include R110's admission Minimum Data Set (MDS) dated 8/7/24, indicated intact cognition, diagnosis of Bipolar disorder, was independent to requiing supervision with activities of daily living (ADL) and received an antispsychotic on a routine basis. R110's care area assessment (CAA) for psychotropic drug use dated 8/7/24, indicated: R110 received an antipsychotic, antidepressant, and hypnotic medication. Resident for drug induced Parkinsonism, multiple falls, chronic back pain, and myelofibrosis for diagnosis of bipolar disorder. Resident appears to tolerate medication without adverse reaction. Nursing	F 758	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? Resident R50□s Medical Record was reviewed and the addition of monitoring for side effects was added to the weekly Mood and Behavior Progress Notes. R50 has been discharged. Resident R110□s Care Plan has been reviewed and the addition of non-Pharmacological interventions have been added. R110 has been discharged. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All residents who are on a psychotropic medication have now been reviewed for and have in place the monitoring of Side Effects/Efficacy of use on a weekly basis in the Progress Notes. All residents who are on psychotropic medication now have non Pharmacological interventions on their individualized Care Plan.	

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F 758	Continued From page 40 staff observe for mood and behavior, and potential adverse reaction with administration of medication. R110's physician's orders dated 8/1/24, indicated olanzapine oral tablet 15 milligrams (mg). Give 15 mg by mouth at bedtime for psychosis. R110's care plan dated 8/5/24, indicated R110 was on antipsychotic medication therapy related to bipolar and psychosis. It further contained the following interventions: -R110 will be free of any discomfort or adverse side effects from antipsychotic medication use through the review date. -monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (olanzapine). -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. -WARNINGS #1: Refer to boxed warnings in the orders or eMAR, or medication reference of choice R110's care plan lacked any indication of non-pharmacological interventions. During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated staff should have developed and implemented non-pharmacological interventions on the care plan for residents who received an antipsychotic medication and verified R110's care plan lacked individualized non pharmacological interventions. During interview on 8/22/24 at 2:19 p.m. the director of nursing (DON) stated non pharmacologic interventions should be developed, implemented, monitored, care	F 758	3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? Re-education for all nurses for identifying that side effect monitoring is done on a weekly basis under the Mood and Behavior Progress Notes. Re-education will also be done for all nurses for identifying Non pharmacological interventions individualized to the resident and care planned as such. Re-education will be completed by 9/18/2024. The policy reviewed to see that systemic changes are sustained is Psychotropic Medications-Rehab/Skilled. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Director of Nursing and Nurse Managers will conduct Audits to ensure appropriate completion of this side effect monitoring and use of non-pharmacological interventions are in place. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the Quality Assurance Performance Improvement committee for further review. 5. What is the date of completion? 9/20/2024	

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F 758	Continued From page 41 planned and documented for residents who receive an antipsychotic medication. R50's admission Minimum Data Set dated 7/9/24, indicated severe cognitive impairment, did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless, did not have physical, verbal, or other behaviors, had diagnoses of dementia and depression and took an antipsychotic and antidepressant medication. R50's care area assessment (CAA) worksheet dated 7/16/24, indicated R50 took duloxetine (an antidepressant) and aripiprazole (an antipsychotic) for depression and psychotropic drug use would be addressed in the care plan in order to minimize risks. R50's physician orders indicated the following orders: 7/4/24, aripiprazole 20 milligrams (MG) by mouth once daily. 7/4/24, duloxetine 30 mg by mouth every evening, and 60 mg by mouth every morning. R50's orders lacked any monitoring for side effects of duloxetine and aripiprazole. R50's care plan was reviewed and lacked information R50 had depression and further lacked any monitoring for side effects of duloxetine and aripiprazole. R50's Pharmacist Medication Review form dated	F 758		

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F 758	Continued From page 42 8/15/24, indicated R50 was on Aspirin 325 mg daily indicated Aspirin was indicated for the prevention and or treatment of a wide variety of cardiovascular condition, and there was general consensus across guidelines that when used for primary or secondary cardiovascular prevention, lower doses of Aspirin have similar efficacy to higher doses, but carry less risk for significant bleeds. Please consider lowering this patient's Aspirin to 81 mg daily. The review lacked information for monitoring for side effects of aripiprazole or duloxetine. R50's Pharmacist Consultant review dated 7/19/24 indicated R50 was on aripiprazole 20 mg daily, please order monthly orthostatic blood pressure monitoring. R50's Pharmacist Consultant review dated 7/4/24 indicated no potential clinically significant medication issues identified at this time. R50's registered nurse (RN) and social worker (SW) mood symptoms 30 day look back report printed 8/21/24, lacked any documentation of whether or not mood symptoms were exhibited. R50's Mood symptoms 30 day look back report printed 8/21/24, also lacked documentation whether or not mood symptoms were exhibited. R50's Behavior 30 day look back task form printed 8/21/24, lacked documentation whether or not R50 had any behaviors. During interview on 8/21/24 at 11:15 a.m., the consulting pharmacist (CP)-A stated antidepressant side effect monitoring included monitoring for central nervous system changes,	F 758		

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F 758	Continued From page 43	F 758		

whether a resident starts falling, weight loss and weight gain and further stated specific manifestations can take a few weeks and did not see any specific orders for R50.

During interview on 8/21/24 at 12:03 p.m., registered nurse (RN)-C stated if a resident was on a psychotropic medication, it was added to the careplan and any monitoring for side effects showed up in the medication administration records. RN-C viewed the orders and stated R50 should have monitoring because R50 was on aripiprazole and duloxetine and verified the orders lacked monitoring and further RN-C viewed R50's care planned and verified R50 did not have a care plan related to psychotropics. RN-C also viewed R50's discontinued orders and verified there were no orders for monitoring and stated it should be there and would have to follow up with the director of nursing.

During interview on 8/21/24 at 11:49 a.m., nursing assistant (NA)-B stated she would have to ask the nurse to see what kind of medications a resident was on and could also look in the Kardex to see if there were any behaviors to watch for.

During interview on 8/22/24 at 12:13 p.m., the director of nursing (DON) stated monitoring was completed weekly and should be part of the documentation and whether the medications are effective and stated monitoring was supposed to be in the nursing orders and checked the care plan and verified the care plan lacked information R50 was on aripiprazole and duloxetine or had any kind of monitoring in place.

A policy, Psychotropic Medications Rehab/Skilled dated 12/6/23, indicated each resident's drug

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

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F 758	Continued From page 44 regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose including duplicate drug therapy, for excessive duration, without adequate monitoring, without adequate indications for its use, in the presence of adverse consequences that indicate the dose should be reduced or discontinued, any combination of the reasons above. Before administration of non-emergency psychotropic medications, the following must be completed: documentation in the electronic medical record (EMR) observations of mood, symptoms or behaviors that cause the resident distress and or endanger the resident or others and response to interventions used. The behavior committee and or care plan team will ensure the care plan is updated. This update will reflect non pharmacological interventions to be used. Throughout the administration of the psychotropic medications, the following must be completed; mood and behavior documentation must continue in order to monitor the effect the medication has on behavior. Monitor for side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in the record and notify the physician and family and legal representative of this change in condition. Non-pharmacological interventions are recommended before medication interventions. Attempts should be documented in the resident care record.	F 758		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data	F 867		9/20/24

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F 867	Continued From page 45 collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions	F 867		

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F 867	Continued From page 46 aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained. §483.75(d)(2) The facility will develop and implement policies addressing: (i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems; (ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and (iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained. §483.75(e) Program activities. §483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care. §483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility. §483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The	F 867		

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F 867	Continued From page 47 number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct quality deficiencies identified in previous surveys related to weekly skin assessments which resulted in deficiencies identified during this survey. This deficient practice had the potential to affect all 61 residents in the facility.	F 867	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The QAPI committee has reviewed and ensured implementation of appropriate action plans for all residents to correct any quality deficiencies related to weekly skin observations.	

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F 867	Continued From page 48 The Certification and Survey Provider Enhanved Reports (Casper)-3 assessment (data was converted to quality measures (QM) to evaluate nursing homes performance) dated 8/11/24, identified the following previous deficiency by month and year. -F686 Treatment/services to prevent/heal pressure ulcers at a scope and severity level of a D. See also F686 Based on interview and document review, the facility failed to ensure weekly skin assessments were completed for 2 of 3 (R3, R12) residents reviewed for pressure ulcer risk. Monthly QAPI meeting minutes dated 5/26/23, indicated performance improvment plan (PIP) for high risk pressure ulcers-current percentage for the month of April 2023 was 9.1%. State was 7.3% and national norm is 9.0%. Continue to see some long term care residents with chronic reoccurring areas that are non-compliant with repositioning/off loading to reduce pressure ulcer risk. Risks and benefits are explained to the residents and documented in point click care (computer program). Although the QAPI minutes provided documentation the facility was working on addressing high risk pressure ulcers, it lacked indication it was addressing missing weekly skin assessments. During interview on 8/22/24 at 3:00 p.m., the director of nursing (DON), stated the facility was working on addressing high risk pressure ulcers by looking at the clinically complex nature of people who were already admitting with pressure ulcers, some of which had wound vacs and trying to promote healing. They also really wanted	F 867	2. How will other residents, having the potential to be affected by the same deficient practice, be identified? The QAPI committee has ensured that all current residents have been reviewed to ensure weekly skin observations have been completed. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not recur? The QAPI committee has ensured that re-education for all nurses will be completed to include the procedure for weekly skin observations. Re-education will be completed by 9/18/2024. The policy reviewed to see that systemic changes are sustained is Skin Assessment Pressure Ulcer Prevention and Documentation Requirements-Rehab/Skilled. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? State what you are monitoring, who is in charge, how often it will QAPI committee will review quality deficiency audits related to weekly skin observations to ensure that the skin observations are completed weekly. Audits will be reviewed monthly at the QAPI committee meetings. 5. What is the date of completion? 9/20/2024	

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F 867	Continued From page 49 involvement with a medical doctor, so the facility decided to get Vohera (name of a wound care company) to come in once a week. The DON also stated they address pressure ulcers in their weekly interdisciplinary team (IDT) meetings and how important documentation was. The main issue was getting the nurse to complete the documentation and not put it to the wayside. It is so important to do a skin assessment. We have provided education and the nurse manager RN-A has recently made time in the nurses schedule that is dedicated to completing skin assessments.	F 867		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;	F 880		9/20/24

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F 880	Continued From page 50 §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review.	F 880		

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F 880	Continued From page 51 The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was donned (applied) for 2 of 2 residents (R42, R18) who were on enhanced barrier precautions (EBP), and 2 of 2 residents (R55, R111) on transmission based precautions, and failed to ensure appropriate hand hygiene and glove use for 3 of 3 residents (R42, R7, R18). Additionally, the facility failed to take appropriate steps to diagnose and manage a COVID-19 outbreak in accordance with Centers for Disease Control (CDC) guidance. Findings include: According to the Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 updated 6/24/24, Infection Control Guidance: SARS-CoV-2 COVID-19 | CDC under the heading, Nursing Homes, indicated the approach to an outbreak investigation could involve either contact tracing (an attempt to find all contacts of a confirmed case in order to test or monitor for infection) or a broad-based approach; however, a broad-based such as unit, floor, or other specific areas of the facility approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing fails to halt transmission. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1	F 880	1. What corrective action will be accomplished for those residents found to have been affected by the deficient practice? The residents named R42 and R18 have been observed to ensure that proper EBP/ PPE is being used by all staff. R55 and R111 have been observed to ensure that proper transmission based precaution PPE is being used by all staff. R42, R7, R18 have been observed to ensure appropriate hand hygiene and glove use is in place. Facility is taking appropriate steps to diagnose and manage a COVID-19 outbreak in accordance with CDC guidance. 2. How will other residents, having the potential to be affected by the same deficient practice, be identified? All current residents who are currently in EBP and Transmission Based Precautions will be observed to see that proper PPE is being donned (applied) used with all interactions by staff. All current residents will be observed to see that proper hand hygiene and glove use is being done with all interactions. Additionally, appropriate steps are in place to diagnose and manage COVID-19 outbreak in accordance with the CDC. 3. What measures will be put into place, or what systemic changes will be made, to ensure that the deficient practice does not	

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F 880	Continued From page 52 (where day of exposure is day 0), day 3, and day 5. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected units or facility-wide every 3 to 7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered. R55: R55's admission Minimum Data Set (MDS) dated 8/4/24, indicated R55 had intact cognition. R55's Admission Record form dated 8/22/24, indicated R55 had COVID-19 on 8/16/24. R55's care plan dated 8/16/24, indicated R55 tested positive for COVID-19 on 8/16/24. Interventions included observing for symptoms, monitoring breath sounds, rate rhythm, and use of any accessory muscles, when possible all services brought to resident in room such as rehabilitation, activities, and dining, droplet and contact precautions wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens. R55's care plan dated 8/20/24, indicated R55 had COVID-19 on 8/16/24, and interventions included encouraging R55 to wear a mask while staff in the room and when going outside of the room, encourage social distancing as appropriate per MDH (Minnesota Department of Health) and CDC (Centers for Disease Control) recommendations, provide a private room and use airborne/contact	F 880	recur? Re-education for all Nurses and Certified nursing assistants including Policy and Procedure for PPE, Hand Washing, and EBP has been given. All Nurses have been retrained on the expectation of taking appropriate steps to diagnose and manage a COVID-19 outbreak in accordance with the CDC guidance. Re-education will be completed by 9/18/2024. The Policy reviewed to see that systemic changes are sustained is the Infection Prevention and Co0ntrol Program, all Service Lines-Enterprise. 4. How will the corrective action be monitored to ensure the deficient practice is being corrected and will not recur? Director of Nursing and Designees will conduct Audits to ensure appropriate PPE is being donned, proper handwashing and glove use are being followed. Audits to ensure that appropriate steps are timely in managing COVID-19 outbreak according to CDC. Audits will be completed weekly for one month, Monthly for a quarter and quarterly thereafter. Audit results will be brought to the quality Assurance Performance Improvement committee for further review as needed. 5. What is the date of completion? 9/20/2024	

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F 880	Continued From page 53 precautions, all cares provided in the private room. R55's Order Summary Report dated 8/22/24, indicated R55 had an order dated 8/21/24, for airborne and contact precautions for 10 days and all cares and therapies were completed in room. R55's nursing progress notes dated 8/20/24, indicated R55 was on isolation droplet precautions and all services were being rendered in R55's room. R5: R5's admission MDS dated 6/25/24, indicated intact cognition. R5's Admission Record form dated 8/22/24, indicated R5 had COVID-19 on 8/17/24. R5's care plan dated 8/21/24, indicated R5 had COVID-19 on 8/17/24. Interventions included to encourage R5 to wear a mask while staff in the room and when going outside of the room. Encourage social distancing as appropriate per MDH/CDC recommendations, provide private room and use contact/airborne precautions. All cares provided in a private room. R5's Order Summary report dated 8/22/24, indicated R5 had an order dated 8/21/24, ok for airborne and contact precautions. Patient can be placed in a single room and all meals, care, and therapy provided in the room for 10 days every shift for COVID-19 for 10 days. R5's progress notes dated 8/20/24, indicated R5 's respiratory infection was potentially a result of	F 880		

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F 880	Continued From page 54 COVID-19 and R5 was on isolation droplet precautions and all services rendered in R5's room. R111: R111's admission MDS dated 8/9/24, indicated intact cognition. R111's Admission Record form dated 8/22/24, indicated R111 had COVID-19 on 8/18/24. R111's care plan dated 8/21/24, indicated R111 tested positive for COVID-19 on 8/18/24. Interventions included to encourage R111 to wear a mask while staff were in the room and when going outside of the room, provide a private room and use airborne/contact precautions, all cares provided in a private room. R111's Order Summary report dated 8/22/24, indicated R111 had an order dated 8/21/24, ok for airborne and contact precautions. Patient can be placed in a single room and all cares, meals, and therapy provided in room for 10 days every shift for COVID-19 for 10 days. R111's progress notes dated 8/20/24 at 7:26 p.m., indicated R111's respiratory infection was potentially a result of COVID-19, was on droplet precautions, and all services rendered were completed in R111's room. R215: R215's admission MDS dated 8/6/24, indicated intact cognition. R215's Admission Record form dated 8/22/24,	F 880		

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F 880	Continued From page 55 indicated R215 had COVID-19 on 8/19/24. R215's care plan dated 8/21/24, indicated R215 tested positive for COVID-19 on 8/19/24. Interventions included, encourage R215 to wear a mask while staff were in the room and when going outside of the room, provide a private room and use airborne/contact precautions, all cares provided in a private room. R215's Order Summary Report dated 8/22/24, indicated the following orders: 8/6/24, complete SARS-COV-2 testing on all residents ongoing per CDC. 8/20/24, notify the provider about any symptoms of hypoxia every shift for COVID. 8/21/24, ok for airborne and contact precautions, single room isolation for all cares for 10 days every shift for COVID. R215's progress notes dated 8/20/24 at 2:23 p.m., indicated R215's family member was updated on the recent COVID positive result. R215's progress notes dated 8/20/24 at 7:46 p.m., indicated R215's respiratory infection is potentially a result of COVID-19 and was on isolation airborne precautions and contact isolation precautions. R4: R4's admission MDS dated 6/23/24, indicated intact cognition. R4's Admission Record form dated 8/22/24, lacked information R4 had COVID-19.	F 880		

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F 880	Continued From page 56 R4's care plan dated 8/21/24, indicated R4 tested positive for COVID-19 on 8/21/24 and was on strict isolation in a private room with airborne and contact precautions. Interventions indicated contact precautions: wear gowns and masks when changing contaminated linens, provide a private room and use contact precautions. The care plan lacked interventions for using an N95 mask. R4's Order summary Report form dated 8/22/24, indicated the following order: 6/21/24, complete SARS CoV 2 testing on all residents ongoing per CDC. 8/22/24, airborne and contact precautions patient can be placed in a single room and all cares, meals and therapy is provided in room every shift for COVID-19 for 10 days. R4's progress notes dated 8/21/24 at 10:59 p.m., indicated R4's infection was potentially a result of COVID-19 and was on airborne and contact isolation precautions. Facility team sheets dated 8/20/24, were divided into 4 teams: team 1, team 2, team 3 and team 4. Team 3 included the following residents: R55, R5, R111, R215, and R4 who all tested positive for COVID-19. Additionally, R110, R43, R12 , and R214, were on Team 3. Facility POC COVID-19 Test forms were reviewed and identified the following: R55 tested positive for COVID-19 on 8/16/24. R5 tested negative for COVID-19 on 8/16/24, and 8/17/24. Additionally, another test dated 8/17/24, indicated R5 tested positive for COVID-19. R111 tested positive for COVID-19 on 8/18/24, no previous tests were located.	F 880		

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F 880	Continued From page 57 R215 tested negative for COVID-19 on 8/17/24, and 8/18/24. R4 tested negative for COVID-19 on 8/20/24, and tested positive for COVID-19 on 8/21/24. R110 tested negative for COVID-19 on 8/16/24, and negative for COVID-19 on 8/22/24. R43 tested negative for COVID-19 on 8/22/24, no previous tests were located. R12 tested negative for COVID-19 on 8/18/24, and on 8/22/24. R214 tested negative for COVID-19 on 8/22/24. Facility form, Monthly Report of Resident Infections in Location dated August 2024, indicated the following: R55 had COVID-19 on 8/16/24, and a productive cough with nasal drainage,, and congestion started on 8/14/24. R5 had COVID-19 on 8/17/24, and had symptoms of a productive cough, nasal drainage with congestion on 8/16/24. R111 had COVID-19 on 8/18/24 and symptoms of a non productive cough started on 8/17/24. R215 had COVID-19 on 8/19/24, and symptoms started on 8/19/24. R4 had COVID-19 on 8/21/24, and symptoms started on 8/21/24. During interview on 8/22/24 at 7:53 a.m., the infection preventionist (IP) stated she worked as the IP every Wednesday, Thursday, and Friday. IP stated if an employee showed up to work with symptoms of a reportable communicable disease, they were tested with a rapid COVID-19 test and if they had signs or symptoms, would be sent home. IP stated they had 5 residents who tested positive for COVID-19, and all were on team 3. IP further stated all staff should wear a surgical mask on the unit and a designated nurse and	F 880		

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F 880	Continued From page 58 nursing assistant (NA) would care for those residents with full PPE to include an N95 mask, gloves, gown, and a face shield. IP stated the N95 masks should fit securely to the face with no other mask located inside the N95 and regular glasses were not sufficient because they were not protective. IP further stated a couple staff were sick, one staff person had not worked at the facility and the other one was sent home as soon as they found out the staff person was COVID-19 positive. IP further stated they completed contact tracing and stated she was just finishing up on that on 8/22/24. IP stated with contact tracing, they look at someone in contact with a person at 6 feet or less for 15 minutes or more and test on day 1, then 48 hours later, and an additional 48 hours after that. IP stated COVID-19 first started when R55's family member was positive for COVID-19, did not mask, and did not tell staff their positive status. IP further stated the 2nd person was R5 on 8/17/24, then R111 on 8/18/24, and then R215 on 8/19/24, and last, R4 tested positive on 8/21/24. IP stated when not working, the director of nursing (DON) or nurse manager will test residents if they have signs and symptoms and will start transmission-based precautions and if a resident had symptoms and tested negative, they would require two negative tests 48 hours apart. IP stated they had four additional residents on team 3 and did not know whether they were tested and verified the residents were R110, R43, R12, and R214 and stated she planned to follow up on those residents 8/22/24. IP stated it was a situation where testing should be done on group three if staff were wearing PPE and a designated nurse and NA looked after the individuals. Further, IP stated hand hygiene occurred prior to entering a room and completing a task such as activities of	F 880		

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F 880	Continued From page 59 daily living, take off the gloves, wash hands and donn new gloves. Not sanitizing hands can bring bacteria and spread infection if donning gloves without performing hygiene. IP stated residents on enhanced barrier precautions (EBP) had incisions, ulcers, catheters, and signage was placed outside the resident's door and a cart was placed in the hallway. If a resident had COVID-19, they were not on EBP, but were on airborne and droplet precautions. IP expected staff to donn a gown and gloves for EBP and the signage instructed staff what the high-risk areas were including dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care, central lines, urinary catheters, feeding tube, tracheostomy, wound care, and any skin opening requiring a dressing according to the CDC. During interview on 8/22/24 at 10:55 a.m., registered nurse (RN)-B stated she tested at home and did not have signs or symptoms of COVID-19 and if there was a COVID-19 outbreak, they tested on day 1, 3, and 5 and further stated with this outbreak, all staff would be tested but did not know whether residents would also be tested and stated if they have signs and symptoms, they were tested right away. During interview on 8/22/24 at 10:57 a.m., nursing assistant (NA)-B stated she tested for COVID-19 this morning and had been testing the last 3 days and was without signs or symptoms. NA-B stated she heard that morning the facility would be testing everyone on the unit and staff due to everyone walking through the floors. During interview on 8/22/24 at 11:02 a.m., RN-F	F 880		

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F 880	Continued From page 60 walked down the hall with four tests for COVID AG cards and stated they were all negative tests for R12, R43, R110, and R214 and stated these residents were on team 3 in the middle of other residents who had COVID. RN-F further stated they test residents and staff, and the test results were placed in a folder. During interview on 8/22/24 at 2:19 p.m., the director of nursing (DON) stated COVID-19 testing was completed on residents who were symptomatic or had an exposure and they watched for signs and symptoms. DON further stated employees with close contact were also tested and stated the first case of COVID-19 was on 8/16/24, then 8/17/24, 8/18/24, 8/19/24, and 8/21/24. DON further stated they tested the other four residents on team 3 who were negative but did not think they completed testing promptly enough. The DON further stated she expected staff to wear an N95, gloves and a gown along with face shields and staff could not wear regular glasses as an eye protectant to prevent the spread of COVID-19. DON further stated the N95 had to be fitted to the face without a surgical mask underneath. Further, the DON stated she expected staff complete hand hygiene before and after glove use. The DON stated signs for EBP went up on admission and expected gloves and gowns to be worn for any close contact. A COVID-19 Confirmed Case Checklist dated 8/31/23, indicated when a case of COVID-19 has been suspected or confirmed in the location, the resident is confined to their room, airborne and contact transmission-based precautions are initiated, employees are assigned to care for the positive resident, source control is implemented on affected units, look back two days from start of	F 880		

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F 880	Continued From page 61 symptoms or positive test, whichever was sooner, to identify all residents, staff and visitors as able who had close contact or higher risk exposure with this resident, initiate outbreak testing via contact tracing or broad-based testing. Test all employees and residents determined to be close contacts/higher risk exposures on day 1, 3, and 5 and contact trace any additional identified positives. If unable to conduct contact tracing, move to broad based testing of all employees and residents on a unit/hall or facility on day 1, day 3, and day 5. If the outbreak becomes uncontained, move to testing of all employees and residents every 3 to 7 days until no new cases of COVID-19 are identified for 14 days. R55's admission Minimum Data Set (MDS) dated 8/4/24, indicated intact cognition and a diagnoses of COVID-19. R55 required partial/moderate assistance with ADL's and mobility. R55's physician's order dated 8/16/24, indicated droplet precautions x 10 days. All cares and therapies in room, every shift for 10 days. R55's care plan dated 8/16/24, indicated R55 has respiratory infection: Tested Positive for COVID on 8/16/2024. It further indicated the following interventions: -observe for symptoms, e.g., cough, changes in functional ability or activity tolerance, O2 saturations, etc. -monitor/document breath sounds, document rate, rhythm, and the use of any accessory muscles. -when possible, all services brought to resident in room (e.g. rehabilitation, activities, dining, etc.).	F 880		

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F 880	Continued From page 62 -DROPLET and CONTACT PRECAUTIONS: Wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens. Bag linens and close bag tightly before taking to laundry. -encourage/assist resident to perform hand hygiene -monitor/document/report new or worsening signs/symptoms of COVID-19 fever of 100.0 or greater, chills, shortness of breath, difficulty breathing, new or change in cough, sore throat, new loss of taste or smell, new sputum production, congestion, runny nose (rhinorrhea), fatigue, muscle or body aches, headache, nausea or vomiting, or diarrhea. -keep door closed for isolation -provide private room if available. R111 (TA) admission Minimum Data Set (MDS) dated 8/9/24, indicated intact cognition and diagnosis of COVID-19. R111 required substantial assistance with mobility, lower extremity impairment on one side, used a walker and a wheelchair, and had a catheter. R111's physician' orders dated 8/18/24, indicated ok for droplet precautions. Patient can be placed in a single room and all cares, meals, and therapy provided in room for 10 days, every shift for COVID-19 for 10 days. R111's care plan dated 8/3/24, indicated has infection testing positive for COVID on 8/18/2024 and is in strict isolation droplet and contact precautions. It further included the following interventions: -monitor/document/report to health care provider s/s of delirium: Changes in behavior, altered mental status, wide variation in cognitive function	F 880		

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F 880	Continued From page 63 throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle. -when possible, all services brought to resident in room (e.g. rehabilitation, activities, dining, etc.). -CONTACT PRECAUTIONS: Wear gowns and masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. -educate resident/family regarding preventive measures to contain the infection. -provide private room and use contact precautions. During observation on 8/19/24 at 5:35 p.m., there was a sign on the outside of R111's and R55's door which indicated: Airborne Precautions everyone must: clean their hands, including before entering and when leaving the room. Put on an N95 or higher level respirator before room entry. Remove respirator after exiting the room and closing the door. Door to room must remain closed. Nursing assistant (NA)-F entered R111's room wearing 2 surgical masks, gown, and personal eye glasses. NA-F then exited the room (after having removed the gown) and donned another gown, and entered R55's room, set her meal tray down, removed her gown, and exited the room. During interview on 8/19/24 at 5:40 p.m. NA-F verified knowing the residents in rooms R111 and R55 were on airborne precautions due to testing positive for COVID-19 and was supposed to be wearing an N95 but was unable too stating "I can't breathe with an N95 mask on so I wear 2 surgical masks instead." R55 was also supposed to wear goggles/eye protection but was unable to	F 880		

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F 880	Continued From page 64 find any stating "sometimes we're short of that." During observation and interview on 8/19/24 at 5:47 p.m., RN-G went into R111's room wearing an N95 with a surgical mask underneath it, a gown, and no eye protection. RN-G stated they weren't wearing eye protection because they were just giving the resident his pills, but should have been. Staff should wear eye protection every time they go into a residents room who are on airborne precautions. All staff have been fitted for an N95 and shouldn't be wearing a surgical mask underneath it. During observation and interview on 8/20/24 at 12:28 p.m., nursing assistant (NA)-G entered R111's room wearing an N95 with a surgical mask underneath, a gown, and no eye protection. NA-G stated they had been fitted for N95's and didn't know if it was acceptable to wear a surgical mask underneath it. NA-G further stated he didn't wear eye protection because he wasn't performing cares and was only bringing the resident his meal tray. During interview on 8/20/24 at 12:35 p.m., registered nurse (RN)-E stated when entering a residents room who is on airborne precautions, staff are required to wear a gown, gloves, N95, and face shield. Anyone who enters the room for any reason needs to wear personal protective equipment (PPE) even if they are not performing cares. All staff have been fitted for an N95 and should not be wearing a surgical mask underneath it. RN-E also verified rooms 206 and 207 were airborne precaution rooms due to residents testing positive for COVID-19. During interview on 8/22/24 at 9:15 a.m., nurse	F 880		

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F 880	Continued From page 65 manager registered nurse (RN)-A stated any staff entering a resident's room who is on airborne precautions was required to wear an N95, face shield, gown, and gloves, even if they weren't performing cares. Staff must wear eye protection and not their own personal eye glasses and they must wear the N95 they have been fitted for. A surgical mask should not be worn underneath. If staff are not wearing the appropriate PPE they are putting themselves and other residents at risk of transmission and could expose them to getting COVID-19.	F 880		

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F 880	Continued From page 66	F 880		

R18

R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 had pressure injury and was dependent on staff for mobility.

R18's care plan revised 4/3/24, indicated R18 required EBP related to open wounds. Interventions including ensuring staff wore gown and glove when performing high contact care activities including transferring repositioning, and personal hygiene.

R18's Kardex printed 8/20/24, directed staff to don gown and gloves when performing high contact care activities such as dressing, providing hygiene, repositioning, changing linins and personal cares.

An observation on 8/19/24 at 1:13 p.m., R18 was seated in a wheelchair in her room with lunch in front of her. Outside her door to the left was a EBP sign and directed staff to gown and glove when providing high contact care.

An observation on 8/20/24 at 2:03 p.m., nursing assistant- (A) and licensed practical nurse (LPN)-A entered to assist R18 back to bed.

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F 880	Continued From page 67 Outside of R20's room to the left of the door was an EBP sign that directed staff to gown and glove when providing high contact care. Hand hygiene was performed upon entrance and gloves were donned however NA-A and LPN-A had not donned a gown. R18 was lifted with the Hoyer lift and placed in bed. NA-A removed R18's slippers. NA-A unfastened R18's brief and tucked it down. NA-A provided cares from the front before LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. NA-A cleaned R18 from the back side and removed gloves. Without performing hand hygiene, R18 applied new gloves and applied barrier cream before placing a clean brief and assisted R18 to roll on their back. LPN-A pulled the brief through and secured. NA-A then removed gloves and without performing hand hygiene donned new gloves. NA-A adjusted R18 to tilt to their right side and covered up. NA-A then removed gloves and tied garbage. Hand hygiene was performed, and NA-A and LPN-A exited the room. An interview on 8/20/24 at 2:17 p.m., NA-B verified the EBP sign to the side of R18's door. R18 stated they had not noticed the sign and should have worn a gown when providing cares to R18. NA-B also verified they had not performed hand hygiene in-between glove exchanges and was supposed to. When interviewed on 8/22/24 at 7:536 a.m., the IP expected staff to perform hand hygiene upon when exchanging gloves during cares. This was important to minimize the risk spreading bacteria and risk of infection for the residents. When interviewed on 8/22/24 at 2:19 p.m., the	F 880		

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F 880	Continued From page 68 Director of Nursing (DON) expected staff to perform hand hygiene before and after glove removal. EBP signs were place for residents with any open area, foley, feeding tube, and wounds. Staff were expected to follow EBP when providing close contact cares such as transferring and personal or hygiene cares. R7 R7's quarterly Minimum Data Set (MDS) dated 5/21/24, indicated R7 was cognitively intact and had diagnoses of heart failure (heart does not pump blood as well as it should), hypertension (high blood pressure), and chronic obstructive pulmonary disease (lung disease which blocks airflow and makes it difficult to breath). R7 required supervision or touching assistance for toileting hygiene and transfers. During observation on 8/19/24 at 2:00 p.m., nursing assistant (NA)-C placed transfer belt around R7, applied gloves, and assisted R7 to stand from her wheelchair in the bathroom. R7 sat on the toilet and was incontinent of bowel, and NA-C removed and threw away the incontinent product. NA-C unlocked R7's wheelchair and backed out of bathroom, grabbed a clean incontinent product, returned to bathroom, and moved wheelchair closer to resident and locked wheelchair. R7 stood up from the toilet, and NA-C wiped R7's, applied clean incontinent product, pulled up R7's underwear and pants and fixed R7's shirt. NA-C assisted R7 into wheelchair	F 880		

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F 880	Continued From page 69	F 880		

grabbing the transfer belt, removed the transfer belt, wiped the toilet seat, then removed gloves and washed hands.

During interview on 8/19/24 at 2:12 p.m., NA-C stated R7 required limited assistance for activities of daily living (ADLs). NA-C stated staff performed hand hygiene between assisting residents and between changes gloves. NA-C stated glove change and hand hygiene should be completed after dirty tasks and before clean tasks, and verified they did not change gloves during toileting and incontinence cares. NA-C stated glove changes and hand hygiene were important to prevent infection.

During interview on 8/22/24 at 7:53 a.m., the infection preventionist (IP) expected staff to take gloves off and perform hand hygiene after assisting with ADLs, such as incontinence cares, and before touching clean items. This was important to minimize the risk of spreading bacteria and risk of infection for the residents.

During interview on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to perform hand hygiene before and after glove removal.

R42

R42's face sheet printed 8/19/24, indicated diagnoses of pneumonia, heart failure, and diabetes

R42's admission Minimum Data Set (MDS)

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 70 assessment dated 7/20/24 indicated R42 had moderate cognitive impairment, no upper or lower extremity impairment, uses a wheelchair, dependent on staff for toileting hygiene, bathing, lower body dressing, and substantial assist for personal hygiene and bed mobility. R42 was frequently incontinent of urine and always incontinent of bowel. R42 has moisture associated skin damage (MASD) R42's careplan indicated R42 required enhanced barrier precautions related to open wounds. Interventions included wearing gown and gloves when performing high contact are activities including dressing, bathing, transferring, providing hygiene, changing linens, repositioning, and/or wound care. R42's Kardex printed 8/19/24 directed staff to don gown and gloves when performing high contact care activities such as dressing, transferring, bathing, hygiene, changing linens, repositioning, and wound care. During observation on 8/20/24 at 1:39 p.m., a sign on was noted on the wall outside R42's door indicated EBP with instructions to don gown and gloves for high contact care. Nursing assistant (NA)-A entered R42's room with shower chair and NA-C entered room with mechanical lift. Both NA-A and NA-C arrived wearing gloves however did not don gowns. NA-D removed blankets and pillows from R42's bed. NA-C removed R42's pants. NA-C reached across R42 and assisted with rolling him to his right side. NA-C's scrub top was observed touching R42's bed. NA-D removed R42's incontinence product and placed mechanical lift sling under R42. NA-C and NA-D then rolled R42 to his left side exposing a	F 880		

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F 880	Continued From page 71 bandage to R42's buttocks. Center of bandage was noted to be saturated with drainage. NA-C disposed of incontinence product in a garbage bag. Without removing gloves or performing hand hygiene, NA-C and NA-D assisted with transferring R42 from bed to the shower chair. Stool was noted on draw sheet on R42's bed. NA-C and NA-D then removed gloves with NA-D washing hands in bathroom. NA-C left room. NA-D brought R42 to the shower room. NA-D applied gloves however did not don gown. NA-D washed, rinsed, and towel dried R42. With the same gloves, NA-D wrapped R42 in sheet and blanket. NA-D then gathered shower linens placing them in bin. NA-D removed gloves and, without performing hand hygiene, took R42 back to his room. NA-D donned gloves however no gown. NA-D removed soiled linens from R42's bed and applied clean linens wearing the same gloves. NA-C entered room wearing gloves and no gown. NA-D removed gloves and donned new gloves without hand hygiene. R42 was transferred from shower chair to bed. NA-D and NA-C assisted with applying incontinence product and dressing R42. NA-C removed gloves and left the room. NA-D tidied room, removed gloves, opened window shades and put on new gloves. No hand hygiene was performed. NA-D then took bag of dirty linen and shower chair back to shower room. During interview on 8/20/24 at 2:52 p.m., NA-D confirmed signage outside R42's room indicating EBP. NA-D stated gowns and gloves are to be worn for cares, transferring, dressing changes, and bathing. NA-D also stated hand hygiene should be performed before and after wearing gloves or when hands are dirty. NA-D confirmed they should have worn a gown when transferring	F 880		

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F 880	Continued From page 72 and bathing R42 and should have performed hand hygiene after removing gloves. During interview on 8/20/24 at 2:52 p.m., NA-C stated residents with wounds and catheters require EBP. Gown and gloves are required depending on level of contact, such as changing or helping residents getting dressed. NA-C stated they did not don a gown because they did not notice a sign outside R42's door. During interview on 8/21/24 at 10:51 a.m., RN-A stated they would expect staff to don gloves and gown for direct care, clothing management, showering, and all other high contact cares for residents on EBP and confirmed staff should have worn gowns when assisting R42. RN-A stated she would expect staff to sanitize hands before donning and after doffing gloves. During interview on 8/21/24 at 1:04 p.m., the director of nursing stated residents are evaluated for EBP on admission. All residents with incisions, wounds, and medical devices inserted in body are placed on EBP. She would expect staff to wear gowns for close contact with residents and remove gowns before leaving the room. The director of nursing confirmed she would have expected NA-D and NA-C to wear gown and gloves when performing cares and bathing for R42. The director of nursing further confirmed she would expect staff to perform hand hygiene between glove change. A policy tilted "Multidrug-Resistant Organisms, MRSA VRE CRE and ESBL, All service Lines-Enterprise" dated 4/12/24 indicated "All resident's with any of the following: wounds and/or indwelling medical devices (e.g., central	F 880		

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F 880	Continued From page 73 line, urinary catheter, feeding tube, tracheostomy/ventilator: regardless of MDRO colonization status" are to be placed on EBP. Personal protective equipment (PPE) are used for "high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care" The policy directs staff to don gloves and gown prior to the high-contact care activity. A policy titled "Hand Hygiene-Enterprise" dated 3/29/22, indicated "HCW [healthcare worker} will use waterless alcohol-based hand sanitizer or soap and water to clean their hands" when entering patient room, before donning gloves, after removing gloves regardless of task completed, when moving from a contaminated body site to a clean body site duringpatient care, when exiting patient room." A policy, Infection Prevention and Control Program, All Service Lines Enterprise, dated 10/30/23, indicated the IP or appointed designee, will comply with state and local public health authority requirements and regulations for identification, reporting, and containing communicable disease and outbreaks. The facility utilizes transmission-based precautions i.e. contact, droplet, airborne, in addition to standard precautions, to prevent or control known and suspected infections. A policy, Standard and Transmission-Based Precautions, All Service Lines Enterprise, dated 4/2/24, indicated EBP expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for	F 880		

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F 880	Continued From page 74 transfer of multi drug resistant organisms (MDROs) to staff hands and clothing. EBP are needed for residents with chronic wounds, and residents with indwelling medical devices. High contact care areas include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, wound care, changing linens and device care. Airborne infection isolation room is needed to provide airborne precautions, unless specified by disease-specific guidelines such as COVID-19. Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE, gown, gloves, N-95, eye protection. A policy, Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID) Enterprise dated 4/19/24, indicated staff shall wear appropriate PPE (gowns, gloves, N95 or respirator plus eye protection) as a form of exposure control when caring for a patient with COVID-19 infection. COVID-19 testing will be conducted according to current CDC guidelines. All residents will be tested according to CDC guidelines following close contact exposure to COVID-19 and during expanded outbreak testing. Facility policy "Hand Hygiene" dated 3/29/20, directed staff to change gloves when moving from a dirty to a clean activity performing hand hygiene in between changing gloves.	F 880		

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety Code survey was conducted on August 20, 2024, by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society Maplewood, 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	K 000		

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

Electronically Signed | 09/10/2024

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 IS NOT REQUIRED. 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. Building Info: GOOD SAMARITAIN SOCIETY MAPLEWOOD is a 2-story building with no basement. GOOD SAMARITAIN SOCIETY MAPLEWOOD was constructed at three different times. The original building was constructed in 1965 and was	K 000		

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K 000	Continued From page 2 determined to be of Type II (111) construction. In 1967 an addition was constructed to the south of the main building and was determined to be of Type II (111) construction. In 1997 an addition was constructed to the south and west of the 1967 building and determined to be of Type II (111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is protected by a full fire sprinkler system. The facility has a fire alarm system with full corridor smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 71 beds and had a census of 60 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 291 SS=F	Emergency Lighting CFR(s): NFPA 101 Emergency Lighting Emergency lighting of at least 1-1/2-hour duration is provided automatically in accordance with 7.9. 18.2.9.1, 19.2.9.1 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and maintain emergency lighting per NFPA 101 (2012 edition), Life Safety Code, sections 19.2.9.1 and 7.9.3.1.1. These deficient findings could have a	K 291	- How the deficiency will be corrected- The environmental services director will complete monthly testing of the emergency lighting for 30 minutes monthly and once annually	9/20/24

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K 291	Continued From page 3 widespread impact on the residents within the facility. Findings include: 1. On 08/20/2024, between 8:00 AM and 10:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that they have been testing the emergency lighting in the facility for 30 seconds monthly and 90 minutes annually. 2. On 08/20/2024, between 8:00 AM and 10:30 AM, it was revealed by observation that the emergency light located in Physical Therapy was non-operational. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 291	for 90 minutes. These test tests will be documented on paper and electronically on the TELS app. by the environmental services director. - How the deficiency could affect others- It affects all residents and staff. - What changes will be made to keep the deficiency from recurring- A document was created to ensure it is completed as needed each month. - How will the facility monitor the corrective action to ensure it will not recur- The director of environmental service will be tasked to monitor the completion of the corrective action. - The date that the deficiency was corrected- This corrective action was implemented on September 2, 2024 to be done monthly going forward.	
K 345 SS=F	Fire Alarm System - Testing and Maintenance CFR(s): NFPA 101 Fire Alarm System - Testing and Maintenance A fire alarm system is tested and maintained in accordance with an approved program complying with the requirements of NFPA 70, National Electric Code, and NFPA 72, National Fire Alarm and Signaling Code. Records of system acceptance, maintenance and testing are readily available. 9.6.1.3, 9.6.1.5, NFPA 70, NFPA 72 This REQUIREMENT is not met as evidenced by:	K 345		9/20/24

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K 345	Continued From page 4 Based on a review of available documentation and staff interview, the facility failed to test the fire alarm system per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.4.1 and 9.6.1.5, and NFPA 72 (2010 edition), National Fire Alarm and Signaling Code, sections 14.4.5.3.1, 14.4.5.3.2, and 14.4.5.3.3. These deficient findings could have a widespread impact on the residents within the facility. Findings include: 1. On 08/20/2024 between 08:00 AM and 10:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the Annual Fire Alarm Test has not been tested since 01/31/2023. 2. On 08/20/2024 between 08:00 AM and 10:30 AM, it was revealed by a review of available documentation that at the time of the survey the facility could not provide documentation showing that the sensitivity of the smoke detectors in the facility have been tested since 10/19/2022. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 345	- How the deficiency will be corrected- Convergint was contacted and a system test was completed and a sensitivity report generated. - How the deficiency could affect others- The deficiency affects all residents and staff. - What changes were made to keep the deficiency from recurring- An updated testing schedule was created to reflect the changes. - How will the facility monitor the corrective action to ensure it will not recur- The environmental services director will monitor the completion of the annual testing. - The date that the deficiency was corrected- This test was completed on August 26, 2024.	
K 347 SS=F	Smoke Detection CFR(s): NFPA 101 Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This REQUIREMENT is not met as evidenced by:	K 347		9/20/24

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K 347	Continued From page 5 Based on observation and staff interview, the facility failed to maintain the resident rooms smoke detectors in accordance with the requirements of NFPA 101 - 2012 edition, Sections 19.3.4.5.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/20/2024 between 8:00 AM and 10:30 AM, There was no documentation available at the time of the inspection to show that the battery powered smoke detectors within the Resident Rooms had been tested monthly since 1/10/23. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 347	- How the deficiency will be corrected- Environmental services director will conduct monthly testing of all battery operated smoke detectors. - How the deficiency could affect others- The deficiency affects all residents. - What changes were made to keep the deficiency from recurring- The director of environmental services with monitor the completion of the task monthly. - How will the facility monitor the corrective action to ensure it will not recur- The director of environmental services will document the completion of testing on paper and on the TELS Application. - The date that the deficiency was completed- Testing was implemented September 2, 2024 and to be done monthly going forward.	
K 362 SS=F	Corridors - Construction of Walls CFR(s): NFPA 101 Corridors - Construction of Walls 2012 EXISTING Corridors are separated from use areas by walls constructed with at least 1/2-hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the transfer of smoke. In nonsprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. Corridor walls may terminate at the underside of ceilings where specifically permitted	K 362		9/20/24

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K 362	Continued From page 6 by Code. Fixed fire window assemblies in corridor walls are in accordance with Section 8.3, but in sprinklered compartments there are no restrictions in area or fire resistance of glass or frames. If the walls have a fire resistance rating, give the rating _____ if the walls terminate at the underside of the ceiling, give brief description in REMARKS, describing the ceiling throughout the floor area. 19.3.6.2, 19.3.6.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain corridor walls per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.6.2.1, 19.3.6.2.2, and 19.3.6.2.3. This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 08/20/2024 between 8:00 AM and 10:30 AM, it was revealed by observation that there were 4 conduit pipes that penetrate the wall around the elevator equipment room that were not sealed with fire caulk. An interview with the Maintenance Manager verified these deficient findings at the time of discovery.	K 362	- How the deficiency will be corrected- Environmental services director will plug the 4 conduits near the east elevator with fire rated putty. - How the deficiency could affect others- This deficiency affects all residents and staff. - What changes were made to keep the deficiency from recurring- Environmental services director will do quarterly inspections of all wall penetrations. - How will the facility monitor the corrective action to ensure it will not recur- The Environmental service director will record the corrective actions on paper. - The date the deficiency was completed- August 22, 2024	
K 920 SS=D	Electrical Equipment - Power Cords and Extens CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords	K 920		9/20/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**08/20/2024**

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 920	Continued From page 7 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: Based on observation and staff interview, the facility failed to maintain the usage of electrical adaptive devices NFPA 99 (2012 edition), Health Care Facilities Code, sections 10.5.2.3.1 and 10.2.4.2.1, NFPA 101 (2012 edition), Life Safety Code, section 9.1.2, NFPA 70, (2011 edition), National Electrical Code, sections 400.8, and UL 1363. This deficient findings could have an isolated impact on the residents within the facility. Findings include: On 08/20/2024, between 8:00 AM and 10:30 AM, it was revealed by observation that there was a printer plugged into a relocatable power tap in the	K 920	- How the deficiency will be corrected- An electrician will be hired to convert the 2 outlet wall box to 4 outlet wall box. - How the deficiency could affect others- This deficiency affects all residents and staff. - What changes were made to keep the deficiency for recurring- Environmental services director will do quarterly inspections of cord use in the two copier rooms. - How will the facility monitor the corrective action to ensure it will not recur- a quarterly audit form will be	

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

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K 920	Continued From page 8 copier room. The relocatable power tap was not an approved RPT for healthcare. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 920	filled out by the Director of environmental services upon completion of the inspection. - The date the deficiency was completed- September 20, 2024	
K 926 SS=F	Gas Equipment - Qualifications and Training CFR(s): NFPA 101 Gas Equipment - Qualifications and Training of Personnel Personnel concerned with the application, maintenance and handling of medical gases and cylinders are trained on the risk. Facilities provide continuing education, including safety guidelines and usage requirements. Equipment is serviced only by personnel trained in the maintenance and operation of equipment. 11.5.2.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to implement medical gas training for staff per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.5.2.1.1, 11.5.2.1.4. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 08/20/2024, between 8:00 AM and 10:30 AM, it was revealed by observations that the necessary PPE for oxygen transfilling were not preset for staff protection. An interview with the Maintenance Manager verified this deficient finding at the time of discovery.	K 926	- How the deficiency will be corrected- A pair of leather gloves was purchased and placed with the other PPE. - How the deficiency could affect others- The deficient act only affects the users of the transfill station safety. - What changes were made to keep the deficiency from recurring- The environmental services director will maintain the supply of PPE at the oxygen fill location. - How will the facility monitor the corrective action to ensure it will not recur- PPE inventory will be done monthly as part of the oxygen room inspections and documented electronically on the	9/20/24

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

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K 926	Continued From page 9	K 926	TELS App. - The date the deficiency was completed- September 9, 2024.	

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
September 3, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: State Nursing Home Licensing Orders
Event ID: N22C11

Dear Administrator:

The above facility was surveyed on August 19, 2024 through August 22, 2024 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:

Renee McClellan, Regional Operations Supervisor
Metro A District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
625 Robert Street N
P.O. Box 64975
Saint Paul, Minnesota 55164-0975
Email: renee.mcclellan@state.mn.us
Office: 651-201-4391 Mobile: 651-328-9282

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
	00900	A. BUILDING: _____ B. WING _____	C 08/22/2024

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

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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 8/19/24 - 8/22/24, a standard licensing survey was conducted completed at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found not in compliance with the MN State Licensure. The following licensing orders were issued: 0255, 0565, 0905, 0920, 1375, 1530, and 1695.	2 000		

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2 000	Continued From page 1 The following complaints were found to be UNSUBSTANTIATED: H52213278C (MN85086). Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the 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 be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is	2 000		

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2 000	Continued From page 2 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		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to ensure the Quality Assessment and Assurance (QAA)/Quality Assurance Process improvement (QAPI) committee was effective in implementing appropriate action plans to correct quality deficiencies identified in previous surveys related to weekly skin assessments which resulted in deficiencies identified during this survey. This deficient practice had the potential to	2 255	"Corrected"	9/20/24

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2 255	Continued From page 3 affect all 61 residents in the facility. The Certification and Survey Provider Enhanved Reports (Casper)-3 assessment (data was converted to quality measures (QM) to evaluate nursing homes performance) dated 8/11/24, identified the following previous deficiency by month and year. -F686 Treatment/services to prevent/heal pressure ulcers at a scope and severity level of a D. See also F686 Based on interview and document review, the facility failed to ensure weekly skin assessments were completed for 2 of 3 (R3, R12) residents reviewed for pressure ulcer risk. Monthly QAPI meeting minutes dated 5/26/23, indicated performance improvment plan (PIP) for high risk pressure ulcers-current percentage for the month of April 2023 was 9.1%. State was 7.3% and national norm is 9.0%. Continue to see some long term care residents with chronic reoccurring areas that are non-compliant with repositioning/off loading to reduce pressure ulcer risk. Risks and benefits are explained to the residents and documented in point click care (computer program). Although the QAPI minutes provided documentation the facility was working on addressing high risk pressure ulcers, it lacked indication it was addressing missing weekly skin assessments. During interview on 8/22/24 at 3:00 p.m., the director of nursing (DON), stated the facility was working on addressing high risk pressure ulcers by looking at the clinically complex nature of people who were already admitting with pressure ulcers, some of which had wound vacs and trying to promote healing. They also really wanted	2 255		

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2 255	Continued From page 4 involvement with a medical doctor, so the facility decided to get Vohera (name of a wound care company) to come in once a week. The DON also stated they address pressure ulcers in their weekly interdisciplinary team (IDT) meetings and how important documentation was. The main issue was getting the nurse to complete the documentation and not put it to the wayside. It is so important to do a skin assessment. We have provided education and the nurse manager RN-A has recently made time in the nurses schedule that is dedicated to completing skin assessments. SUGGESTED METHOD OF CORRECTION: The quality assurance committee could identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee will monitor these area on a regular basis and make recommendations for any changes. The administratior will be reponsible for implementation. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by:	2 565		9/20/24

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2 565	Continued From page 5 Based on interview and document review the facility failed to ensure comprehensive care plans were developed for 1 of 1 resident (R50) and failed to ensure non-pharmacological interventions were developed and implemented for 1 of 1 resident (R110) reviewed for psychotropic drug use. Findings include: R50's admission Minimum Data Set dated 7/9/24, indicated severe cognitive impairment, did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless, did not have physical, verbal, or other behaviors, had diagnoses of dementia and depression and took an antipsychotic and antidepressant medication. R50's care area assessment (CAA) worksheet dated 7/16/24, indicated R50 took duloxetine (an antidepressant) and aripiprazole (an antipsychotic) for depression and psychotropic drug use would be addressed in the care plan in order to minimize risks. R50's physician orders indicated the following orders: 7/4/24, aripiprazole 20 milligrams (MG) by mouth once daily. 7/4/24, duloxetine 30 mg by mouth every evening, and 60 mg by mouth every morning. R50's orders lacked any monitoring for side effects of duloxetine and aripiprazole. R50's care plan was reviewed and lacked information R50 had a specific care plan for depression, and further lacked any monitoring for side effects of duloxetine and aripiprazole. R50's Pharmacist Medication Review form dated	2 565	"Corrected"	

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2 565	Continued From page 6 8/15/24, indicated R50 was on Aspirin 325 mg daily indicated Aspirin was indicated for the prevention and or treatment of a wide variety of cardiovascular condition, and there was general consensus across guidelines that when used for primary or secondary cardiovascular prevention, lower doses of Aspirin have similar efficacy to higher doses, but carry less risk for significant bleeds. Please consider lowering this patient's Aspirin to 81 mg daily. The review lacked information for monitoring for side effects of aripiprazole or duloxetine. R50's Pharmacist Consultant review dated 7/19/24 indicated R50 was on aripiprazole 20 mg daily, please order monthly orthostatic blood pressure monitoring. R50's Pharmacist Consultant review dated 7/4/24 indicated no potential clinically significant medication issues identified at this time. During interview on 8/21/24 at 11:15 a.m., the consulting pharmacist (CP)-A stated antidepressant side effect monitoring included monitoring for central nervous system changes, whether a resident starts falling, weight loss and weight gain and further stated specific manifestations can take a few weeks and did not see any specific orders for R50. During interview on 8/21/24 at 12:03 p.m., registered nurse (RN)-C stated if a resident was on a psychotropic medication, it was added to the careplan and any monitoring for side effects showed up in the medication administration records. RN-C viewed the orders and stated R50 should have monitoring because R50 was on aripiprazole and duloxetine and verified the orders lacked monitoring and further RN-C	2 565		

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2 565	Continued From page 7 viewed R50's care plan and verified R50 did not have a care plan related to psychotropics. RN-C also viewed R50's discontinued orders and verified there were no orders for monitoring and stated it should be there and would have to follow up with the director of nursing. During interview on 8/21/24 at 11:49 a.m., nursing assistant (NA)-B stated she would have to ask the nurse to see what kind of medications a resident was on and could also look in the Kardex to see if there were any behaviors to watch for. During interview on 8/22/24 at 12:13 p.m., the director of nursing (DON) stated monitoring was completed weekly and should be part of the documentation and whether the medications are effective and stated monitoring was supposed to be in the nursing orders and checked the care plan and verified the care plan lacked information R50 was on aripiprazole and duloxetine or had any kind of monitoring in place. R110's admission Minimum Data Set (MDS) dated 8/7/24, indicated intact cognition, diagnosis of Bipolar disorders, was independent to supervision with ADL's and received an antispsychotic on a routine basis. R110's care area assessment (CAA) worksheet for psychotropic drug use dated 8/7/24, indicated: R110 received an antipsychotic, antidepressant, and hypnotic medication. Resident for drug induced Parkinsonism, multiple falls, chronic back pain, and myelofibrosis for diagnosis of bipolar disorder. Resident appears to tolerate medication without adverse reaction. Nursing staff observe for mood and behavior, and potential adverse reaction with administration of medication.	2 565		

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

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2 565	Continued From page 8 R110's physician's orders dated 8/1/24, indicated olanzapine oral tablet 15 milligrams (mg). Give 15 mg by mouth at bedtime for psychosis. R110's care plan dated 8/5/24, indicated R110 was on antipsychotic medication therapy related to bipolar and psychosis. It further contained the following interventions: -R110 will be free of any discomfort or adverse side effects from antipsychotic medication use through the review date. -monitor resident condition based on clinical practice guidelines or clinical standards of practice related to use of (olanzapine). -consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. -WARNINGS #1: Refer to boxed warnings in the orders or eMAR, or medication reference of choice R110's care plan lacked any indication of non-pharmacological interventions. During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated when a resident comes in as a new admission a baseline care plan was initiated by the admitting nurse, MDS nurse or the DON. After that they continue to develop a more comprehensive care plan which was driven by the admission assessment. As things change, the care plan was continuously updated and the MDS nurse had a huge part in that but all departments are included. RN-A further stated staff should be developing and impletmenting non-pharmacological interventions on the care plan for residents who receive an antipsychotic medication and verified R110's care plan lacked individualized non pharmacological interventions.	2 565		

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2 565	Continued From page 9 During interview on 8/22/24 at 2:19 p.m. the director of nursing (DON) stated non pharmacologic interventions should be developed, monitored, care planned and documented for residents who receive an antipsychotic medication. A policy, Care Plan-R/S, LTC, Therapy & Rehab, dated 11/1/23, indicated the purpose was to develop a comprehensive care plan using an interdisciplinary team approach, to provide guidance to the interdisciplinary team (IDT) in developing the initial care plan. The comprehensive care plan includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. Each resident will have an individualized, person-centered, comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs. Any problems, needs and concerns identified will be addressed through use of departmental assessments, the Resident Assessment Instrument (RAI) and review of the physician's orders. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee should review and revise policies and procedures related to creating and implementing a comprehensive individualized care plan as needed to ensure cares meet the specific needs of each individual resident. The director of nursing or designee should develop a system to educate staff and develop a monitoring system such as measurable	2 565		

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2 565	Continued From page 10 audits to ensure individual care plans are created and implemented. The results of those audits should be taken to the QAPI committee to determine compliance or the need for further monitoring. The administrator should be responsible to ensure this occurs. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning Subp. 4. Positioning. Residents must be positioned in good body alignment. The position of residents unable to change their own position must be changed at least every two hours, including periods of time after the resident has been put to bed for the night, unless the physician has documented that repositioning every two hours during this time period is unnecessary or the physician has ordered a different interval. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure 1 of 2 residents (R18) who were at risk for pressure ulcers were repositioned in a timely manner to prevent pressure injury. Findings include: R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was at risk for pressure injury and was dependent on staff for mobility.	2 905	"corrected"	9/20/24

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2 905	Continued From page 11 R18's skin Care Area Assessment (CAA) indicated R18 was at risk for pressure injury due to immobility and weakness. A review of R18's nursing and provider orders showed: -on 3/21/24, R18 required cleansing and barrier cream to be applied to wounds on the right buttock and posterior thigh. -on 7/24/24, R18 required cleaning and skin prep applied to the right heel daily. R18's weekly skin observation dated 7/25/24, indicated R18 had a healing right heel wound and no other skin concerns. R18's medical record lacked evidence weekly skin observations had been completed since 7/25/24. R18's care plan revised 4/3/24, indicated R18 had potential for pressure ulcer development related to impaired mobility, weakness, history of falls, and use of a diuretic. R18 further had a known pressure insult of suspected deep tissue injury to both feels. Interventions included to assist to turn/reposition with a goal of every 2 hours, float heels off bed, provide pressure reducing mattress and gel cushion in wheelchair, and notify the nurse immediately of any new skin breakdown. R18's Kardex printed 8/20/24, indicated R18 was a high risk for skin injury and had history of previous skin breakdowns. Staff were directed to notify the nurse of any new areas, redness, blisters, or bruises noted during care activities. When interviewed on 8/19/24, at 1:13 p.m., R18 was in a manual wheelchair with the legs elevated straight out. Pillows were positioned under R18's legs. R18's lunch was sitting in front	2 905		

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2 905	Continued From page 12 on the bedside table. R18 stated "I have been sitting here for so long it hurts". At 1:20 p.m., health information management (HIM) came in to assist. R18 told HIM "Sitting up too long and it hurts". A continuous observation on 8/20/24 at 10:58 a.m., R18 was in their room seated in a broada wheelchair. R18 was slightly reclined, and the feet were not elevated. In front of R18 was the bedside table. At 11:58 a.m., R18 remained in the same position and no staff had entered the room. At 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. The lunch tray was set down on the bedside table and a pillow was placed behind R18's shoulders/back to help R18 sit up a bit more. R18's broada chair had not been adjusted. NA-A obtained a chair and assisted R18 with lunch. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. NA-A had left R18's room without providing repositioning or checking for incontinence. At 12:55 p.m., housekeeper (HSK)-A entered R18's room for room cleaning. At 1:10 p.m., hsk-A had completed cleaning R18's room. At 1:28 p.m., no other staff had entered R18's room to offer repositioning or check for incontinence care. At 1:35 p.m., NA-B had entered R18's room and removed the pillow and reclined R18 all the way back in the broada chair. R18's feet were now elevated. R18 had not been repositioned for 2 hours and 40 minutes. When interviewed on 8/20/24 at 1:40 p.m., NA-E stated the Kardex, and care plan gave information about the cares residents need. NA-E was not sure if R18 had any skin concerns or was at risk for breakdown but knew R18 was usually reclined after lunch and should be	2 905		

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2 905	Continued From page 13 repositioned every 2 hours. R18 did not like too many pillows and was repositioned by tilting the wheelchair back. NA-E verified R18 required to be reclined so their feet were then elevated for it to be considered a change in position. NA-E further stated NA-E usually did not work on this unit and they understood R18's routine a little better. When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 required total assistance with repositioning and ADLs. R18 required a hoyer lift to get in and out of bed and should be repositioned about every 2 hours. NA-A verified they had not offered R18 to be repositioned after lunch as she appeared to be comfortable. An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. NA-A and LPN-A finished cares and then tilted R18 to her right side and covered her up. When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-B did not think R18 was in the same position for long periods of time. LPN-B stated skin observations were completed on shower days and verified R18 had not had a skin observation documented since 7/25/24. LPN-B was going to complete a skin observation today. When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated staff should be completing skin observations and reporting any new skin altercations so the correct follow up was	2 905		

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2 905	Continued From page 14 in place. RN-A stated repositioning and incontinent cares should happen frequently for R18 and wasn't sure about an exact time frame, but multiple times a shift. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to complete weekly skin observations weekly with bathing. Nurses should also assess and document any skin alterations when they occur. DON further stated residents should not be in one position for long periods of time and repositioning frequency should be on the care plan and Kardex. A facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised 4/26/24, directed staff to develop an individualized repositioning schedule for residents unable to position themselves. This positioning placed should be communicated to the nursing assistants using the Kardex. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents at risk for pressure ulcers to assure they are receiving the necessary treatment/services to prevent pressure ulcers from developing and to promote healing of pressure ulcers. The director of nursing or designee should conduct 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 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.	2 905		

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2 905	Continued From page 15 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
2 920	MN Rule 4658.0525 Subp. 6 B Rehab - ADLs Subp. 6. Activities of daily living. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review the facility failed to ensure routine incontinent care was provided for 1 of 3 residents (R18) reviewed for dependent activities of daily living (ADL's). Findings include: R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 was always incontinent of bladder and bowel and required maximal assistance from staff for incontinent cares. R18's care plan revised 4/3/24, indicated R18 had incontinence related to impaired mobility, weakness, and use of a diuretic. Interventions included to monitor for signs of urinary tract infection, use incontinence products, check for incontinence frequently and provide brief change	2 920	"Corrected"	9/20/24

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2 920	Continued From page 16 and incontinence cares as needed. R18's Kardex printed 8/20/24, indicated R18 required frequent checks for incontinence and assistance with incontinence cares. A continuous observation on 8/20/24 at 10:58 a.m., R18 was in their room seated in a broada wheelchair. R18 was slightly reclined, and the feet were not elevated. In front of R18 was the bedside table. At 11:58 a.m., the resident remained in the same position and no staff had entered the room. At 12:123 p.m., nursing assistant (NA)-A entered R18's room with their lunch tray. T NA-A obtained a chair and assisted R18 with lunch. At 12:30 p.m., NA-A cleaned up R18 and removed the lunch tray leaving the remainder of the juice and water on R18's tray in front of them. NA-A had left R18's room without providing repositioning or checking for incontinence. At 12:55 p.m., housekeeper (HSK)-A entered R18's room for room cleaning. A At 1:10 p.m., hsk-A had completed cleaning R18's room. At 1:28 p.m., no other staff had entered R18's room to offer repositioning or check for incontinence care. At 1:35 p.m., NA-B had entered R18's room and removed the pillow and reclined R18 all the way back in the broada chair. R18's feet were now elevated. NA-B had not asked or offered R18 incontinent cares. When interviewed on 8/20/24 at 1:40 p.m., NA-B stated the Kardex, and care plan gave information about the cares residents need. NA-B was not sure if R18 had any skin concerns or was at risk for breakdown but knew R18 was usually reclined after lunch and should be repositioned every 2 hours. NA-B further stated NA-A usually did not work on this unit and they understood R18's routine a little better.	2 920		

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2 920	Continued From page 17 NA-B verified they did not check or ask R18 about incontinence. When interviewed on 8/20/24 at 1:55 p.m., NA-A stated R18 was incontinent and required total assistance with repositioning and ADLs. R18 required a hoyer lift to get in and out of bed and should be repositioned and checked for incontinence about every 2 hours. NA-A verified they had not offered repositioning after lunch as she appeared to be resting comfortably. NA-A further stated R18 had not been checked for incontinence or changed since before lunch and stated was going to go do that now. An observation on 8/20/24 at 2:03 p.m., NA-A and licensed practical nurse (LPN)-A entered to assist R18 back to bed. Hand hygiene was performed upon entrance and gloves were donned however NA-A and LPN-A had not donned a gown. R18 was lifted with the Hoyer lift and placed in bed. NA-A removed R18's slippers. R18 had knee high nylon stockings in place and was wearing a nightgown/dress. NA-A unfastened R18's brief and tucked it down. NA-A provided cares from the front before LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. R18 cleaned R18 from the back side and removed gloves. NA-A applied barrier cream before placing a clean brief and assisted R18 to roll on their back. LPN-A pulled the brief through and secured. NA-A adjusted R18 to tilt to their right side and covered up. When interviewed on 8/20/24 at 2:20 p.m., LPN-B stated R18 had fragile skin and was prone to skin breakdown. R18 required frequent position changes and heels elevated. LPN-B stated R18 was dependent with ADLs and was incontinent.	2 920		

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2 920	Continued From page 18 LPN-B sated incontinent cares or checks should be completed every couple hours, or when R18 was repositioned. When interviewed on 8/21/24 at 2:19 p.m., registered nurse (RN)-A stated repositioning and incontinent cares should happen frequently for R18 as R18 was at risk for skin breakdown. RN-A stated there wasn't a specific time frame, but multiple times a shift. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) stated incontinence cares were not completed on a specific timeframe but generally residents should check in the morning, after breakfast, before lunch, etc. The checks are individualized to the resident and should be included on the care plan. A facility policy for incontinent/ADL cares was requested however was not recieved. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, should review all residents who are dependent on staff for incontinent cares to ensure they are receiving the necessary treatment/services. The DON or designee can conduct audits for a specific amount of time to ensure appropriate care and services 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.	2 920		

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21375	Continued From page 19	21375		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure appropriate personal protective equipment (PPE) was donned (applied) for 2 of 2 residents (R42, R18) who were on enhanced barrier precautions (EBP), and 2 of 2 residents (R55, R111) on transmission based precautions, and failed to ensure appropriate hand hygiene and glove use for 3 of 3 residents (R42, R7, R18). Additionally, the facility failed to take appropriate steps to diagnose and manage a COVID-19 outbreak in accordance with Centers for Disease Control (CDC) guidance. Findings include: According to the Centers for Disease Control (CDC) Infection Control Guidance: SARS-CoV-2 updated 6/24/24, Infection Control Guidance: SARS-CoV-2 COVID-19 | CDC under the heading, Nursing Homes, indicated the approach to an outbreak investigation could involve either contact tracing (an attempt to find all contacts of a confirmed case in order to test or monitor for infection) or a broad-based approach; however, a broad-based such as unit, floor, or other specific areas of the facility approach is preferred if all potential contacts cannot be identified or managed with contact tracing or if contact tracing	21375	"Corrected"	9/20/24

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21375	Continued From page 20 fails to halt transmission. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5. If additional cases are identified, strong consideration should be given to shifting to the broad-based approach if not already being performed and implementing quarantine for residents in affected areas of the facility. As part of the broad-based approach, testing should continue on affected units or facility-wide every 3 to 7 days until there are no new cases for 14 days. If antigen testing is used, more frequent testing (every 3 days), should be considered. R55: R55's admission Minimum Data Set (MDS) dated 8/4/24, indicated R55 had intact cognition. R55's Admission Record form dated 8/22/24, indicated R55 had COVID-19 on 8/16/24. R55's care plan dated 8/16/24, indicated R55 tested positive for COVID-19 on 8/16/24. Interventions included observing for symptoms, monitoring breath sounds, rate rhythm, and use of any accessory muscles, when possible all services brought to resident in room such as rehabilitation, activities, and dining, droplet and contact precautions wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens. R55's care plan dated 8/20/24, indicated R55 had COVID-19 on 8/16/24, and interventions included encouraging R55 to wear a mask while staff in	21375		

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21375	Continued From page 21 the room and when going outside of the room, encourage social distancing as appropriate per MDH (Minnesota Department of Health) and CDC (Centers for Disease Control) recommendations, provide a private room and use airborne/contact precautions, all cares provided in the private room. R55's Order Summary Report dated 8/22/24, indicated R55 had an order dated 8/21/24, for airborne and contact precautions for 10 days and all cares and therapies were completed in room. R55's nursing progress notes dated 8/20/24, indicated R55 was on isolation droplet precautions and all services were being rendered in R55's room. R5: R5's admission MDS dated 6/25/24, indicated intact cognition. R5's Admission Record form dated 8/22/24, indicated R5 had COVID-19 on 8/17/24. R5's care plan dated 8/21/24, indicated R5 had COVID-19 on 8/17/24. Interventions included to encourage R5 to wear a mask while staff in the room and when going outside of the room. Encourage social distancing as appropriate per MDH/CDC recommendations, provide private room and use contact/airborne precautions. All cares provided in a private room. R5's Order Summary report dated 8/22/24, indicated R5 had an order dated 8/21/24, ok for airborne and contact precautions. Patient can be placed in a single room and all meals, care, and therapy provided in the room for 10 days every	21375		

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21375	Continued From page 22 shift for COVID-19 for 10 days. R5's progress notes dated 8/20/24, indicated R5 's respiratory infection was potentially a result of COVID-19 and R5 was on isolation droplet precautions and all services rendered in R5's room. R111: R111's admission MDS dated 8/9/24, indicated intact cognition. R111's Admission Record form dated 8/22/24, indicated R111 had COVID-19 on 8/18/24. R111's care plan dated 8/21/24, indicated R111 tested positive for COVID-19 on 8/18/24. Interventions included to encourage R111 to wear a mask while staff were in the room and when going outside of the room, provide a private room and use airborne/contact precautions, all cares provided in a private room. R111's Order Summary report dated 8/22/24, indicated R111 had an order dated 8/21/24, ok for airborne and contact precautions. Patient can be placed in a single room and all cares, meals, and therapy provided in room for 10 days every shift for COVID-19 for 10 days. R111's progress notes dated 8/20/24 at 7:26 p.m., indicated R111's respiratory infection was potentially a result of COVID-19, was on droplet precautions, and all services rendered were completed in R111's room. R215: R215's admission MDS dated 8/6/24, indicated	21375		

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21375	Continued From page 23 intact cognition. R215's Admission Record form dated 8/22/24, indicated R215 had COVID-19 on 8/19/24. R215's care plan dated 8/21/24, indicated R215 tested positive for COVID-19 on 8/19/24. Interventions included, encourage R215 to wear a mask while staff were in the room and when going outside of the room, provide a private room and use airborne/contact precautions, all cares provided in a private room. R215's Order Summary Report dated 8/22/24, indicated the following orders: 8/6/24, complete SARS-COV-2 testing on all residents ongoing per CDC. 8/20/24, notify the provider about any symptoms of hypoxia every shift for COVID. 8/21/24, ok for airborne and contact precautions, single room isolation for all cares for 10 days every shift for COVID. R215's progress notes dated 8/20/24 at 2:23 p.m., indicated R215's family member was updated on the recent COVID positive result. R215's progress notes dated 8/20/24 at 7:46 p.m., indicated R215's respiratory infection is potentially a result of COVID-19 and was on isolation airborne precautions and contact isolation precautions. R4: R4's admission MDS dated 6/23/24, indicated intact cognition. R4's Admission Record form dated 8/22/24,	21375		

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21375	Continued From page 24 lacked information R4 had COVID-19. R4's care plan dated 8/21/24, indicated R4 tested positive for COVID-19 on 8/21/24 and was on strict isolation in a private room with airborne and contact precautions. Interventions indicated contact precautions: wear gowns and masks when changing contaminated linens, provide a private room and use contact precautions. The care plan lacked interventions for using an N95 mask. R4's Order summary Report form dated 8/22/24, indicated the following order: 6/21/24, complete SARS CoV 2 testing on all residents ongoing per CDC. 8/22/24, airborne and contact precautions patient can be placed in a single room and all cares, meals and therapy is provided in room every shift for COVID-19 for 10 days. R4's progress notes dated 8/21/24 at 10:59 p.m., indicated R4's infection was potentially a result of COVID-19 and was on airborne and contact isolation precautions. Facility team sheets dated 8/20/24, were divided into 4 teams: team 1, team 2, team 3 and team 4. Team 3 included the following residents: R55, R5, R111, R215, and R4 who all tested positive for COVID-19. Additionally, R110, R43, R12 , and R214, were on Team 3. Facility POC COVID-19 Test forms were reviewed and identified the following: R55 tested positive for COVID-19 on 8/16/24. R5 tested negative for COVID-19 on 8/16/24, and 8/17/24. Additionally, another test dated 8/17/24, indicated R5 tested positive for COVID-19. R111 tested positive for COVID-19 on 8/18/24, no	21375		

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21375	Continued From page 25 previous tests were located. R215 tested negative for COVID-19 on 8/17/24, and 8/18/24. R4 tested negative for COVID-19 on 8/20/24, and tested positive for COVID-19 on 8/21/24. R110 tested negative for COVID-19 on 8/16/24, and negative for COVID-19 on 8/22/24. R43 tested negative for COVID-19 on 8/22/24, no previous tests were located. R12 tested negative for COVID-19 on 8/18/24, and on 8/22/24. R214 tested negative for COVID-19 on 8/22/24. Facility form, Monthly Report of Resident Infections in Location dated August 2024, indicated the following: R55 had COVID-19 on 8/16/24, and a productive cough with nasal drainage,, and congestion started on 8/14/24. R5 had COVID-19 on 8/17/24, and had symptoms of a productive cough, nasal drainage with congestion on 8/16/24. R111 had COVID-19 on 8/18/24 and symptoms of a non productive cough started on 8/17/24. R215 had COVID-19 on 8/19/24, and symptoms started on 8/19/24. R4 had COVID-19 on 8/21/24, and symptoms started on 8/21/24. During interview on 8/22/24 at 7:53 a.m., the infection preventionist (IP) stated she worked as the IP every Wednesday, Thursday, and Friday. IP stated if an employee showed up to work with symptoms of a reportable communicable disease, they were tested with a rapid COVID-19 test and if they had signs or symptoms, would be sent home. IP stated they had 5 residents who tested positive for COVID-19, and all were on team 3. IP further stated all staff should wear a surgical mask on the unit and a designated nurse and	21375		

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21375	Continued From page 26 nursing assistant (NA) would care for those residents with full PPE to include an N95 mask, gloves, gown, and a face shield. IP stated the N95 masks should fit securely to the face with no other mask located inside the N95 and regular glasses were not sufficient because they were not protective. IP further stated a couple staff were sick, one staff person had not worked at the facility and the other one was sent home as soon as they found out the staff person was COVID-19 positive. IP further stated they completed contact tracing and stated she was just finishing up on that on 8/22/24. IP stated with contact tracing, they look at someone in contact with a person at 6 feet or less for 15 minutes or more and test on day 1, then 48 hours later, and an additional 48 hours after that. IP stated COVID-19 first started when R55's family member was positive for COVID-19, did not mask, and did not tell staff their positive status. IP further stated the 2nd person was R5 on 8/17/24, then R111 on 8/18/24, and then R215 on 8/19/24, and last, R4 tested positive on 8/21/24. IP stated when not working, the director of nursing (DON) or nurse manager will test residents if they have signs and symptoms and will start transmission-based precautions and if a resident had symptoms and tested negative, they would require two negative tests 48 hours apart. IP stated they had four additional residents on team 3 and did not know whether they were tested and verified the residents were R110, R43, R12, and R214 and stated she planned to follow up on those residents 8/22/24. IP stated it was a situation where testing should be done on group three if staff were wearing PPE and a designated nurse and NA looked after the individuals. Further, IP stated hand hygiene occurred prior to entering a room and completing a task such as activities of daily living, take off the gloves, wash hands and	21375		

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21375	Continued From page 27 donn new gloves. Not sanitizing hands can bring bacteria and spread infection if donning gloves without performing hygiene. IP stated residents on enhanced barrier precautions (EBP) had incisions, ulcers, catheters, and signage was placed outside the resident's door and a cart was placed in the hallway. If a resident had COVID-19, they were not on EBP, but were on airborne and droplet precautions. IP expected staff to donn a gown and gloves for EBP and the signage instructed staff what the high-risk areas were including dressing, bathing, showering, transferring, changing linens, providing hygiene, changing briefs, or assisting with toileting, device care, central lines, urinary catheters, feeding tube, tracheostomy, wound care, and any skin opening requiring a dressing according to the CDC. During interview on 8/22/24 at 10:55 a.m., registered nurse (RN)-B stated she tested at home and did not have signs or symptoms of COVID-19 and if there was a COVID-19 outbreak, they tested on day 1, 3, and 5 and further stated with this outbreak, all staff would be tested but did not know whether residents would also be tested and stated if they have signs and symptoms, they were tested right away. During interview on 8/22/24 at 10:57 a.m., nursing assistant (NA)-B stated she tested for COVID-19 this morning and had been testing the last 3 days and was without signs or symptoms. NA-B stated she heard that morning the facility would be testing everyone on the unit and staff due to everyone walking through the floors. During interview on 8/22/24 at 11:02 a.m., RN-F walked down the hall with four tests for COVID AG cards and stated they were all negative tests	21375		

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21375	Continued From page 28 for R12, R43, R110, and R214 and stated these residents were on team 3 in the middle of other residents who had COVID. RN-F further stated they test residents and staff, and the test results were placed in a folder. During interview on 8/22/24 at 2:19 p.m., the director of nursing (DON) stated COVID-19 testing was completed on residents who were symptomatic or had an exposure and they watched for signs and symptoms. DON further stated employees with close contact were also tested and stated the first case of COVID-19 was on 8/16/24, then 8/17/24, 8/18/24, 8/19/24, and 8/21/24. DON further stated they tested the other four residents on team 3 who were negative but did not think they completed testing promptly enough. The DON further stated she expected staff to wear an N95, gloves and a gown along with face shields and staff could not wear regular glasses as an eye protectant to prevent the spread of COVID-19. DON further stated the N95 had to be fitted to the face without a surgical mask underneath. Further, the DON stated she expected staff complete hand hygiene before and after glove use. The DON stated signs for EBP went up on admission and expected gloves and gowns to be worn for any close contact. A COVID-19 Confirmed Case Checklist dated 8/31/23, indicated when a case of COVID-19 has been suspected or confirmed in the location, the resident is confined to their room, airborne and contact transmission-based precautions are initiated, employees are assigned to care for the positive resident, source control is implemented on affected units, look back two days from start of symptoms or positive test, whichever was sooner, to identify all residents, staff and visitors as able who had close contact or higher risk exposure	21375		

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21375	Continued From page 29 with this resident, initiate outbreak testing via contact tracing or broad-based testing. Test all employees and residents determined to be close contacts/higher risk exposures on day 1, 3, and 5 and contact trace any additional identified positives. If unable to conduct contact tracing, move to broad based testing of all employees and residents on a unit/hall or facility on day 1, day 3, and day 5. If the outbreak becomes uncontained, move to testing of all employees and residents every 3 to 7 days until no new cases of COVID-19 are identified for 14 days. R55's admission Minimum Data Set (MDS) dated 8/4/24, indicated intact cognition and a diagnoses of COVID-19. R55 required partial/moderate assistance with ADL's and mobility. R55's physician's order dated 8/16/24, indicated droplet precautions x 10 days. All cares and therapies in room, every shift for 10 days. R55's care plan dated 8/16/24, indicated R55 has respiratory infection: Tested Positive for COVID on 8/16/2024. It further indicated the following interventions: -observe for symptoms, e.g., cough, changes in functional ability or activity tolerance, O2 saturations, etc. -monitor/document breath sounds, document rate, rhythm, and the use of any accessory muscles. -when possible, all services brought to resident in room (e.g. rehabilitation, activities, dining, etc.). -DROPLET and CONTACT PRECAUTIONS: Wear gowns, gloves, N95 masks (if available), and eye protection when changing contaminated linens. Bag linens and close bag tightly before taking to laundry.	21375		

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21375	Continued From page 30 -encourage/assist resident to perform hand hygiene -monitor/document/report new or worsening signs/symptoms of COVID-19 fever of 100.0 or greater, chills, shortness of breath, difficulty breathing, new or change in cough, sore throat, new loss of taste or smell, new sputum production, congestion, runny nose (rhinorrhea), fatigue, muscle or body aches, headache, nausea or vomiting, or diarrhea. -keep door closed for isolation -provide private room if available. R111 (TA) admission Minimum Data Set (MDS) dated 8/9/24, indicated intact cognition and diagnosis of COVID-19. R111 required substantial assistance with mobility, lower extremity impairment on one side, used a walker and a wheelchair, and had a catheter. R111's physician' orders dated 8/18/24, indicated ok for droplet precautions. Patient can be placed in a single room and all cares, meals, and therapy provided in room for 10 days, every shift for COVID-19 for 10 days. R111's care plan dated 8/3/24, indicated has infection testing positive for COVID on 8/18/2024 and is in strict isolation droplet and contact precautions. It further included the following interventions: -monitor/document/report to health care provider s/s of delirium: Changes in behavior, altered mental status, wide variation in cognitive function throughout the day, communication decline, disorientation, periods of lethargy, restlessness and agitation, altered sleep cycle. -when possible, all services brought to resident in room (e.g. rehabilitation, activities, dining, etc.). -CONTACT PRECAUTIONS: Wear gowns and	21375		

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21375	Continued From page 31 masks when changing contaminated linens. Place soiled linens in bags marked biohazard. Bag linens and close bag tightly before taking to laundry. -educate resident/family regarding preventive measures to contain the infection. -provide private room and use contact precautions. During observation on 8/19/24 at 5:35 p.m., there was a sign on the outside of R111's and R55's door which indicated: Airborne Precautions everyone must: clean their hands, including before entering and when leaving the room. Put on an N95 or higher level respirator before room entry. Remove respirator after exiting the room and closing the door. Door to room must remain closed. Nursing assistant (NA)-F entered R111's room wearing 2 surgical masks, gown, and personal eye glasses. NA-F then exited the room (after having removed the gown) and donned another gown, and entered R55's room, set her meal tray down, removed her gown, and exited the room. During interview on 8/19/24 at 5:40 p.m. NA-F verified knowing the residents in rooms R111 and R55 were on airborne precautions due to testing positive for COVID-19 and was supposed to be wearing an N95 but was unable too stating "I can't breathe with an N95 mask on so I wear 2 surgical masks instead." R55 was also supposed to wear goggles/eye protection but was unable to find any stating "sometimes we're short of that." During observation and interview on 8/19/24 at 5:47 p.m., RN-G went into R111's room wearing an N95 with a surgical mask underneath it, a gown, and no eye protection. RN-G stated they weren't wearing eye protection because they	21375		

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21375	Continued From page 32 were just giving the resident his pills, but should have been. Staff should wear eye protection every time they go into a residents room who are on airborne precautions. All staff have been fitted for an N95 and shouldn't be wearing a surgical mask underneath it. During observation and interview on 8/20/24 at 12:28 p.m., nursing assistant (NA)-G entered R111's room wearing an N95 with a surgical mask underneath, a gown, and no eye protection. NA-G stated they had been fitted for N95's and didn't know if it was acceptable to wear a surgical mask underneath it. NA-G further stated he didn't wear eye protection because he wasn't performing cares and was only bringing the resident his meal tray. During interview on 8/20/24 at 12:35 p.m., registered nurse (RN)-E stated when entering a residents room who is on airborne precautions, staff are required to wear a gown, gloves, N95, and face shield. Anyone who enters the room for any reason needs to wear personal protective equipment (PPE) even if they are not performing cares. All staff have been fitted for an N95 and should not be wearing a surgical mask underneath it. RN-E also verified rooms 206 and 207 were airborne precaution rooms due to residents testing positive for COVID-19. During interview on 8/22/24 at 9:15 a.m., nurse manager registered nurse (RN)-A stated any staff entering a resident's room who is on airborne precautions was required to wear an N95, face shield, gown, and gloves, even if they weren't performing cares. Staff must wear eye protection and not their own personal eye glasses and they must wear the N95 they have been fitted for. A surgical mask should not be worn underneath. If	21375		

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21375	Continued From page 33 staff are not wearing the appropriate PPE they are putting themselves and other residents at risk of transmission and could expose them to getting COVID-19. R18 R18's quarterly Minimum Data Set (MDS) dated 7/23/24, indicated R18 had cognitive impairment and diagnoses of heart disease, Alzheimer's Disease, and anxiety disorder. R18's MDS also indicated R18 had pressure injury and was dependent on staff for mobility. R18's care plan revised 4/3/24, indicated R18 required EBP related to open wounds. Interventions including ensuring staff wore gown and glove when performing high contact care activities including transferring repositioning, and personal hygiene. R18's Kardex printed 8/20/24, directed staff to don gown and gloves when performing high contact care activities such as dressing, providing hygiene, repositioning, changing linins and personal cares. An observation on 8/19/24 at 1:13 p.m., R18 was seated in a wheelchair in her room with lunch in front of her. Outside her door to the left was a EBP sign and directed staff to gown and glove when providing high contact care. An observation on 8/20/24 at 2:03 p.m., nursing assistant- (A) and licensed practical nurse (LPN)-A entered to assist R18 back to bed. Outside of R20's room to the left of the door was an EBP sign that directed staff to gown and glove when providing high contact care. Hand hygiene was performed upon entrance and gloves were	21375		

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

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21375	Continued From page 34 donned however NA-A and LPN-A had not donned a gown. R18 was lifted with the Hoyer lift and placed in bed. NA-A removed R18's slippers. NA-A unfastened R18's brief and tucked it down. NA-A provided cares from the front before LPN-A assisted to turn R18 to the side. NA-A removed R18's wet brief. R18's bottom had blanchable redness and skin was intact. NA-A cleaned R18 from the back side and removed gloves. Without performing hand hygiene, R18 applied new gloves and applied barrier cream before placing a clean brief and assisted R18 to roll on their back. LPN-A pulled the brief through and secured. NA-A then removed gloves and without performing hand hygiene donned new gloves. NA-A adjusted R18 to tilt to their right side and covered up. NA-A then removed gloves and tied garbage. Hand hygiene was performed, and NA-A and LPN-A exited the room. An interview on 8/20/24 at 2:17 p.m., NA-B verified the EBP sign to the side of R18's door. R18 stated they had not noticed the sign and should have worn a gown when providing cares to R18. NA-B also verified they had not performed hand hygiene in-between glove exchanges and was supposed to. When interviewed on 8/22/24 at 7:536 a.m., the IP expected staff to perform hand hygiene upon when exchanging gloves during cares. This was important to minimize the risk spreading bacteria and risk of infection for the residents. When interviewed on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to perform hand hygiene before and after glove removal. EBP signs were place for residents with any open area, foley, feeding tube, and wounds. Staff were expected to follow EBP when providing	21375		

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21375	Continued From page 35 close contact cares such as transferring and personal or hygiene cares. R7 R7's quarterly Minimum Data Set (MDS) dated 5/21/24, indicated R7 was cognitively intact and had diagnoses of heart failure (heart does not pump blood as well as it should), hypertension (high blood pressure), and chronic obstructive pulmonary disease (lung disease which blocks airflow and makes it difficult to breath). R7 required supervision or touching assistance for toileting hygiene and transfers. During observation on 8/19/24 at 2:00 p.m., nursing assistant (NA)-C placed transfer belt around R7, applied gloves, and assisted R7 to stand from her wheelchair in the bathroom. R7 sat on the toilet and was incontinent of bowel, and NA-C removed and threw away the incontinent product. NA-C unlocked R7's wheelchair and backed out of bathroom, grabbed a clean incontinent product, returned to bathroom, and moved wheelchair closer to resident and locked wheelchair. R7 stood up from the toilet, and NA-C wiped R7's, applied clean incontinent product, pulled up R7's underwear and pants and fixed R7's shirt. NA-C assisted R7 into wheelchair grabbing the transfer belt, removed the transfer belt, wiped the toilet seat, then removed gloves and washed hands. During interview on 8/19/24 at 2:12 p.m., NA-C stated R7 required limited assistance for activities of daily living (ADLs). NA-C stated staff performed hand hygiene between assisting residents and between changes gloves. NA-C stated glove change and hand hygiene should be completed after dirty tasks and before clean	21375		

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21375	Continued From page 36 tasks, and verified they did not change gloves during toileting and incontinence cares. NA-C stated glove changes and hand hygiene were important to prevent infection. During interview on 8/22/24 at 7:53 a.m., the infection preventionist (IP) expected staff to take gloves off and perform hand hygiene after assisting with ADLs, such as incontinence cares, and before touching clean items. This was important to minimize the risk of spreading bacteria and risk of infection for the residents. During interview on 8/22/24 at 2:19 p.m., the Director of Nursing (DON) expected staff to perform hand hygiene before and after glove removal. R42 R42's face sheet printed 8/19/24, indicated diagnoses of pneumonia, heart failure, and diabetes R42's admission Minimum Data Set (MDS) assessment dated 7/20/24 indicated R42 had moderate cognitive impairment, no upper or lower extremity impairment, uses a wheelchair, dependent on staff for toileting hygiene, bathing, lower body dressing, and substantial assist for personal hygiene and bed mobility. R42 was frequently incontinent of urine and always incontinent of bowel. R42 has moisture associated skin damage (MASD) R42's careplan indicated R42 required enhanced barrier precautions related to open wounds. Interventions included wearing gown and gloves when performing high contact are activities including dressing, bathing, transferring, providing	21375		

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21375	Continued From page 37 hygiene, changing linens, repositioning, and/or wound care. R42's Kardex printed 8/19/24 directed staff to don gown and gloves when performing high contact care activities such as dressing, transferring, bathing, hygiene, changing linens, repositioning, and wound care. During observation on 8/20/24 at 1:39 p.m., a sign on was noted on the wall outside R42's door indicated EBP with instructions to don gown and gloves for high contact care. Nursing assistant (NA)-A entered R42's room with shower chair and NA-C entered room with mechanical lift. Both NA-A and NA-C arrived wearing gloves however did not don gowns. NA-D removed blankets and pillows from R42's bed. NA-C removed R42's pants. NA-C reached across R42 and assisted with rolling him to his right side. NA-C's scrub top was observed touching R42's bed. NA-D removed R42's incontinence product and placed mechanical lift sling under R42. NA-C and NA-D then rolled R42 to his left side exposing a bandage to R42's buttocks. Center of bandage was noted to be saturated with drainage. NA-C disposed of incontinence product in a garbage bag. Without removing gloves or performing hand hygiene, NA-C and NA-D assisted with transferring R42 from bed to the shower chair. Stool was noted on draw sheet on R42's bed. NA-C and NA-D then removed gloves with NA-D washing hands in bathroom. NA-C left room. NA-D brought R42 to the shower room. NA-D applied gloves however did not don gown. NA-D washed, rinsed, and towel dried R42. With the same gloves, NA-D wrapped R42 in sheet and blanket. NA-D then gathered shower linens placing them in bin. NA-D removed gloves and, without performing hand hygiene, took R42 back	21375		

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21375	Continued From page 38 to his room. NA-D donned gloves however no gown. NA-D removed soiled linens from R42's bed and applied clean linens wearing the same gloves. NA-C entered room wearing gloves and no gown. NA-D removed gloves and donned new gloves without hand hygiene. R42 was transferred from shower chair to bed. NA-D and NA-C assisted with applying incontinence product and dressing R42. NA-C removed gloves and left the room. NA-D tidied room, removed gloves, opened window shades and put on new gloves. No hand hygiene was performed. NA-D then took bag of dirty linen and shower chair back to shower room. During interview on 8/20/24 at 2:52 p.m., NA-D confirmed signage outside R42's room indicating EBP. NA-D stated gowns and gloves are to be worn for cares, transferring, dressing changes, and bathing. NA-D also stated hand hygiene should be performed before and after wearing gloves or when hands are dirty. NA-D confirmed they should have worn a gown when transferring and bathing R42 and should have performed hand hygiene after removing gloves. During interview on 8/20/24 at 2:52 p.m., NA-C stated residents with wounds and catheters require EBP. Gown and gloves are required depending on level of contact, such as changing or helping residents getting dressed. NA-C stated they did not don a gown because they did not notice a sign outside R42's door. During interview on 8/21/24 at 10:51 a.m., RN-A stated they would expect staff to don gloves and gown for direct care, clothing management, showering, and all other high contact cares for residents on EBP and confirmed staff should have worn gowns when assisting R42. RN-A	21375		

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21375	Continued From page 39 stated she would expect staff to sanitize hands before donning and after doffing gloves. During interview on 8/21/24 at 1:04 p.m., the director of nursing stated residents are evaluated for EBP on admission. All residents with incisions, wounds, and medical devices inserted in body are placed on EBP. She would expect staff to wear gowns for close contact with residents and remove gowns before leaving the room. The director of nursing confirmed she would have expected NA-D and NA-C to wear gown and gloves when performing cares and bathing for R42. The director of nursing further confirmed she would expect staff to perform hand hygiene between glove change. A policy tilted "Multidrug-Resistant Organisms, MRSA VRE CRE and ESBL, All service Lines-Enterprise" dated 4/12/24 indicated "All resident's with any of the following: wounds and/or indwelling medical devices (e.g., central line, urinary catheter, feeding tube, tracheostomy/ventilator: regardless of MDRO colonization status" are to be placed on EBP. Personal protective equipment (PPE) are used for "high-contact resident care activities: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use, wound care" The policy directs staff to don gloves and gown prior to the high-contact care activity. A policy titled "Hand Hygiene-Enterprise" dated 3/29/22, indicated "HCW [healthcare worker} will use waterless alcohol-based hand sanitizer or soap and water to clean their hands" when entering patient room, before donning gloves, after removing gloves regardless of task completed, when moving from a contaminated body site to a clean body site during patient care,	21375		

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21375	Continued From page 40 when exiting patient room." A policy, Infection Prevention and Control Program, All Service Lines Enterprise, dated 10/30/23, indicated the IP or appointed designee, will comply with state and local public health authority requirements and regulations for identification, reporting, and containing communicable disease and outbreaks. The facility utilizes transmission-based precautions i.e. contact, droplet, airborne, in addition to standard precautions, to prevent or control known and suspected infections. A policy, Standard and Transmission-Based Precautions, All Service Lines Enterprise, dated 4/2/24, indicated EBP expand the use of PPE beyond situations in which exposure to blood and body fluids is anticipated and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multi drug resistant organisms (MDROs) to staff hands and clothing. EBP are needed for residents with chronic wounds, and residents with indwelling medical devices. High contact care areas include transfers, dressing, assisting during bathing, providing hygiene, changing briefs, or assisting with toileting, working with resident in therapy gym, wound care, changing linens and device care. Airborne infection isolation room is needed to provide airborne precautions, unless specified by disease-specific guidelines such as COVID-19. Post clear signage on the door or wall outside of the resident room indicating the type of precautions and required PPE, gown, gloves, N-95, eye protection. A policy, Emerging Threats-Acute Respiratory Syndromes Coronavirus (COVID) Enterprise	21375		

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21375	Continued From page 41 dated 4/19/24, indicated staff shall wear appropriate PPE (gowns, gloves, N95 or respirator plus eye protection) as a form of exposure control when caring for a patient with COVID-19 infection. COVID-19 testing will be conducted according to current CDC guidelines. All residents will be tested according to CDC guidelines following close contact exposure to COVID-19 and during expanded outbreak testing. Facility policy "Hand Hygiene" dated 3/29/20, directed staff to change gloves when moving from a dirty to a clean activity performing hand hygiene in between changing gloves. TIME PERIOD FOR CORRECTION: Twenty-one (21) days. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee, could develop or revise the policies and procedures related to infection control program and surveillance. The DON or designee could provide education to all involved staff. The DON or designee could develop a monitoring system to ensure ongoing compliance and report the findings to the Qualify Assurance Committee.	21375		
21530	MN Rule 4658.1310 A.B.C Drug Regimen Review A. The drug regimen of each resident must be reviewed at least monthly by a pharmacist currently licensed by the Board of Pharmacy. This review must be done in accordance with Appendix N of the State Operations Manual, Surveyor Procedures for Pharmaceutical Service Requirements in Long-Term Care, published by	21530		9/20/24

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21530	Continued From page 42 the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system. It is not subject to frequent change. B. The pharmacist must report any irregularities to the director of nursing services and the attending physician, and these reports must be acted upon by the time of the next physician visit, or sooner, if indicated by the pharmacist. For purposes of this part, "acted upon" means the acceptance or rejection of the report and the signing or initialing by the director of nursing services and the attending physician. C. If the attending physician does not concur with the pharmacist's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the quality assessment and assurance committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist must refer the matter directly to the quality assessment and assurance committee. This MN Requirement is not met as evidenced by: Based on interview and document review, the consulting pharmacist (CP) failed to address an appropriate indication for an antidepressant for 1 of 1 resident (R212) reviewed for psychotropic medications.	21530	"Corrected"	

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21530	Continued From page 43 Findings include: R212's comprehensive Minimum Data Set (MDS) in progress dated 8/15/24, indicated intact cognition, had coronary artery disease and hypertension (high blood pressure), acute myocardial infarction (heart attack), presence of an aortocoronary bypass graft, and had an encounter for surgical after care following surgery on the circulatory system. Further, R212 did not have little interest or pleasure in doing things, and did not feel down, depressed, or hopeless. R212's physician orders dated 8/9/24, indicated R212 took bupropion (an antidepressant) HCL ER (extended release) 150 mg by mouth two times a day for status post CABG (coronary artery bypass grafting). R212's Medical Diagnosis form dated 8/21/24 at 1:39 p.m., indicated the following diagnoses: encounter for surgical aftercare following surgery on the circulatory system, presence of aortocoronary bypass graft, non-ST elevation myocardial infarction (heart attack), atherosclerotic heart disease of native coronary artery, essential hypertension. The form lacked information R212 had depression. R212's hospital discharge summary dated 8/9/24, indicated R212 was to continue taking the following medication: bupropion 150 mg take 1 tablet twice a day for S/P CABG. R212's nurse practitioner (NP) progress note dated 8/15/24, indicated R212 took bupropion 150 mg twice daily, further R212's mood and affect was normal.	21530		

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21530	Continued From page 44 R212's pharmacist medication review dated 8/15/24, indicated the following recommendations: R212 was prescribed quetiapine (an antipsychotic) 25 mg tablet daily at bedtime with an associated diagnosis of "S/P CABG" listed with it in the electronic medical record (EMR). Per CMS (Centers for Medicare and Medicaid Services) guidelines, this may not be a sufficient diagnosis to warrant the use of an antipsychotic. Antipsychotics should be reserved for situations where psychosis/delusions are present or situations where the patient poses an acute risk for harm to self or other. Please clarify the diagnosis for the Seroquel and update the EMR-if an adequate diagnosis is not present, consider tapering off of this medication. The pharmacist medication review lacked information regarding bupropion and an associated diagnosis of S/P CABG. During interview on 8/21/24 at 11:09 a.m., the consulting pharmacist (CP)-A stated bupropion was an antidepressant medication and a diagnosis of CABG was not a correct indication for bupropion and stated he wrote the recommendation for the quetiapine and stated the rationale would hold true for any psychotropic R212 was on. During interview on 8/22/24 at 12:00 p.m., the director of nursing (DON) stated CP-A completed pharmacy reviews and sends them over, they are printed and reviews for the physician are provided to the medical director and if a review is for nursing, the review is provided to the nurses. DON further stated the pharmacist should have identified the incorrect indication on the first initial review for the bupropion and further, it was important to have the correct diagnosis to track	21530		

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21530	Continued From page 45 R212's depressive mood. A policy, Psychotropic Medications Rehab/Skilled dated 12/6/23, indicated the resident will be free from any chemical restraint imposed for the purposes of discipline or convenience and not required to treat the resident's medical symptoms. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used without adequate indications for its use. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to utilize a process which ensures the diagnoses for a medication is obtained. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21530		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced	21695		9/20/24

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21695	Continued From page 46 by: Based on observation, interview, and document review, the facility failed to ensure reclining foot rests functioned appropriately for 1 of 1 resident (R212) and failed to ensure a clean communal shower room which had the potential to affect all residents who used the shower room. Findings include, R212's comprehensive Minimum Data Set (MDS) in progress dated 8/15/24, indicated intact cognition, had coronary artery disease and hypertension (high blood pressure), acute myocardial infarction (heart attack), presence of an aortocoronary bypass graft, and had an encounter for surgical after care following surgery on the circulatory system. R212's physician orders form indicated the following order: 8/16/24, bumetanide 1 milligram (MG) by mouth daily for edema (fluid collecting in body tissues) and shortness of breath. R212's care plan dated 8/12/24, identified R212 took a diuretic. During interview on 8/19/24, at 1:13 p.m., R212 stated she mentioned to a few staff that the recliner chair did not work when trying to put her feet up, the foot rest would not stay in the upright position. R212 stated she mentioned the concern on 8/18/24, and again the morning of 8/19/24. During interview on 8/21/24 at 7:18 a.m., the manager of ancillary services (MOAS)-A stated he becomes aware of repairs thru the use of a maintenance slip or if there is something more	21695	"Corrected"	

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	00900	A. BUILDING: _____ B. WING _____	C 08/22/2024

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21695	Continued From page 47 severe or if something was urgent, a direct phone call was completed. MOAS-A further stated maintenance slips were used for everything to make him aware. A list of maintenance slips were requested from the past three weeks including completed orders and uncompleted work orders. During interview on 8/21/24 at 7:43 a.m., the MOAS-A provided the maintenance slips and further stated if in a hurry, instructs to fill out a slip, but if it is something like a remote not working, MOAS-A will look at the remote and not necessarily fill out a slip, but if a slip is not filled out, will look at the issue immediately or the same day. The work orders lacked information regarding R212's reclining chair. During interview and observation on 8/21/24 at 11:39 a.m., nursing assistant (NA)-B answered R212's call light and pulled the lever to recline R212 in the recliner chair. The foot rest would not stay in the elevated position. NA-B stated when the back of the chair is pulled back, the chair wouldn't stay in a reclined position and stated a lot of the chairs this style have been doing this since they got them and stated R212 had been wanting a new chair and stated somebody told R212 on 8/20/24, that they could not interchange the chairs, but did not know who told R212 the chairs could not be changed. NA-B further stated R212 mentioned the chair issue to her 8/20/24, but did not talk to maintenance. R212 stated she had swelling in her feet. During interview on 8/21/24, at 11:45 a.m., and 11:47 a.m., registered nurse (RN)-B stated if a recliner chair wasn't functioning, they contacted maintenance who will repair or replace a chair. RN-B stated she was not aware R212's leg rest	21695		

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21695	Continued From page 48 on the chair was not functioning. RN-B stated MOAS-A was pretty quick and usually came up on the same day of any requests. RN-B further stated R212 had heart surgery and it would be important to elevate her legs for the swelling and edema. At 11:47 a.m., RN-B called and notified MOAS-A that R212's recliner chair was not working and would come up to look at the chair. During interview on 8/21/24 at 2:21 p.m., NA-B stated R212 was able to respond appropriately and could make her needs known. During interview on 8/22/24 at 7:33 a.m., MOAS-A stated the recliners had two springs that held the leg rest up and the manufacturer provided springs in three different tensions and stated the stiffness of the springs were used based on a resident's weight and residents used their legs and the lever to put their legs down, but if they don't have the strength, adjustments are made with a different tension spring. MOAS-A stated he did not know how long R212 had the problem and was first made aware of it around 12:00 p.m., on 8/21/24. During interview and observation 8/22/24 at 10:51 a.m., R212 was able to recline herself in the reclining chair and put the foot rest down and stated it was much better. During interview on 8/22/24 at 12:00 p.m., the director of nursing (DON) stated she expected staff to complete a slip to notify maintenance and further stated she expected staff to contact maintenance and stated she would contact MOAS-A to see if there was a schedule for the shower room and expected housekeepers keep a schedule.	21695		

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21695	Continued From page 49 R13's quarterly MDS dated 5/14/24, indicated R13 was cognitively intact and had diagnoses of heart failure and diabetes. Furthermore, R13's MDS indicated R13 required partial/moderate assistance to shower. When interviewed on 8/19/24 at 12:18 p.m., R13 was seated in their wheelchair in the room. R13 stated there was mold growing in the shower room. R13 stated she had reported it before about a year ago and it was cleaned up and looked great however it was returning. R13 stated it was between the tiles and along the edges of the floor. An observation on 8/19/24 at 12:26 p.m., the lower-level shower room for the odd number hallway was observed. The room had a small ivory/white tiled floor. Grout in between the tiles were whit/light colored in most of the areas. However, several areas of the floor had darker black grout between the tiles. An observation on 8/21/24 at 12:28 p.m., the lower-level shower room for the even number hallway was observed. The room had a small ivory/white tiled floor. There was dark grout in between the tiles under the shower and along the shower floor and wall. When interviewed on 8/21/24 at 12:11 p.m., housekeeper (HSK)-A stated shower rooms were cleaned daily, and maintenance completed any deep cleaning and was not aware of any schedule for deep cleaning. HSK-A stated the shower room on the odd hallways did not get used much and most residents used the even hall shower. HSK-A was aware of the black grout between the tiles and along the wall and stated the mop used did not get in deep and mostly	21695		

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21695	Continued From page 50 cleaned the surface of the tiles. HSK- stated they have tried to use their fingernail over the mop sponge to try to dig in between the tiles some, but it was hard to get it removed. When interviewed on 8/21/24 at 12:28 p.m., the MOAS-A verified the dark grout on the tile floor in the even number shower room and stated they needed to have a deep clean. MOAS-A further stated there was not a routine deep cleaning schedule and it was just as needed. MOAS-A was not aware of them needing cleaning and was not sure when the last time it was done. MOAS-A was able to confirm the shower rooms have not been deep cleaned in the past 8 months since their return. A policy, Resident Environment, dated 2/2/24, indicated the facility will provide a safe, clean, comfortable environment that allows the residents use of some personal belongings. Resident rooms will be designed and equipped for adequate nursing care, safety and comfort and will ensure full visual privacy for each resident as well as the following, housekeeping and maintenance services and functional furniture appropriate to resident needs. SUGGESTED METHOD OF CORRECTION: The administrator, maintenance supervisor, or designee could ensure a preventative maintenance program was developed to accurately reflect ongoing preventative maintenance and cleaning scheduled or needed in the facility on a routine basis. The facility could create policies and procedures, educate staff on these changes and perform environmental rounds/audits periodically to ensure preventative maintenance and cleaning is adequately	21695		

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21695	Continued From page 51 completed. The facility could report those findings to the quality assurance performance improvement (QAPI) committee for further recommendations to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21695		