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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

ID: NT3S
Facility ID: 00956

1. MEDICARE/MEDICAID PROVIDER NO. (L1) **245488**

2. STATE VENDOR OR MEDICAID NO. (L2) **502043300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WOODLAND**
(L4) **100 BUFFALO HILLS LANE**
(L5) **BRAINERD, MN** (L6) **56401**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP (L9)

6. DATE OF SURVEY **05/02/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35) **06/30**

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

12. Total Facility Beds **42** (L18)

13. Total Certified Beds **42** (L17)

10. THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements Compliance Based On:
___ 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	42			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NE II 05/23/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Michaelyn Bruer, Enforcement Specialist 05/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION **07/01/1987** (L24)

23. LTC AGREEMENT BEGINNING DATE (L41)

24. LTC AGREEMENT ENDING DATE (L25)

25. LTC EXTENSION DATE: (L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE: (L28)

29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245488

May 23, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Dear Mr. Cerney:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective May 1, 2018 the above facility is certified for or recommended for:

42 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 42 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

P r o t e c t i n g , M a i n t a i n i n g a n d I m p r o v i n g t h e H e a l t h o f A l l M i n n e s o t a n s

Electronically delivered
May 23, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: Project Number S5488028

Dear Mr. Cerney:

On April 2, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 15, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On May 2, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 18, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 15, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 15, 2018, effective May 1, 2018 and therefore remedies outlined in our letter to you dated April 2, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

May 23, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Re: Reinspection Results - Project Number S5488028

Dear Mr. Cerney:

On May 2, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on March 15, 2018, with orders received by you on April 2, 2018. At this time these correction orders were found corrected.

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

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

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(L4) **100 BUFFALO HILLS LANE**
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3. Termination 4. CHOW
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___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

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17. SURVEYOR SIGNATURE Date :
Debra Vincent, HFE NE II 04/16/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Debby Baker, Enforcement Specialist 04/25/2018 (L20)

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29. INTERMEDIARY/CARRIER NO. **00140** (L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539 (L32)

32. DETERMINATION OF APPROVAL DATE (L33)

DETERMINATION APPROVAL

Electronically delivered
April 2, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

RE: Project Number S5488028

Dear Mr. Cerney:

On March 15, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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

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

> **Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;**
>
> **Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;**
>
> **Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and**

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
705 5th Street Northwest, Suite A
Bemidji, Minnesota 56601-2933
Email: lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 24, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by April 24, 2018 the following remedy will be imposed:

• Per instance civil money penalty. (42 CFR 488.430 through 488.444)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have

been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by June 15, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 15, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING ______ B. WING ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(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 A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted 3/12/18-3/15/18, during a recertification survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	E 000		
E 026 SS=C	Roles Under a Waiver Declared by Secretary CFR(s): 483.73(b)(8) [(b) Policies and procedures. The [facilities] must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:] (8) [(6), (6)(C)(iv), (7), or (9)] The role of the [facility] under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials.	E 026		4/24/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/12/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING ______ B. WING ______	03/15/2018

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E 026	Continued From page 1 *[For RNHCIs at §403.748(b):] Policies and procedures. (8) The role of the RNHCI under a waiver declared by the Secretary, in accordance with section 1135 of Act, in the provision of care at an alternative care site identified by emergency management officials. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facilty failed to ensure their policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Findings include: On 3/15/18, at 9:35 a.m. the emergency preparedness policies and procedure manual dated 1/5/18, was reviewed with the director of nursing (DON), director of maintenance (DM), and quality assurance and performance improvement (QAPI) coordinator. Upon review the facility did not have policies and procedures in its emergency plan describing the facility's role in providing care and treatment at alternate care sites under an 1135 waiver. The QAPI coordinator stated we do not have any information in our policy related to this requirement.	E 026	Based on interview and policy review, the facility has updated policies and procedures to address the role of the facility under a waiver declared by the secretary, in accordance with section 1135 of the Act, in the provision of care and treatment at an alternate care site identified by emergency management officials. Emergency management plan (III.A.1) was updated to include "In the addition to the above for the event the Secretary declaring 1135 waiver, we have agree ments to continue care and treatment for other facilities residents at our facility or for our residents at an alternate care site during emergencies. Details and particulars are outlined in the agreements with each respective facility which are signed, scanned and attached to this plan. As stated above, Woodland will work with John Bowen, Crow Wing County Emergency Director or designee to help designate alternative sites and facilitate operations with ones that are chosen. Woodland, if able and as appropriate, will supply staff, equipment and supplies to provide cares and treatment at the alternate care site. Once the president	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

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E 026	Continued From page 2	E 026	declares a major disaster or emergency under the Stafford Act or an emergency under the National Emergency Act, and his secretary declares a public health emergency, the Administrator or designee will submit requests to operate under that authority or for other relief that may be possible outside the authority to the CMS Regional Office closest to our area. Information about the Woodland facility and justification for requesting the waiver will be provided on the request. The Administrator or designee will be held accountable for oversight of responsibilities during a waiver period." Date for completion: April 24, 2018	
E 035 SS=C	LTC and ICF/IID Sharing Plan with Patients CFR(s): 483.73(c)(8) [(c) The [LTC facility and ICF/IID] must develop and maintain an emergency preparedness communication plan that complies with Federal, State and local laws and must be reviewed and updated at least annually.] The communication plan must include all of the following: (8) A method for sharing information from the emergency plan, that the facility has determined is appropriate, with residents [or clients] and their families or representatives. This REQUIREMENT is not met as evidenced by: Based on interview and policy review, the facility failed to ensure their emergency preparedness communication plan included a method for sharing information the facility has determined appropriate, with residents and their families or	E 035	Based on interview and policy review the facility has updated their emergency preparedness communication plan to include a method for sharing information the facility has determined appropriate,	4/24/18

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E 035	Continued From page 3 representatives. This had the potential to affect all residents residing in the facility and their families/representatives. Findings include: On 3/15/18, at 9:35 a.m. the emergency preparedness policies and procedure manual dated 1/5/18, was reviewed with the director of nursing (DON), director of maintenance (DM), and quality assurance and performance improvement (QAPI) coordinator. The policy lacked information on informing residents and their families or representatives on the emergency preparedness plan. At 11:35 a.m. the QAPI coordinator stated we have not shared this information with the residents, their families or representatives.	E 035	with residents and their families or representatives. This had the potential to affect all residents residing in the facility and their families/representatives. The facility will send letters to our current Residents, Families or Representatives which will inform them and Emergency Preparedness Plan is in place and is updated on an annual basis in accordance with the Center for Medicare and Medicaid Services. The letter will indicate sections highlighted within the plan such as a Hazard Analysis, Definitions of Policies and Procedures, Responsibilities and Actions, Information, Training and Exercises. They will know what is available for them to view if they contact the Administrator or Director of Nursing (Numbers will be provided). In addition, a letter will be included in the Admission packet for new Residents to view. This was updated in the Emergency Management Plan (III.C.5) on 4/6/18 Letters to Residents, Families and Representatives. Date for completion: April 24, 2018	
F 000	INITIAL COMMENTS On March 12, 13, 14, and 15, 2018, a recertification survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and	F 000		

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F 000	Continued From page 4 Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 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 document review, the facility failed to provide assistance with activities of daily living in accordance with the care plan for 1 of 4 residents (R16) who was dependent upon staff for all activities of daily living. Findings include: R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnosis including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required	F 677	R16 is now receiving bathing, toileting, personal hygiene and oral cares per plan of care. All residents who require assistance with ADLs were reviewed and observed to ensure care plan approaches were being followed. Re-education was provided to all Nursing Assistants on GSS policy and procedures for ADLs per residents plan of care on 4/13/18. Record review and observation audits	4/24/18

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F 677	Continued From page 5 extensive assistance with all activities of daily living and was totally incontinent of bowel and bladder. The Activities of Daily Living Care Area Assessment (CAA) did not trigger at the time of the admission MDS. The Urinary Incontinence Care Area Assessment (CAA) dated 10/26/17, indicated R16 was totally incontinent of bowel and bladder and required assistance to check and change an incontinence brief. R16 required total assistance with all activities of daily living. The Bladder Assessment dated 10/16/17, indicated R16 was incontinent of bowel and bladder and identified the staff was to assist with check and change every two hours. R16's care plan dated 1/11/18, directed the staff to provide the following care: - Bathing, assist of one. - Oral Cares: Assist of one with mouth cares. - Personal hygiene: requires assist of one with personal hygiene - Toilet use: Extensive assist of two to check and change. On 3/13/18, at 7:36 p.m. nursing assistant (NA)-A and NA-E entered R16's room to assist with bedtime (HS) cares. R16 was observed to be resting in bed fully dressed. NA-A removed R16's pants. as NA-E opened R16's incontinent brief and performed perineal cares for R16. The NA's rolled R16 onto her side and completed perineal cares and applied a fresh incontinence brief. The NA's then dressed R16 in a fresh pajama top and	F 677	will be conducted by DON or designee to ensure care plan approaches for ADL care is being followed. Audits to include R16 and 3 random other residents daily for 5 days x 2 weeks, weekly X□s 4 then monthly x□s 3. Audit results will be reported to QAPI Committee for further recommendation. Date for completion: April 24, 2018	

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F 677	Continued From page 6 covered her with the blankets. R16 was observed to yell out during the cares. NA-E explained to R16 on three occasions that as soon as the cares were done she would be allowed to rest. NA-E stated " we are all done now, you have a good night" as she covered R16 with a blanket and turned out the lights. The NA's were not observed to assist R16 with washing her hands, face, upper body or provide oral cares. - At 7:48 p.m. NA-E confirmed R16 had received bedtime (HS) cares and the next time the staff would assist her with cares would be during "last rounds" at the end of the shift. NA-E confirmed R16 had not received oral cares and had not been given the opportunity to wash her face, hands or upper body. - At 7:50 p.m. NA-A confirmed R16 had been dressed in her pajamas and had not received assistance with oral cares or washing her upper body. NA-A stated he/she would return to R16 and complete HS cares. On 3/14/18, during continuous observations from 7:07 a.m. to 10:50 a.m. R16 was not observed to receive assistance with incontinence cares. At 7:07 a.m. R16 was observed seated in a reclining geri chair in the hallway by the nurses station. At 7:14 a.m. R16 was wheeled to the dining room and served breakfast. R16 remained in the dining room until 9:30 a.m. at which time she was wheeled into the activity room/ Cedar lounge area. - At 10:46 a.m. NA-D stated she did not know when the last time R16 had been assisted with incontinence cares.	F 677		

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- At 10:50 a.m. NA-C stated she had assisted R16 out of bed at 6:30 a.m. and had not assisted her with incontinence cares since that time.

- At 10:52 a.m. NA-C and NA-D wheeled R16 from the Cedar lounge to her room and transferred R16 from the chair to the bed via a full body mechanical lift. Once in bed, NA-C and NA-D changed R16's incontinence brief. R16 was observed to be incontinent of urine.

- At 11:05 a.m. NA-C confirmed R16 had not received incontinence cares between 6:30 a.m. and 10:50 a.m. a total of 4 hours and 20 minutes.

- At 1:45 p.m. registered nurse (RN)-A stated bedtime cares were to include washing the residents face, hands, and upper body along with oral cares. RN-A stated R16 was to be assisted with incontinence cares every two hours. RN-A confirmed R16 had not received cares in accordance with her care plan.

On 3/15/18, at 1:15 p.m. the director of nurses stated R16 was to receive cares in accordance to the care plan.

The Oral Hygiene policy dated 9/2012 and revised on 10/2017, directed the staff to provide oral cares.

The Bathing policy dated 9/2012, and revised on 10/2017, directed the staff to bathe the residents upper and lower body.

The Toileting Program policy dated 9/2017, and revised on 2/2016, directed the staff to provide assistance with check and change every two hours.

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F 677	Continued From page 8 A policy related to care plans was requested and none was provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate skin care to 1 of 1 resident (R16) observed to have an open wound. In addtion, the facility failed to ensure proper positioning had been provided for 1 of 1 resident (R12) reviewed for positioning. Findings include: R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnosis including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required extensive assistance with all activities of daily living. R16's care plan dated 1/9/18, indicated R16 had a history of itching, scratching and picking at skin on extremities. The plan directed the staff to encourage R16 to stop scratching/picking at	F 684	R16 ongoing skin concerns were relayed to the primary MD on 4/5/18. Adjustments to the treatment plan for R16 skin concerns were updated 4/12/18. R12 was repositioned per plan of care upon notification by surveyor. R12 caregivers were re-educated on following the care plan for repositioning. All residents who have care plans for positioning needs were reviewed and observed to ensure interventions were being followed. Re-education to be provided on 4/12/18 to nursing staff by DNS or designee on reporting any skin issues to charge nurse and following care plan	4/24/18

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F 684	Continued From page 9 scabs, apply lotion twice a day and as needed. R16's Skin Observation dated 3/11/18, identified multiple scabs on both upper and lower extremities. The treatments section of the form directed the staff to leave the area "open to air" and apply lotion. On 3/12/16, at 3:20 p.m. R16 was observed seated in a geri chair in her room. R16's right forearm was observed to have an area approximately 1/2 inch square in which the top layer for skin had been removed. The wound bed was observed to be bright red, however, it was not bleeding. A dressing was not observed to be covering the wound. On 3/13/18, at 7:40 p.m. during bedtime cares, R16's right forearm area continued to be open to air without a dressing. On 3/14/18, at 7:10 a.m. R16 was observed to be dressed in a long sleeved shirt. The wound on the right forearm could not be observed. - At 1:30 p.m. nursing assistant (NA)-C was observed to use a small white cloth and washed R16's right forearm. After cleansing, NA-C applied a band-aide over the wound. Review of R16's Progress Notes from 2/1/18 - 3/15/18, did not include documentation related to the right forearm wound. Review of R16's Treatment Record (ETAR) for 3/2018, did not include monitoring of the right forearm area. At 1:50 p.m. registered nurse (RN)-D stated she	F 684	interventions for positioning needs. Nurses will be provided re-education on GSS Policy and procedure for assessing, documenting, and treating skin issues at the April 12th nurses meeting. Audits to be completed by record review and observation audits by DNS or designee to ensure proper documentation and treatment of skin issues and proper positioning daily for 5 days x 2 weeks, weekly x 4 then monthly X s 3. All audit results will be reviewed by facility QAPI committee for further recommendations. Date for completion: April 24, 2018	

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was aware of the open area on R16's right forearm. RN-D stated at this time R16 did not have a treatment for the wound and the staff was to apply lotion to the wound. At 1:53 p.m. RN-D observed R16's right forearm and confirmed the wound was present and covered with a band-aide. RN-D stated she did not know when the band-aide was applied.

- At 2:15 p.m. RN-B reviewed R16's medical record. RN-B confirmed the skin assessment dated 3/12/18 only identified "picked area", however, if R16 had an open area, it should have been addressed in the progress notes. RN-B stated a care plan should have been developed for the care and treatment of the area and the treatment should have been added to the ETAR. RN-B confirmed R16's record lacked direction for the care and treatment of the open area.

On 3/15/18, at 1:22 p.m. the director of nurses confirmed the open area should have been noted in the clinical record and a monitoring system developed.

The Wound and Pressure Ulcer Management policy dated 9/2013 and revised on 1/2017, directed the staff to provide appropriate wound care and management as well as accurate assessment and documentation.
R12's quarterly Minimum Data Set (MDS) dated 1/8/18, indicated R12 had severe cognitive impairment and diagnoses which included dementia and pain-unspecified. The MDS indicated R12 was dependent of 2+ staff for all activities of daily living (ADL). The MDS also indicated that R12 utilized a wheelchair and had functional limitations of range of motion (ROM) to upper and lower extremities on both sides.

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R12's Falls Care Assessment (CAA) dated 3/7/18, indicated R12 had difficulty maintaining sitting balance, required total mechanical lift to transfer, and had a reclining Broda wheelchair (wheelchair that may have a reclining back and/or lateral support).

R12's care plan dated last reviewed/revised 3/9/18, indicated R12 had dementia, did not verbalize and did not exhibit understanding of what was said to her, had limited physical mobility, and a self-care deficit with all areas of activities of daily living. The care plan directed:
- To use neck pillow for positioning, as needed, however, remove for meals.
- 3 hour limit of sitting in wheelchair (reclined at activities/rest, elevate @ meals).
- Place pillow to right side of chair when up if leaning to right
- Recline in wheelchair when not eating.

During continuous observations on 3/13/18, from 6:40 p.m. until 8:31 p.m., R12 was observed sitting in a Broda wheelchair, with shoulder bolster cushions positioned on the right and left sides of the chair. The chair was in an upright (not reclined) position. R12's eyes were closed, her head drooping forward, and she was leaning to the right.

On 3/13/18, at 7:33 p.m. an unidentified staff member entered room, and administered liquid Tylenol to R12. The staff left room without repositioning R12 or placing chair in reclined position.

On 3/14/18, at 7:04 a.m. R12 sat in Broda chair, in an upright position, in her room, with her head

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leaning to the right.

- At 7:29 a.m. R12 was transported by unidentified staff to the large activities room. R12 was observed to be leaning significantly to the right side, with chair in an upright position.

- At 7:49 a. m. R 12 was observed sitting upright in the Broda chair, leaning to the right, with her ear nearly touching her shoulder.

- At 7:57 p.m. the Director of Nursing (DON) transported R12 to the dining room. R12 continued to lean to the right, with her right ear almost resting on shoulder. DON repositioned R12 at this time. On continuous observation until 9:07 a.m. R12 was observed to be leaning significantly to the right with right ear touching right shoulder. The back of R12's head was resting on the outer portion of the right shoulder bolster on the chair.

- At 9:08 a.m. R12 was transported to the activities room, by the DON. R12 remained in an upright position, leaning to the right with her eyes closed.

- At 9:23 a.m. an activity began. R12's positioning was unchanged.

- At 11:33 a.m. R12 was sitting in activities area, in the Broda chair, with head tilted to the right, resting on the outside of the padded area and drooping forward. The chair was in a reclining position.

- At 12:14 p.m. R12 was observed sitting in the dining area, reclined in the Broda chair with her head tilted to the right resting on the outside of

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the pad.

R12's Positioning Assessment and Evaluation dated 2/26/18, indicated that R12 did not make needs known and was dependent on staff to anticipate and meet all needs. Upright in wheelchair for meals and recline in wheelchair when not eating. The evaluation indicated not to use neck pillow which was inconsistent with care plan that directed staff to use the pillow for positioning as needed.

R12's Occupational Therapy (OT) Plan of Care dated 3/24/17, indicated R12 presented with a decline in neck positioning over the past 3 weeks due to progressing dementia and increased stiffness to neck. Patient demonstrated increased forward head and neck flexion. The OT goal of therapy was for R12 to be able to hold her midline head positioning with no use of neck pillow for 2.5 hours with appropriate positioning; reclined while in Broda wheelchair and upright ONLY for meals.

R12's Therapist Progress & Discharge Summary - Occupational Therapy, dated 4/7/17, indicated gains in upright positioning for meals and good positioning when semi-reclined. The plan directed staff to position R12 in semi-reclined position when attending activities and upright for meals.

On 3/13/18, at 6:14 p.m. family member (FM)-I stated there are many times visiting, R12 is slumped over in the chair and staff had to be reminded to sit her upright. FM-I indicated she visited 3-4 times per week.

On 3/15/18, at 08:49 a.m. RN-B stated R12 had been in Broda chair since admission and there had been no decline. RN-B stated staff should

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F 684	Continued From page 14 follow the care plan of reclining her chair when she is not eating. A neck pillow was used in the past and was pushing her head forward, so it was discontinued. Now that R12 was on Hospice, therapy was not indicated, although facility would look at positioning. RN-B stated staff had not identified R12 had positioning issues. RN-B stated they would leave resident in the upright position for up to 30 minutes after eating due to regurgitation issues. This was not on the care plan. The Mobility Support and Positioning: Positioning Procedure last revised 10/17, did not specify how to address positioning for residents with neck weakness in order to keep the neck in a forward mid-line position.	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 document review, the facility failed to ensure a resident	F 686	R16 is repositioned upon notification by surveyor and care givers were	4/24/18

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	245488	A. BUILDING ______ B. WING ______	03/15/2018

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F 686	Continued From page 15 identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 4 resident (R16) in the sample identified at risk for pressure ulcers. Findings include: R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnoses including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required extensive assistance with all activities of daily living and at risk for the development of pressure ulcers. The Pressure Ulcer Care Area Assessment (CAA) dated 10/26/17, identified R16 at risk for the development of pressure ulcer and indicated R16 had an individualized turning/repositiong program and required a full body mechanical lift for transfers. R16's Braden Scale for Predicting Pressure Sore Risk dated 3/12/18, indicated R16 was at high risk for the development of pressure ulcers. R16's Positioning Assessment and Evaluation dated 3/12/18, indicated R16 was at high risk for pressure ulcers and directed the staff to turn and reposition R16 at least every two ours. R16's care plan dated 1/11/18, identified R16 at risk for the development of pressure ulcers and directed staff to assist R16 with turning and repositiong every two hours. On 3/14/18, during continuous observations from	F 686	re-educated on positioning needs per plan of care. All residents who are at risk for pressure ulcer development have been reviewed to ensure proper positioning as being followed per plan of care. Reeducation to be provided to all Nursing staff by DNS or designee on Pressure Ulcer prevention and treatment per GSS Policy and Procedures. 4/12/18 and 4/13/18. All residents identified as high risk will re re-evaluated for turning and repositioning frequency and care plans updated accordingly. Audits to be completed by record review and Observation audits by DNS or designee to Ensure pressure ulcer prevention interventions Are being followed daily for 5 days x 2 weeks, weekly x□s4 then monthly X□s 3. Date for completion: April 24, 2018	

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F 686	Continued From page 16 7:07 a.m. to 10:50 a.m. R16 was not observed to receive assistance with repositiong. At 7:07 a.m. R16 was observed seated in a reclining geri chair in the hallway by the nurses station. At 7:14 a.m. R16 was wheeled to the dining room and served breakfast. R16 remained in the dining room until 9:30 a.m. at which time she was wheeled into the activity room/ Cedar lounge area. - At 10:46 a.m. NA-D stated she did not know the last time R16 had been assisted with incontinence cares. - At 10:50 a.m. NA-C stated she had assisted R16 out of bed at 6:30 a.m. and had not assisted her with repositiong cares since that time. - At 10:52 a.m. NA-C and NA-D wheeled R16 from the Cedar lounge to her room and transferred R16 from the chair to bed via a full body mechanical lift. R16's geri chair was observed to be equipped with a pressure redistribution cushion. R16's skin was observed to be pink and intact. - At 11:05 a.m. NA-C confirmed R16 had not received assistance to repositiong between 6:30 a.m. and 10:50 a.m. a total of 4 hours and 20 minutes. - At 1:45 p.m. registered nurse (RN)-A stated R16 was to be repositioned every two hours in accordance with her care plan. On 3/15/18, at 1:15 p.m. the director of nursing stated R16 was to receive cares in accordance with her care plan. The Mobility Support and Positioning policy dated	F 686		

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F 686	Continued From page 17 2/2013, directed the staff to to develop an individualized repositioning schedule based on the residents risk factors.	F 686		
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	F 758		4/24/18

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F 758	Continued From page 18 §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §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 observation, interview and document review the facility failed to ensure a clinical rationale for the extended use of an as needed (PRN) antianxiety medication (Ativan/lorazepam) beyond 14 days and a specific duration for use was documented for 1 of 5 residents (R29) whose medication regimen was reviewed. Findings include: R29's significant change Minimum Data Set (MDS) dated 2/23/18, indicated R29 was cognitively intact and had diagnoses which included malignant neoplasm of left kidney, diabetes mellitus, depression and anxiety. The MDS also indicated R29 received antianxiety medication 7 days during the assessment period. R29's Psychotropic Drug Use Care Area Assessment (CAA) dated 2/23/18, indicated R29 had a diagnosis of anxiety and received Ativan daily. The CAA also indicated R29 was referred to St. Croix Hospice to help maintain emotional and	F 758	R29 PRN order for Ativan was Discontinued on 3/21/18. All other residents who receive PRN psychotropic medications were reviewed to ensure clinical rational for the extended use was documented per regulation. All licensed nursing staff will be provided With reeducation regarding GSS Policy And Procedure for use of psycho tropic medication by DNS or designee April 12th. In addition, a stop date will be placed on any PRN psychotropic medication with 14 day time frame to ensure medication will be discontinued and or need to get additional orders and rational for medication use by MD for extension of medication.	

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F 758	Continued From page 19 physical comfort during end of life related to end stage renal carcinoma. R29's Order Summary Report print date 3/14/18, included order's for lorazepam 0.25 milliliters (ml) give three times daily related to anxiety disorder, and lorazepam intensol concentrate 0.25 ml by mouth every four hours as needed PRN for anxiety. The start date of the PRN lorazepam was 2/22/18. The order lacked a duration for use. R29's Medication Record indicated lorazepam was scheduled and administered daily, additionally, PRN lorazepam was administered on 3/3, 3/7, 3/8, and 3/9/18. On 3/13/18, at 1:50 p.m. R29 was observed in her room, lying in bed. R29 was resting with her eyes closed and the television on. No adverse mood or behaviors were observed. On 3/14/18, at 12:29 p.m. R29 was observed lying in bed while visiting with her granddaughter. No adverse mood or behaviors were observed. The granddaughter stated my grandmother is not as anxious as she was when she first came, she was scared but has settled down. R29's Consultant Pharmacist Medication Review dated 2/22/18, included the following pharmacist recommendation: "A specific duration for use for greater than 14 days is required for R29's PRN Ativan use. R29's record lacked physician documentation of a clinical rationale for the long term use or identify a duration of use for the PRN lorazepam. The PRN lorazepam was available for use as needed for anxiety in addition to scheduled lorazepam.	F 758	DON or designee to provide audits for R29 and random other residents receiving PRN psychotropic medication to ensure compliance with GSS Policy and Procedures Weekly x□s 4 then monthly x□s 3. Results to be reviewed by QAPI Committee for further recommendation. Date for completion: April 24, 2018	

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F 758	Continued From page 20 On 3/14/2018, at 11:55 a.m. registered nurse (RN)-A confirmed R29 had episodes of increased anxiety and utilized her PRN lorazepam. RN-A stated we have been adjusting her scheduled lorazepam, however, we failed to address the PRN Lorazepam. RN-A confirmed R29's lorazepam should have had the 14 day parameter or clinical rationale for long term use. RN-A confirmed the PRN lorazepam order was not addressed. RN-A confirmed the PRN order had been in place since R29's admission on 2/16/18. On 3/15/18, at 8:29 a.m. consulting pharmacist (CP) stated a recommendation had been provided to the facility in February requesting the PRN lorazepam be addressed for the 14 day parameter and or justification and duration of the PRN medication use. - At 2:40 p.m. the director of nursing stated she would have expected there to be a documented rational and duration for the continued use of PRN lorazepam as required. The facility Psychotropic Medications Policy, revised 6/17, directed staff to ensure PRN psychotropic medications had clear parameters. PRN orders for psychotropic drugs are limited to 14 days. If the attending/prescribing practitioner believes that it is appropriate to extend the order past 14 days, rational should be documented in the medical record and indications of the duration of use for the PRN medication identified.	F 758		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals	F 809		4/24/18

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F 809	Continued From page 21 §483.60(f)(1) Each resident must receive and the facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that breakfast was no later than 14 hours after the evening meal for 1 of 1 residents (R27) reviewed that required assistance with eating. Findings include: R27's admission Minimum Data Set (MDS) dated 2/8/18, indicated R27 displayed mild cognitive impairments and had diagnoses of anemia and weakness. The assessment indicated R27 had the ability to eat independently after set up. R27's care plan dated 2/15/18, indicted R27 was able to eat independently after set up. R27's Progress Note dated 3/8/18, indicated R27	F 809	R27 Resident no longer resides in facility. All residents would be affected by deficient practice. Room tray cart delivery times were adjusted to meet the 14 hour perimeter times between dinner and breakfast. Delivery times are posted in the dining room. Care center dietary staff will be educated on the 14 hour parameter for meals and tray cart delivery times during department meeting on 4/10/18 by Dietician. For staff unable to attend meeting they will be educated by their next shift.	

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F 809 Continued From page 22
had returned to the facility following hospitalization due to pneumonia with sepsis.

R27's Progress Note dated 3/13/18, at 4:18 p.m. indicated R27 was on clostridium difficile (C-Diff) contact isolation precautions.

On 3/13/18, at 5:30 p.m. R27 was observed resting in bed. Nursing assistant (NA)-B was observed to apply personal protective equipment (PPE) including a gown, gloves and a mask and delivered a meal to to R27. The meal consisted of a cup of soup, a meat sandwich, ice cream and beverages. NA-B placed the meal items on an over-bed table next to the window and exited the room. At no time was NA-B observed to attempt to assist R27 with the meal.

- At 6:03 p.m. NA-A applied PPE and entered R27's room. NA-A raised the bed and sat next to R27 in an attempt to feed him. At 6:10 p.m. NA-A placed R27's food in the garbage and reported R27 refused to eat. No other staff members were observed to attempt to assist R27 with any type of nourishment.

- At 7:20 p.m. activity aide (AA)-A was observed to pass the evening snacks to the residents in their room. AA-A was not observed to attempt to offer R27 as snack as R27 was observed sleeping in his bed.

Review of R27's bedtime (HS) snack report indicated R27 had been sleeping when offered a snack on 3/13/18. R27 had not received a snack.

On 3/14/18, at 7:30 a.m. R27 was observed to be awake sitting on the edge of his bed. NA-C and licensed practical nurse (LPN)-A were observed

F 809

Other residents may be affected by deficient practices are those residents who request to eat in their rooms. The facility does accommodate individuals who have specific requests for meal times outside of the guidelines. These residents will be offered a substantial snack.

Measures have been put in place to ensure
this deficient practice does not re- occur this includes sending the room tray out at set
times and posting the set times in the dining room.

Audits to be completed by dietician on delivery times of room tray cart 4x's week x's1, then 2x's per week x's 2 weeks, then weekly x's 3 weeks.

Results to be reported to QAPI committee For further recommendations

Date for completion: April 24, 2018

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F 809	Continued From page 23 to assist R27 with morning cares. At 8:00 a.m. R27 was observed to be transferred from the bed into a reclining geri chair in his room. - At 9:00 a.m. R27 was observed to be sleeping in the geri chair in his room. R27 had not been offered breakfast. - At 9:24 a.m. cook-A stated the breakfast trays would be dished and delivered to the residents in their rooms between 9:30 a.m. and 10:00 a.m. Cook-A stated she did not prepare and deliver the breakfast trays to the nursing unit until the last resident in the dining room had been served. Cook-A confirmed R27's tray had not been sent to the nursing unit from the kitchen yet. - At 9:30 a.m. dietary aide (DA)-A was observed to deliver the meal cart containing 8 breakfast trays to the nurses station. DA-A stated all of the residents who ate in their rooms were able to feed themselves. - At 9:43 a.m. NA-F donned PPE, entered R27's room and delivered a breakfast tray. - At 9:50 a.m. NA-F left R27's room. NA-F was not observed to attempt to assist R27 with the meal. R27 was not observed to attempt to feed himself. - At 9:56 a.m. NA-C entered R27's room and assisted him with the meal. R27 had not attempted to feed himself. - At 2:20 p.m. registered nurse (RN)-B stated the staff were to assist the residents when the meals were delivered to them. RN-B stated R27 had been rapidly declining since returning from the	F 809		

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F 809	Continued From page 24 hospital on 3/8/18. R27 required extensive assistance with activities of daily living including eating. RN-B confirmed R27 had not had a snack on the evening of 3/13/18, and did not receive assistance with breakfast until 10:00 a.m. RN-B confirmed R27 had not been offered a meal between 6:00 p.m. on 3/13/18 and 10:00 a.m. on 3/14/18, a total of 16 hours. On 3/15/18, at 8:35 a.m. the dietary director (DD) stated the breakfast trays were to leave the kitchen between 9:30 a.m. and 9:45 a.m. The DD stated the residents who eat in their rooms were to be independent in eating, however, R27 was under contact isolation precautions due to C-Diff. R27 had also had a rapid decline in his health and required additional assistance. The staff members could have asked for his breakfast tray earlier, but confirmed it had not been requested. The DD confirmed R27 was not offered a meal for greater than 14 hours. The Frequency of Meals and Snacks policy dated 2/2013 and revised on 9/2017, indicated the facility was to ensure no more than 14 hours between a substantial evening meal and breakfast the following day.	F 809		
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.	F 880		4/24/18

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F 880	Continued From page 25 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the 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	F 880		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 26 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to complete hand hygiene during personal cares for 1 of 4 residents (R16) observed to receive to receive personal cares, the facility failed to ensure personal protective equipment (PPE) was appropriately utilized by the housekeeping staff for 1 of 1 resident (R27) observed in contact precautions. The facility also failed to ensure appropriate linen handling for 1 of 1 residents (R27) observed in contact precaution. The facility failed to ensure the infection control surveillance was completed in real time. Lastly, the facility failed to develop and implement a program to reduce the risk of a Legionella (a bacterium) in the facility water system to prevent cases and outbreaks of Legionnaires' disease (a serious type of pneumonia). This had the potential to affect all 30 residents who resided in the facility.	F 880	R27 Resident no longer resides in facility. Direct care staff were educated on linen handling and housekeepers were re-educated on use of PPE. The infection control surveillance log was updated to include R27 infection. R16 Direct care staff were re -educated on hand hygiene procedure. All residents would be affected by deficient practice. All nursing and housekeeping staff will be re-educated on hand-washing, gloves and	

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	245488	A. BUILDING ______ B. WING ______	03/15/2018

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F 880	Continued From page 27 Findings include: Hand Hygiene R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnosis including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required extensive assistance with all activities of daily living . R16's care plan dated 1/11/18, directed the staff to provide assistance with all activities of daily living. On 3/13/18, at 7:36 p.m. nursing assistant (NA)-A and NA-E entered R16's room to assist with bedtime (HS) cares. R16 was observed to be resting in bed fully dressed. NA-A donned gloves removed R16's pants. NA-E also donned gloves as he/she opened R16's incontinence brief. NA-E utilized a wash cloth and soap and water as he/she washed R16's perineal area. NA-E then used the same cloth to wash R16's hips. The two NA's rolled R16 onto her side as NA-E finished washing R16's anal area and buttocks. R16 was observed to be incontinent of urine. NA-E and NA-A removed their gloves as they assisted R16 to reposition in bed, remove R16's shirt and placed a fresh pajama top on R16. NA-E pulled up the covers and completed room order. Upon exiting the room, NA-E gathered the laundry, garbage and turned off the light. At no time were the NA's observed to wash their hands or utilize hand sanitizer during the cares or before leaving the room. - At 7:48 p.m. NA-E confirmed hand hygiene had	F 880	use of PPE policy and procedure by DNS or Designee meetings April 12, and April 13, 2018. Legionella water testing was completed 3/22/18. All staff to be educated on GSS Policy and Procedure on Legionnaire□s disease and Water Management Program. All nursing will also be provided re-education on promptly updating the infection control surveillance log. Observation audits to be completed R16 and 3 random residents each week x,s 3 times per week x□s 4 then monthly x□s 4 to ensure proper hand-washing, glove use and PPE use by DNS or designee. Audits will also be conducted to ensure the infection control log is completed Timely by the DNS or designee. Daily x□s 5 then weekly x□s 3, then monthly x□s4. Maintenance director or designee will conduct weekly audits for cold water and domestic water temps. All audit results will be reviewed by facility QAPI committee for further recommendation.	

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F 880	Continued From page 28 not been completed during the cares. NA-E stated she would be washing her hands in the soiled utility room. On 3/14/18, at 1:45 p.m. registered nurse (RN)-A stated staff was to perform hand hygiene as necessary during personal cares. The Hand Washing and Glove Use Policy dated 2/13, and revised on 12/17, directed the staff to complete hand hygiene before and after using gloves and and after direct resident contact. Contact Precautions R27's admission Minimum Data Set (MDS) dated 2/8/18, indicated R27 displayed mild cognitive impairments and had diagnosis of anemia and weakness. R27's Progress Note dated 3/13/18, at 4:18 p.m. indicated R27 was on clostridium difficile (C-Diff) contact isolation precautions. On 3/13/18, at 12:11 p.m. housekeeping staff member (HSKP)-A was observed outside of R27's room with a housekeeping cart. HSKP-A was observed to don personal protective equipment (PPE) consisting of a gown, gloves and mask. Once the PPE was applied, HSKP-A gathered a cleaning cloth from the cart and spayed the rag with cleaner. HSKP-A then entered R27's room. - At 12:15 p.m. HSKP-A exited R27's room while wearing the PPE, placed the cloth into a collection bag and removed a small bucket containing the toilet bowel brush and toilet bowl cleaner. HSKP-A then carried the items into R27's room. - At 12:17 p.m. HSKP-A returned to the cleaning cart wearing the PPE and replaced the bucket of	F 880	Date for completion: April 24, 2018	

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F 880	Continued From page 29	F 880		

toilet bowl cleaner into the cart. HSKP-A then entered a soiled utility room and returned carrying red bags along with clear plastic bags.
- At 12:19 p.m. HSKP-A exited R27's room carrying a large red bag encased in a clear plastic bag. HSKP-A continued to be donned in the PPE as she placed the large bag on the end of the cleaning cart and gathered a dust mop and returned to R27's room.
- At 12:21 p.m. HSKP-A exited R27's room wearing the PPE, replaced the mop and walked into the soiled utility room. Upon exiting the soiled utility room, HSKP-A was observed to have removed the PPE while in the utility room. HSKP-A was then observed to utilize hand sanitizer in the hallway.

- At 12:26 p.m. HSKP-A stated she was to wear PPE while cleaning R27's room due to contact precautions. HSKP-A stated she had been trained on how to utilize PPE, but was not aware PPE was not to be worn outside of the potentially infection room. Additionally, she stated she was done cleaning rooms for the day so toilet bowl cleaner and mop were not used in any other rooms.

The Contact Precaution policy dated 6/2016, revised on 1/2017, directed the staff to ensure PPE had been removed prior to leaving the resident room.

On 3/15/18, at 1:00 p.m. RN-C stated all PPE was to be removed prior to exiting the resident room contaminated with C- Diff.

Linen Handling

On 3/12/18, at 11:00 a.m. R27's room was

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F 880	Continued From page 30	F 880		

observed to be equipped with two tall (approximately 3 foot by one foot) red containers near the room door. The containers were observed to have lids on them, however, the lids were propped open and overflowing. The first red bin contained garbage, the second contained soiled laundry.

On 3/14/18, at 7:30 a.m. R27's room was not observed to have red bins for laundry or garbage by the door.

- At 7:35 a.m. NA-D and licensed practical nurse (LPN)-A were observed to assist R27 with morning cares. NA-D utilized three wash cloths as she assisted R27 to wash his face, arms, and back. After each use, NA-D placed the soiled washcloths onto the floor next to R27's bed. NA-D then assisted R27 with perineal cares. NA-D again placed the washcloth and towels onto the floor.

- At 7:46 a.m. NA-D picked the soiled laundry off of the floor and carried it into R27's bathroom. NA-D then picked up a partially filled red bag of laundry off of the bathroom floor and placed the soiled laundry in the bag. NA-D then returned the bag to the floor.

- At 7:48 a.m. NA-D confirmed the red bag on the floor of the bathroom contained R27's soiled laundry. NA-D stated there had been a laundry container in R27's room, however, she did not know why it had been removed.

A linen handling policy was requested and none was provided.

On 3/15/18, at 1:15 p.m. RN-C stated soiled

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F 880	Continued From page 31	F 880		

laundry was to be placed in a laundry bag. The laundry bags were not to be placed on the resident's floor.

Surveillance System

On 3/15/18, at 12:50 p.m. RN-C/infection control preventionist stated the facility surveillance system included tracking and trending of all bacterial and viral infections. RN-C stated the charge nurse was responsible for filling out the infection control logs as concerns were identified. RN-C stated she reviewed the infection control logs 1-2 times per week.

Review of the 3/18, Monthly Report of Resident Infection in Center, did not include R27's Clostridium difficile infection or the implementation of contact isolation precautions.

- At 3:00 p.m. RN-C confirmed R27's clostridium difficile infection had been identified on 3/8/18, and had not been added to the infection control log.

The Surveillance policy dated as revised on 10/17, directed the staff to identify, track and prevent nosocomial infections. The policy directed the staff to include data collection to ensure corrective actions could be completed. The staff were to implement process and outcome surveillance.

Legionella Review

On 3/15/18, at 1:40 p.m. the environmental services director (ESD) verified he was responsible for the implementation of facility policies pertaining to water born illness. The ESD

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F 880	Continued From page 32 stated National Campus had recently developed policies for Legionella , however, he had not implemented the policies. Review of the Legionnaires' Disease and Water Management Program dated 8/17, directed the facility to conduct a facility assessment to identify areas in the facility in which the building connected to the municipal water supply, how the water was distributed, how cold water was heated and then distributed, how waste water was discarded, where pools, hot tubs, cooling towers and water heaters or boilers were located. In addition the facility was to describe how the water system (using a flow diagram) was distributed within the facility, identity area where Legionella could grow and spread, control measures and corrective action along with the applications of the control measures. - At 1:50 p.m. the ESD stated in addition to the policy, National Campus had recently sent information from a "TELS" cooperation which directed the individual campus how to test and monitor the water system. The ESD stated he had ordered a water testing kit, however, it had not arrived at the facility. The ESD confirmed the facility had all the tools to completed a water assessment and testing, but the they had not been completed.	F 880		
F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		4/24/18

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F 883	Continued From page 33	F 883		

each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the following:
(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and
(B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-
(i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;
(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;
(iii) The resident or the resident's representative has the opportunity to refuse immunization; and
(iv)The resident's medical record includes documentation that indicates, at a minimum, the

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F 883	Continued From page 34 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R31, R17, R21) received pneumococcal vaccinations in accordance with the Center for Disease Control (CDC) recommendations. Findings include: The Center for Disease Control and Prevention identified "Adults 65 years of age or older who have not previously received PCV13 and who have previously received one or more doses of PPSV23 (pneumococcal polysaccharide vaccine 23) should receive a dose of PCV13. The dose of PCV13 should be administered at least one year after the most recent PPSV23 dose. R31 was an 84 year old female admitted to the facility on 1/29/18. Review of the undated Minnesota Immunization Report indicated R31 had received a Pneumococcal conjugated (PCV13) immunization. However, R31 had not received the pneumococcal PPSV23 immunization. R31's undated clinical immunization report lacked documentation as to why R31 had not received the PPSV23. R17 was an 84 year old male admitted to the	F 883	Residents R31 was offered PPSV23 on 4/12/18; R17 Pneumonia vaccine administration record was retrieved and immunizations were given 7/10/1999 and 1/3/2011. This has been updated in facility records. R27 is no longer a resident at this facility. R31will be given the Pneumococcal Vaccine informational sheet prior to vaccination administration. Consent will be obtained and acceptance or refusals of vaccination will be documented on EMAR and nursing progress note and immuni zation record on electronic medical record. Residents that did not receive the vaccine were reviewed and offered to receive the vaccine as appropriate. Re-education to be provided to Nurses On GSS policy and procedure of	

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F 883	Continued From page 35 facility on 1/2/18. Review of R17's undated Minnesota Immunization Report indicated R17 had received a PPSV23 immunization on 1/3/11. However R17 had not received a PCV13 immunization. R17's undated clinical immunization report lacked documentation as to why R17 had not received a PCV13 immunization. R27 was a 91 year old male admitted to the facility on 3/8/18. Review of R27's undated Minnesota Immunization Report indicated R27 had received a PPSV23 immunization on 11/11/99, however, R27 had not received a PCV13 immunization. R27's undated clinical immunization report lacked documentation as to why R27 had not received a PCV13 immunization. On 3/15/18, at 9:35 a.m. registered nurse (RN)-A stated the health information specialist and the charge nurses were responsible for checking the immunization records and following up to make sure the immunizations were discussed with the resident's primary physicians. RN-A confirmed the aforementioned residents were lacking pneumococcal immunizations. - At 1:00 p.m. the infection control preventionist/ RN-C stated all resident immunizations were to be reviewed upon admission and addressed with the primary physician as needed. The Immunization for Residents policy revised on 11/16, directed the staff to review the influenza and pneumococcal vaccinations upon admission with the resident and/or representative. The policy directed both PCV13 and PPSV23 immunizations to be administered to all adults	F 883	pneumococcal vaccine by DNS or designee on 4/12/18. All new residents will be offered pneumococcal vaccine if not already received. Pneumococcal vaccine will also be placed on admission checklist to give informational sheet and to give pneumococcal vaccine per MD order if indicated. Audits will be conducted by DNS or designee to Ensure pneumococcal vaccine was offered and given As appropriate. Audits and education will be reported to Quality Assurance and with follow up action as needed. Date for completion: April 24, 2018	

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F 883	Continued From page 36 aged 65 and order for the prevention of pneumococcal disease in accordance to the CDC guidelines.	F 883		
F 921 SS=C	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that kitchen equipment and kitchen floor was kept in a sanitary manner. This has the potential to affect all 30 of 30 residents who received meals from the kitchen. Findings include: On 3/12/18, at 10:30 a.m. the initial tour of the kitchen was completed with Registered Dietician (RD)-A. The following concerns were identified and verified by (RD)-A: -The floors throughout the kitchen were observed to have approximately one inch of debris along the floor boards. On 3/14/18, at 11:01 a.m., during a tour of the kitchen with (RD)-A the following areas of concern were noted and confirmed by (RD)-A: -The toaster, which was located on a counter in the prep area, had a layer of dried debris on the outer surface and numerous crumbs surrounding it. -The two ovens, one located on each side of the six burner stove, were observed to be splattered	F 921	Kitchen equipment and kitchen floors were cleaned on 3/15/18. Kitchen tile that is altered will be replaced by 5/10/18. All residents would be affected by Deficient practice. Cleaning schedule has been updated and frequency of cleaning equipment and floor has been increased. Care Center kitchen staff will be re-educated on the updated cleaning schedules during department meeting on 4/10/18. For staff unable to attend the meeting they will be educated by their next shift. Current care center kitchen staff will also complete a competency on cleaning schedules by April 20th. Some changes that were made were obtaining different cleaning equipment to clean hard to reach areas	4/24/18

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F 921	Continued From page 37 with black debris build-up on the sides nearest the stove top. -The large oven/steamer was coated with a white, flaky substance, on the interior of the oven. (RD)-A confirmed this was lime build-up. (RD)-A stated ovens are to be cleaned monthly; tops of stoves and floors daily. The General Sanitation Procedure dated as last revised 9/17, stated the food preparation, kitchen, and serving areas were cleaned and sanitized on a regular basis to limit contamination and prevent food borne illness.	F 921	better. Cleaning schedules to be reviewed and observation audits will be done 5x□s a week x□s 4 weeks then weekly x□s 2 months. Audits and education will be reported to Quality Assurance and with follow up action as needed. Date for completion: April 24, 2018	

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

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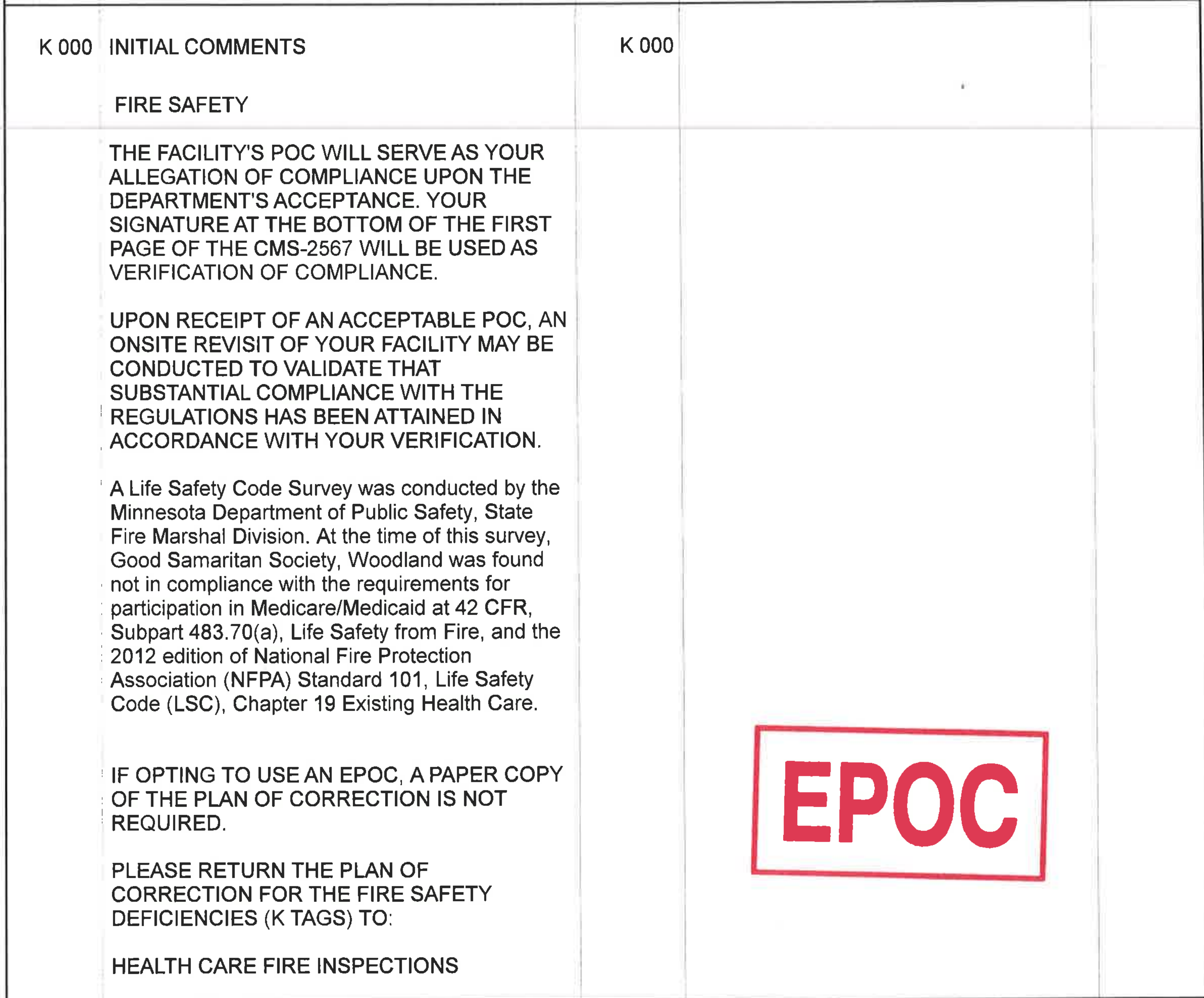
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE** **BRAINERD, MN 56401**



(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 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey, Good Samaritan Society, Woodland 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) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. IF OPTING TO USE AN EPOC, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTH CARE FIRE INSPECTIONS	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		04/12/2018

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245488	A. BUILDING **01 - 100 MAIN BUILDING** B. WING ______	**03/14/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE** **BRAINERD, MN 56401**

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K 000	Continued From page 1 STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145, or By e-mail to both: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency Good Samaritan Society, Woodland is a 1-story building without a basement. The building was constructed in 1982 and was determined to be of Type V(111) construction. The building is separated from the apartment building with a 2-hour fire barrier and is divided into 3 smoke zones with 1-hour fire barriers. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 42 beds and had a	K 000		

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K 000	Continued From page 2 census of 36 at the time of the survey.	K 000		
K 133 SS=F	The requirement at 42 CR, Subpart 483.70(a) is NOT MET: Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that a two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 19.1.3.3. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 12 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include:	K 133	1) The unapproved expanding foam in the penetrations around conduit was removed and replaced with approved fire rated caulking (3M FIRE BARRIER MOULDABLE PUTTY STIX MP+) on both sides of fire wall in area 1 near resident room 106. 2) The 90 minute door at same location had a misaligned door frame which caused the door to bind thus not latch. Door frame was adjusted to eliminate	4/9/18

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

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K 133	Continued From page 3 On facility tour between 8:30 a.m. to 12:30 p.m. on 03/14/2018, observations revealed the following deficient conditions: 1. The penetrations around the conduit located above the doors in the Area 1 fire wall by resident room 106 had an unapproved expanding foam used to seal the annular space around the conduit. 2. The 90 minute door at the same location did not fully close and latch into the frame due to the door binding in the frame. This deficient condition was confirmed by a Maintenance Supervisor.	K 133	binding allowing door to come to latch. This door and all fire doors will be checked annually and monitored monthly during fire drills. 2a) Fire door inspections to be completed on GSS form #712	
K 211 SS=F	Means of Egress - General CFR(s): NFPA 101 Means of Egress - General Aisles, passageways, corridors, exit discharges, exit locations, and accesses are in accordance with Chapter 7, and the means of egress is continuously maintained free of all obstructions to full use in case of emergency, unless modified by 18/19.2.2 through 18/19.2.11. 18.2.1, 19.2.1, 7.1.10.1 This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition and the NFPA 80 Standard for Fire Doors and Other Opening Protectives 2010 edition. This deficient practice could affect 42 of 42 residents, as well as an undetermined number	K 211	1) Fire door inspections and documentation for all fire rated doors in the facility will be done on an annual basis. 1a) Fire door inspections to be completed on GSS Form #712	4/6/18

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K 211	Continued From page 4 of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 8:30 a.m. to 12:30 p.m. on 03/14/2018, during a records review and an interview with the Maintenance Supervisor, the facility had not completed the fire door inspection or inspection documentation for all of the fire rated doors located throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 211		
K 363 SS=F	Corridor - Doors CFR(s): NFPA 101 Corridor - Doors Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas resist the passage of smoke and are made of 1 3/4 inch solid-bonded core wood or other material capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Corridor doors and doors to rooms containing flammable or combustible materials have positive latching hardware. Roller latches are prohibited by CMS regulation. These requirements do not apply to auxiliary spaces that do not contain flammable or combustible material. Clearance between bottom of door and floor covering is not exceeding 1 inch. Powered doors complying with 7.2.1.9 are permissible if provided with a device capable of keeping the door closed when a force of 5 lbf is applied. There is no	K 363		4/6/18

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K 363	Continued From page 5 impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility had 1 of several corridor doors that did not meet the requirements of NFPA 101 "The Life Safety Code" 2012 edition. This deficient practice could affect 12 of 42 residents, as well as an undetermined number of staff, and visitors if smoke from a fire were allowed to enter the exit access corridors making it untenable. Findings include: On facility tour between 8:30 a.m. to 12:30 p.m. on 03/14/2018, observations revealed that in Area 1 of the facility the resident room 124 has a door with a 3/8 inch gap in the upper right side of the door. This deficient condition was confirmed by a	K 363	1) The door to residents room 124 in area 1 of the facility was misaligned to the frame causing gap at top edge. The door was re-adjusted and weather stripping added to door frame to eliminate gap and seal the door to frame.	

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K 363	Continued From page 6 Maintenance Supervisor.	K 363		
K 712 SS=F	Fire Drills CFR(s): NFPA 101 Fire Drills Fire drills include the transmission of a fire alarm signal and simulation of emergency fire conditions. Fire drills are held at expected and unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Where drills are conducted between 9:00 PM and 6:00 AM, a coded announcement may be used instead of audible alarms. 19.7.1.4 through 19.7.1.7 This REQUIREMENT is not met as evidenced by: Based on review of reports, records and staff interview, it was determined that the facility failed to conduct several fire drills in accordance with the NFPA 101 "The Life Safety Code" 2012 edition (LSC) section 19.7.1.6, during the last 12-month period. This deficient practice could affect 42 of 42 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 8:3a.m. to 12:30 p.m. on 03/13/2018, during the review of all available fire drill documentation and interview with a maintenance staff member the following deficient conditions were found: 1. It was revealed that the facility did not conduct 2 overnight shift fire drill in the third and fourth	K 712	1) Fire drills for our overnight shift for 3rd and 4th quarter of 2017 we could not find any documentation that they ever occurred. We now have in place a schedule for fire drills for all 3 of our shifts. The schedule will be such that all 3 shifts will undergo drills in all 4 quarters of 2018. 1a) Documentation will be done on Fire Drill Report approved by Minnesota State Fire Marshal. 2) The fire alarm monitoring company (Brothers Fire) will be part of procedure for all drills. 1st and 2nd shift will use audible alarm, monitoring company will be called prior to drill to put system in test and called after completion of drill to verify they received signal and to put system	3/26/18

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K 712	Continued From page 7 quarter. 2. It was revealed that the facility did not conduct 5 of 12 tests of the DACT ensuring that the fire alarm signal was received by the monitoring company. This deficient condition was confirmed by a Maintenance Supervisor.	K 712	back on-line. 3rd shift drills will use coded announcement method. Monitoring company will be called later that morning to put system in test, signal will be sent, monitoring company called to verify they received signal, and system put back on-line. 2a) Brothers fire will provide us with annual activity report as documentation of system activity during drills.	
K 914 SS=F	Electrical Systems - Maintenance and Testing CFR(s): NFPA 101 Electrical Systems - Maintenance and Testing Hospital-grade receptacles at patient bed locations and where deep sedation or general anesthesia is administered, are tested after initial installation, replacement or servicing. Additional testing is performed at intervals defined by documented performance data. Receptacles not listed as hospital-grade at these locations are tested at intervals not exceeding 12 months. Line isolation monitors (LIM), if installed, are tested at intervals of less than or equal to 1 month by actuating the LIM test switch per 6.3.2.6.3.6, which activates both visual and audible alarm. For LIM circuits with automated self-testing, this manual test is performed at intervals less than or equal to 12 months. LIM circuits are tested per 6.3.3.3.2 after any repair or renovation to the electric distribution system. Records are maintained of required tests and associated repairs or modifications, containing date, room or area tested, and results. 6.3.4 (NFPA 99) This REQUIREMENT is not met as evidenced by:	K 914		5/1/18

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K 914	Continued From page 8 Based on observations and staff interview, that the electrical testing and maintenance was not maintained in accordance with NFPA 99 Standards for Health Care Facilities 2012 edition, section 6.3.4. This could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 8:30 a.m. to 12:30 p.m. on 03/14/2018, during a records review and an interview with the Maintenance Supervisor, the facility could not provide any documentation for the completion of the annual electrical outlet inspection and testing for the electrical outlets located in the patient/resident rooms located throughout the facility. This deficient condition was confirmed by a Maintenance Supervisor.	K 914	1) Good Samaritan Society has a policy/procedure the testing of receptacles that was not in place at the time of survey. All electrical outlets will be inspected for visual, continuity grounding, polarity and retention force on an annual basis. All residents rooms will be tested and documentation made. 1a) Documentation will be made on GSS Form #627	
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 observations and staff interview, that	K 926	1) Good Samaritan Society does have in	4/15/18

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

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K 926	Continued From page 9 the facilities failed to provide continuing education, including safety guidelines and usage requirements in accordance with NFPA 99(12) Section 11.5.2.1. This could negatively affect 42 of 42 residents as well as an undetermined number of staff, and visitors to the facility. Findings include: On facility tour between 8:30 a.m. to 12:30 p.m. on 03/14/2018, during a records review and an interview with the Maintenance Supervisor and the Director of Nursing it was found that the facility did not have a policy or any training documentation verifying that staff involved with the care, use, and handling of oxygen have received initial training and continuing education concerning the safety guidelines and usage requirements for oxygen. This deficient condition was confirmed by a Maintenance Supervisor.	K 926	place procedure and policy for the safe handling and Administration of Medical Gas (Oxygen). However we were unable to provide documentation at the time of survey. Procedure: revised issue 01/2018 Policy: revised issue 10/2017 1a) Training - Initial and continuing education: Initial training is scheduled to take place Thurs. Apr.12th and Fri. Apr.13th. Northwest Respiratory (provider on our medical gas supplies) will conduct an in-service seminar on Safe Handling and Administration of Medical Gas all staff will be required to take part in the seminar. All new staff will be required to take part in the initial training at time of orientation. Continuing Education will take place by means of policy, procedure and annual training seminars.	

Electronically delivered
April 2, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Woodland
100 Buffalo Hills Lane
Brainerd, MN 56401

Re: State Nursing Home Licensing Orders - Project Number S5488028

Dear Mr. Cerney:

The above facility was surveyed on March 12, 2018 through March 15, 2018 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Lyla Burkman, Unit Supervisor, at (218) 308-2104 or lyla.burkman@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00956	A. BUILDING: ______ B. WING ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

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2 000	Initial Comments	2 000		

*****ATTENTION******

NH LICENSING CORRECTION ORDER

In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.

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

INITIAL COMMENTS:
You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm> The State licensing orders are delineated on the attached Minnesota

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE
Electronically Signed | | 04/12/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00956	A. BUILDING: ______ B. WING ______	03/15/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WOODLAND	100 BUFFALO HILLS LANE BRAINERD, MN 56401

(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
2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 3/12/18-3/15/18, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide appropriate skin care to 1 of 1 resident (R16) observed to have an open wound. In addtion, the facility failed to ensure proper positioning had been provided for 1 of 1 resident (R12) reviewed for positioning. Findings include: R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnosis including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required	2 830	Complete	4/12/18

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2 830	Continued From page 3	2 830		

extensive assistance with all activities of daily living.

R16's care plan dated 1/9/18, indicated R16 had a history of itching, scratching and picking at skin on extremities. The plan directed the staff to encourage R16 to stop scratching/picking at scabs, apply lotion twice a day and as needed.

R16's Skin Observation dated 3/11/18, identified multiple scabs on both upper and lower extremities. The treatments section of the form directed the staff to leave the area "open to air" and apply lotion.

On 3/12/16, at 3:20 p.m. R16 was observed seated in a geri chair in her room. R16's right forearm was observed to have an area approximately 1/2 inch square in which the top layer for skin had been removed. The wound bed was observed to be bright red, however, it was not bleeding. A dressing was not observed to be covering the wound.

On 3/13/18, at 7:40 p.m. during bedtime cares, R16's right forearm area continued to be open to air without a dressing.

On 3/14/18, at 7:10 a.m. R16 was observed to be dressed in a long sleeved shirt. The wound on the right forearm could not be observed.

- At 1:30 p.m. nursing assistant (NA)-C was observed to use a small white cloth and washed R16's right forearm. After cleansing, NA-C applied a band-aide over the wound.

Review of R16's Progress Notes from 2/1/18 - 3/15/18, did not include documentation related to the right forearm wound.

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Review of R16's Treatment Record (ETAR) for 3/2018, did not include monitoring of the right forearm area.

At 1:50 p.m. registered nurse (RN)-D stated she was aware of the open area on R16's right forearm. RN-D stated at this time R16 did not have a treatment for the wound and the staff was to apply lotion to the wound. At 1:53 p.m. RN-D observed R16's right forearm and confirmed the wound was present and covered with a band-aide. RN-D stated she did not know when the band-aide was applied.

- At 2:15 p.m. RN-B reviewed R16's medical record. RN-B confirmed the skin assessment dated 3/12/18 only identified "picked area", however, if R16 had an open area, it should have been addressed in the progress notes. RN-B stated a care plan should have been developed for the care and treatment of the area and the treatment should have been added to the ETAR. RN-B confirmed R16's record lacked direction for the care and treatment of the open area.

On 3/15/18, at 1:22 p.m. the director of nurses confirmed the open area should have been noted in the clinical record and a monitoring system developed.

The Wound and Pressure Ulcer Management policy dated 9/2013 and revised on 1/2017, directed the staff to provide appropriate wound care and management as well as accurate assessment and documentation.

R12's quarterly Minimum Data Set (MDS) dated 1/8/18, indicated R12 had severe cognitive impairment and diagnoses which included

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2 830	Continued From page 5	2 830		

dementia and pain-unspecified. The MDS indicated R12 was dependent of 2+ staff for all activities of daily living (ADL). The MDS also indicated that R12 utilized a wheelchair and had functional limitations of range of motion (ROM) to upper and lower extremities on both sides.

R12's Falls Care Assessment (CAA) dated 3/7/18, indicated R12 had difficulty maintaining sitting balance, required total mechanical lift to transfer, and had a reclining Broda wheelchair (wheelchair that may have a reclining back and/or lateral support).

R12's care plan dated last reviewed/revised 3/9/18, indicated R12 had dementia, did not verbalize and did not exhibit understanding of what was said to her, had limited physical mobility, and a self-care deficit with all areas of activities of daily living. The care plan directed:
- To use neck pillow for positioning, as needed, however, remove for meals.
- 3 hour limit of sitting in wheelchair (reclined at activities/rest, elevate @ meals).
- Place pillow to right side of chair when up if leaning to right
- Recline in wheelchair when not eating.

During continuous observations on 3/13/18, from 6:40 p.m. until 8:31 p.m., R12 was observed sitting in a Broda wheelchair, with shoulder bolster cushions positioned on the right and left sides of the chair. The chair was in an upright (not reclined) position. R12's eyes were closed, her head drooping forward, and she was leaning to the right.

On 3/13/18, at 7:33 p.m. an unidentified staff member entered room, and administered liquid Tylenol to R12. The staff left room without

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2 830	Continued From page 6	2 830		

repositioning R12 or placing chair in reclined position.

On 3/14/18, at 7:04 a.m. R12 sat in Broda chair, in an upright position, in her room, with her head leaning to the right.

- At 7:29 a.m. R12 was transported by unidentified staff to the large activities room. R12 was observed to be leaning significantly to the right side, with chair in an upright position.

- At 7:49 a. m. R 12 was observed sitting upright in the Broda chair, leaning to the right, with her ear nearly touching her shoulder.

- At 7:57 p.m. the Director of Nursing (DON) transported R12 to the dining room. R12 continued to lean to the right, with her right ear almost resting on shoulder. DON repositioned R12 at this time. On continuous observation until 9:07 a.m. R12 was observed to be leaning significantly to the right with right ear touching right shoulder. The back of R12's head was resting on the outer portion of the right shoulder bolster on the chair.

- At 9:08 a.m. R12 was transported to the activities room, by the DON. R12 remained in an upright position, leaning to the right with her eyes closed.

- At 9:23 a.m. an activity began. R12's positioning was unchanged.

- At 11:33 a.m. R12 was sitting in activities area, in the Broda chair, with head tilted to the right, resting on the outside of the padded area and drooping forward. The chair was in a reclining position.

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2 830	Continued From page 7	2 830		

- At 12:14 p.m. R12 was observed sitting in the dining area, reclined in the Broda chair with her head tilted to the right resting on the outside of the pad.

R12's Positioning Assessment and Evaluation dated 2/26/18, indicated that R12 did not make needs known and was dependent on staff to anticipate and meet all needs. Upright in wheelchair for meals and recline in wheelchair when not eating. The evaluation indicated not to use neck pillow which was inconsistent with care plan that directed staff to use the pillow for positioning as needed.

R12's Occupational Therapy (OT) Plan of Care dated 3/24/17, indicated R12 presented with a decline in neck positioning over the past 3 weeks due to progressing dementia and increased stiffness to neck. Patient demonstrated increased forward head and neck flexion. The OT goal of therapy was for R12 to be able to hold her midline head positioning with no use of neck pillow for 2.5 hours with appropriate positioning; reclined while in Broda wheelchair and upright ONLY for meals.

R12's Therapist Progress & Discharge Summary - Occupational Therapy, dated 4/7/17, indicated gains in upright positioning for meals and good positioning when semi-reclined. The plan directed staff to position R12 in semi-reclined position when attending activities and upright for meals.

On 3/13/18, at 6:14 p.m. family member (FM)-I stated there are many times visiting, R12 is slumped over in the chair and staff had to be reminded to sit her upright. FM-I indicated she visited 3-4 times per week.

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2 830	Continued From page 8 On 3/15/18, at 08:49 a.m. RN-B stated R12 had been in Broda chair since admission and there had been no decline. RN-B stated staff should follow the care plan of reclining her chair when she is not eating. A neck pillow was used in the past and was pushing her head forward, so it was discontinued. Now that R12 was on Hospice, therapy was not indicated, although facility would look at positioning. RN-B stated staff had not identified R12 had positioning issues. RN-B stated they would leave resident in the upright position for up to 30 minutes after eating due to regurgitation issues. This was not on the care plan. The Mobility Support and Positioning: Positioning Procedure last revised 10/17, did not specify how to address positioning for residents with neck weakness in order to keep the neck in a forward mid-line position. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure skin problems are minimized and rapidly addressed if developed. All appropriate staff could be educated on these systems. The DON or designee could develop monitoring systems to ensure ongoing compliance and present results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		
2 855	MN Rule 4658.0520 Subp. 2 E. Adequate and Proper Nursing Care;Oral Hygiene Subp. 2. Criteria for determining adequate and proper care. The criteria for determining	2 855		4/12/18

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2 855	Continued From page 9 adequate and proper care include: E. Assistance as needed with oral hygiene to keep the mouth, teeth, or dentures clean. Measures must be used to prevent dry, cracked lips This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance with activities of daily living in accordance with the care plan for 1 of 4 residents (R16) who was dependent upon staff for all activities of daily living. Findings include: R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnosis including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required extensive assistance with all activities of daily living and was totally incontinent of bowel and bladder. The Activities of Daily Living Care Area Assessment (CAA) did not trigger at the time of the admission MDS. The Urinary Incontinence Care Area Assessment (CAA) dated 10/26/17, indicated R16 was totally incontinent of bowel and bladder and required assistance to check and change an incontinence brief. R16 required total assistance with all activities of daily living. The Bladder Assessment dated 10/16/17, indicated R16 was incontinent of bowel and bladder and identified the staff was to assist with	2 855	Complete	

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2 855	Continued From page 10	2 855		

Continued From page 10

check and change every two hours.

R16's care plan dated 1/11/18, directed the staff to provide the following care:

- Bathing, assist of one.
- Oral Cares: Assist of one with mouth cares.
- Personal hygiene: requires assist of one with personal hygiene
- Toilet use: Extensive assist of two to check and change.

On 3/13/18, at 7:36 p.m. nursing assistant (NA)-A and NA-E entered R16's room to assist with bedtime (HS) cares. R16 was observed to be resting in bed fully dressed. NA-A removed R16's pants. as NA-E opened R16's incontinent brief and performed perineal cares for R16. The NA's rolled R16 onto her side and completed perineal cares and applied a fresh incontinence brief. The NA's then dressed R16 in a fresh pajama top and covered her with the blankets. R16 was observed to yell out during the cares. NA-E explained to R16 on three occasions that as soon as the cares were done she would be allowed to rest. NA-E stated " we are all done now, you have a good night" as she covered R16 with a blanket and turned out the lights. The NA's were not observed to assist R16 with washing her hands, face, upper body or provide oral cares.

- At 7:48 p.m. NA-E confirmed R16 had received bedtime (HS) cares and the next time the staff would assist her with cares would be during "last rounds" at the end of the shift. NA-E confirmed R16 had not received oral cares and had not been given the opportunity to wash her face, hands or upper body.

- At 7:50 p.m. NA-A confirmed R16 had been

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2 855	Continued From page 11	2 855		

Continued From page 11

dressed in her pajamas and had not received assistance with oral cares or washing her upper body. NA-A stated he/she would return to R16 and complete HS cares.

On 3/14/18, during continuous observations from 7:07 a.m. to 10:50 a.m. R16 was not observed to receive assistance with incontinence cares. At 7:07 a.m. R16 was observed seated in a reclining geri chair in the hallway by the nurses station. At 7:14 a.m. R16 was wheeled to the dining room and served breakfast. R16 remained in the dining room until 9:30 a.m. at which time she was wheeled into the activity room/ Cedar lounge area.

- At 10:46 a.m. NA-D stated she did not know when the last time R16 had been assisted with incontinence cares.

- At 10:50 a.m. NA-C stated she had assisted R16 out of bed at 6:30 a.m. and had not assisted her with incontinence cares since that time.

- At 10:52 a.m. NA-C and NA-D wheeled R16 from the Cedar lounge to her room and transferred R16 from the chair to the bed via a full body mechanical lift. Once in bed, NA-C and NA-D changed R16's incontinence brief. R16 was observed to be incontinent of urine.

- At 11:05 a.m. NA-C confirmed R16 had not received incontinence cares between 6:30 a.m. and 10:50 a.m. a total of 4 hours and 20 minutes.

- At 1:45 p.m. registered nurse (RN)-A stated bedtime cares were to include washing the residents face, hands, and upper body along with oral cares. RN-A stated R16 was to be assisted with incontinence cares every two hours. RN-A

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2 855	Continued From page 12 confirmed R16 had not received cares in accordance with her care plan. On 3/15/18, at 1:15 p.m. the director of nurses stated R16 was to receive cares in accordance to the care plan. The Oral Hygiene policy dated 9/2012 and revised on 10/2017, directed the staff to provide oral cares. The Bathing policy dated 9/2012, and revised on 10/2017, directed the staff to bathe the residents upper and lower body. The Toileting Program policy dated 9/2017, and revised on 2/2016, directed the staff to provide assistance with check and change every two hours. A policy related to care plans was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to ensure oral care is offered and provided as individually assessed to be required. The DON or designee could educate all appropriate staff on the systems. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance group for ongoing recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 855		
2 905	MN Rule 4658.0525 Subp. 4 Rehab - Positioning	2 905		4/12/18

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2 905	Continued From page 13	2 905		

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 document review, the facility failed to ensure a resident identified at risk for pressure ulcers received the necessary care and treatment to prevent the development of pressure ulcers for 1 of 4 resident (R16) in the sample identified at risk for pressure ulcers.

Complete

Findings include:

R16's admission Minimum Data Set (MDS) dated 10/17/17, identified R16 with severe cognitive impairments and diagnoses including Alzheimer's disease, dementia and status post hip fracture. The assessment indicated R16 required extensive assistance with all activities of daily living and at risk for the development of pressure ulcers.

The Pressure Ulcer Care Area Assessment (CAA) dated 10/26/17, identified R16 at risk for the development of pressure ulcer and indicated R16 had an individualized turning/repositiong program and required a full body mechanical lift for transfers.

R16's Braden Scale for Predicting Pressure Sore

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GOOD SAMARITAN SOCIETY - WOODLAND	**100 BUFFALO HILLS LANE BRAINERD, MN 56401**

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2 905	Continued From page 14 Risk dated 3/12/18, indicated R16 was at high risk for the development of pressure ulcers. R16's Positioning Assessment and Evaluation dated 3/12/18, indicated R16 was at high risk for pressure ulcers and directed the staff to turn and reposition R16 at least every two ours. R16's care plan dated 1/11/18, identified R16 at risk for the development of pressure ulcers and directed staff to assist R16 with turning and repositiong every two hours. On 3/14/18, during continuous observations from 7:07 a.m. to 10:50 a.m. R16 was not observed to receive assistance with repositiong. At 7:07 a.m. R16 was observed seated in a reclining geri chair in the hallway by the nurses station. At 7:14 a.m. R16 was wheeled to the dining room and served breakfast. R16 remained in the dining room until 9:30 a.m. at which time she was wheeled into the activity room/ Cedar lounge area. - At 10:46 a.m. NA-D stated she did not know the last time R16 had been assisted with incontinence cares. - At 10:50 a.m. NA-C stated she had assisted R16 out of bed at 6:30 a.m. and had not assisted her with repositiong cares since that time. - At 10:52 a.m. NA-C and NA-D wheeled R16 from the Cedar lounge to her room and transferred R16 from the chair to bed via a full body mechanical lift. R16's geri chair was observed to be equipped with a pressure redistribution cushion. R16's skin was observed to be pink and intact. - At 11:05 a.m. NA-C confirmed R16 had not	2 905		

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2 905	Continued From page 15 received assistance to repositiong between 6:30 a.m. and 10:50 a.m. a total of 4 hours and 20 minutes. - At 1:45 p.m. registered nurse (RN)-A stated R16 was to be repositioned every two hours in accordance with her care plan. On 3/15/18, at 1:15 p.m. the director of nursing stated R16 was to receive cares in accordance with her care plan. The Mobility Support and Positioning policy dated 2/2013, directed the staff to to develop an individualized repositioning schedule based on the residents risk factors. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop systems to minimize the risk of pressure ulcers and ensure appropriate treatment should they develop. The DON could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 905		
21015	MN Rule 4658.0610 Subp. 7 Dietary Staff Requirements- Sanitary conditi Subp. 7. Sanitary conditions. Sanitary procedures and conditions must be maintained in the operation of the dietary department at all times.	21015		4/12/18

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21015	Continued From page 16 This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that kitchen equipment and kitchen floor was kept in a sanitary manner. This has the potential to affect all 30 of 30 residents who received meals from the kitchen. Findings include: On 3/12/18, at 10:30 a.m. the initial tour of the kitchen was completed with Registered Dietician (RD)-A. The following concerns were identified and verified by (RD)-A: -The floors throughout the kitchen were observed to have approximately one inch of debris along the floor boards. On 3/14/18, at 11:01 a.m., during a tour of the kitchen with (RD)-A the following areas of concern were noted and confirmed by (RD)-A: -The toaster, which was located on a counter in the prep area, had a layer of dried debris on the outer surface and numerous crumbs surrounding it. -The two ovens, one located on each side of the six burner stove, were observed to be splattered with black debris build-up on the sides nearest the stove top. -The large oven/steamer was coated with a white, flaky substance, on the interior of the oven. (RD)-A confirmed this was lime build-up. (RD)-A stated ovens are to be cleaned monthly; tops of stoves and floors daily. The General Sanitation Procedure dated as last revised 9/17, stated the food preparation, kitchen, and serving areas were cleaned and sanitized on a regular basis to limit contamination and prevent	21015	Complete	

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21015	Continued From page 17 food borne illness. SUGGESTED METHOD OF CORRECTION: The director of food and nutrition services (DFNS) or designee could develop systems to ensure sanitary conditions are developed and maintained in the kitchen. The DFNS could educate all appropriate staff. The DFNS or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21015		
21040	MN Rule 4658.0620 Subp. 3 Frequency of Meals; Time between meals Subp. 3. Time between meals. Up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group, such as the resident council, agrees to this meal span and a nourishing evening snack is provided. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure that breakfast was no later than 14 hours after the evening meal for 1 of 1 residents (R27) reviewed that required assistance with eating. Findings include: R27's admission Minimum Data Set (MDS) dated 2/8/18, indicated R27 displayed mild cognitive impairments and had diagnoses of anemia and	21040	Complete	4/12/18

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weakness. The assessment indicated R27 had the ability to eat independently after set up.

R27's care plan dated 2/15/18, indicted R27 was able to eat independently after set up.

R27's Progress Note dated 3/8/18, indicated R27 had returned to the facility following hospitalization due to pneumonia with sepsis.

R27's Progress Note dated 3/13/18, at 4:18 p.m. indicated R27 was on clostridium difficile (C-Diff) contact isolation precautions.

On 3/13/18, at 5:30 p.m. R27 was observed resting in bed. Nursing assistant (NA)-B was observed to apply personal protective equipment (PPE) including a gown, gloves and a mask and delivered a meal to to R27. The meal consisted of a cup of soup, a meat sandwich, ice cream and beverages. NA-B placed the meal items on an over-bed table next to the window and exited the room. At no time was NA-B observed to attempt to assist R27 with the meal.

- At 6:03 p.m. NA-A applied PPE and entered R27's room. NA-A raised the bed and sat next to R27 in an attempt to feed him. At 6:10 p.m. NA-A placed R27's food in the garbage and reported R27 refused to eat. No other staff members were observed to attempt to assist R27 with any type of nourishment.

- At 7:20 p.m. activity aide (AA)-A was observed to pass the evening snacks to the residents in their room. AA-A was not observed to attempt to offer R27 as snack as R27 was observed sleeping in his bed.

Review of R27's bedtime (HS) snack report

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indicated R27 had been sleeping when offered a snack on 3/13/18. R27 had not received a snack.

On 3/14/18, at 7:30 a.m. R27 was observed to be awake sitting on the edge of his bed. NA-C and licensed practical nurse (LPN)-A were observed to assist R27 with morning cares. At 8:00 a.m. R27 was observed to be transferred from the bed into a reclining geri chair in his room.

- At 9:00 a.m. R27 was observed to be sleeping in the geri chair in his room. R27 had not been offered breakfast.

- At 9:24 a.m. cook-A stated the breakfast trays would be dished and delivered to the residents in their rooms between 9:30 a.m. and 10:00 a.m. Cook-A stated she did not prepare and deliver the breakfast trays to the nursing unit until the last resident in the dining room had been served. Cook-A confirmed R27's tray had not been sent to the nursing unit from the kitchen yet.

- At 9:30 a.m. dietary aide (DA)-A was observed to deliver the meal cart containing 8 breakfast trays to the nurses station. DA-A stated all of the residents who ate in their rooms were able to feed themselves.

- At 9:43 a.m. NA-F donned PPE, entered R27's room and delivered a breakfast tray.

- At 9:50 a.m. NA-F left R27's room. NA-F was not observed to attempt to assist R27 with the meal. R27 was not observed to attempt to feed himself.

- At 9:56 a.m. NA-C entered R27's room and assisted him with the meal. R27 had not attempted to feed himself.

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- At 2:20 p.m. registered nurse (RN)-B stated the staff were to assist the residents when the meals were delivered to them. RN-B stated R27 had been rapidly declining since returning from the hospital on 3/8/18. R27 required extensive assistance with activities of daily living including eating. RN-B confirmed R27 had not had a snack on the evening of 3/13/18, and did not receive assistance with breakfast until 10:00 a.m. RN-B confirmed R27 had not been offered a meal between 6:00 p.m. on 3/13/18 and 10:00 a.m. on 3/14/18, a total of 16 hours.

On 3/15/18, at 8:35 a.m. the dietary director (DD) stated the breakfast trays were to leave the kitchen between 9:30 a.m. and 9:45 a.m. The DD stated the residents who eat in their rooms were to be independent in eating, however, R27 was under contact isolation precautions due to C-Diff. R27 had also had a rapid decline in his health and required additional assistance. The staff members could have asked for his breakfast tray earlier, but confirmed it had not been requested. The DD confirmed R27 was not offered a meal for greater than 14 hours.

The Frequency of Meals and Snacks policy dated 2/2013 and revised on 9/2017, indicated the facility was to ensure no more than 14 hours between a substantial evening meal and breakfast the following day.

SUGGESTED METHOD OF CORRECTION:
The director of food and nutrition services (DFNS) or designee could develop systems to ensure meals and snacks are offered and provided in a timely manner. The DFNS could educate all appropriate staff. The DFNS or designee could develop monitoring systems to

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21040	Continued From page 21 ensure ongoing compliance and report results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21040		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		4/12/18

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21390	Continued From page 22 This MN Requirement is not met as evidenced by: See F880 SUGGESTED METHOD OF CORRECTION: The infection preventionist (IP) or designee could develop systems to ensure a comprehensive infection program is developed, implemented, and monitored. The IP could educate all appropriate staff. The IP or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance group for further recommendations. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390	Complete	
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If	21540		4/12/18

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the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA.

This MN Requirement is not met as evidenced by:
Based on observation, interview and document review the facility failed to ensure a clinical rationale for the extended use of an as needed (PRN) antianxiety medication (Ativan/lorazepam) beyond 14 days and a specific duration for use was documented for 1 of 5 residents (R29) whose medication regimen was reviewed.

Complete

Findings include:

R29's significant change Minimum Data Set (MDS) dated 2/23/18, indicated R29 was cognitively intact and had diagnoses which included malignant neoplasm of left kidney, diabetes mellitus, depression and anxiety. The MDS also indicated R29 received antianxiety medication 7 days during the assessment period.

R29's Psychotropic Drug Use Care Area Assessment (CAA) dated 2/23/18, indicated R29 had a diagnosis of anxiety and received Ativan daily. The CAA also indicated R29 was referred to St. Croix Hospice to help maintain emotional and physical comfort during end of life related to end stage renal carcinoma.

R29's Order Summary Report print date 3/14/18, included order's for lorazepam 0.25 milliliters (ml) give three times daily related to anxiety disorder, and lorazepam intensol concentrate 0.25 ml by mouth every four hours as needed PRN for anxiety. The start date of the PRN lorazepam was 2/22/18. The order lacked a duration for use.

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R29's Medication Record indicated lorazepam was scheduled and administered daily, additionally, PRN lorazepam was administered on 3/3, 3/7, 3/8, and 3/9/18.

On 3/13/18, at 1:50 p.m. R29 was observed in her room, lying in bed. R29 was resting with her eyes closed and the television on. No adverse mood or behaviors were observed.

On 3/14/18, at 12:29 p.m. R29 was observed lying in bed while visiting with her granddaughter. No adverse mood or behaviors were observed. The granddaughter stated my grandmother is not as anxious as she was when she first came, she was scared but has settled down.

R29's Consultant Pharmacist Medication Review dated 2/22/18, included the following pharmacist recommendation: "A specific duration for use for greater than 14 days is required for R29's PRN Ativan use.

R29's record lacked physician documentation of a clinical rationale for the long term use or identify a duration of use for the PRN lorazepam. The PRN lorazepam was available for use as needed for anxiety in addition to scheduled lorazepam.

On 3/14/2018, at 11:55 a.m. registered nurse (RN)-A confirmed R29 had episodes of increased anxiety and utilized her PRN lorazepam. RN-A stated we have been adjusting her scheduled lorazepam, however, we failed to address the PRN Lorazepam. RN-A confirmed R29's lorazepam should have had the 14 day parameter or clinical rationale for long term use. RN-A confirmed the PRN lorazepam order was not addressed. RN-A confirmed the PRN order had

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been in place since R29's admission on 2/16/18.

On 3/15/18, at 8:29 a.m. consulting pharmacist (CP) stated a recommendation had been provided to the facility in February requesting the PRN lorazepam be addressed for the 14 day parameter and or justification and duration of the PRN medication use.

- At 2:40 p.m. the director of nursing stated she would have expected there to be a documented rational and duration for the continued use of PRN lorazepam as required.

The facility Psychotropic Medications Policy, revised 6/17, directed staff to ensure PRN psychotropic medications had clear parameters. PRN orders for psychotropic drugs are limited to 14 days. If the attending/prescribing practitioner believes that it is appropriate to extend the order past 14 days, rational should be documented in the medical record and indications of the duration of use for the PRN medication identified.

SUGGESTED METHOD OF CORRECTION:
The director of nursing (DON) or designee could develop systems to ensure unnecessary medications are identified and addressed by the appropriate practitioner. The DON could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report results to the quality assurance group for further recommendations.

TIME PERIOD FOR CORRECTION: Twenty-one (21) days.