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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: O99K

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00617

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245598**

2.STATE VENDOR OR MEDICAID NO.
(L2) **641543100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ARLINGTON**
(L4) **411 SEVENTH AVENUE NORTHWEST**
(L5) **ARLINGTON, MN** (L6) **55307**

4. TYPE OF ACTION: **2** (L8)

1. Initial	**2. Recertification**
3. Termination	**4. CHOW**
5. Validation	**6. Complaint**
7. On-Site Visit	**9. Other**
8. Full Survey After Complaint	

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/27/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **35** (L18)

13.Total Certified Beds **35** (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
	35			
(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 :
Gloria Derfus, HFE NEII 12/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 12/19/2017 (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
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/07/2017
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245598

December 19, 2017

Ms. Krista Swoboda, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, MN 55307

Dear Ms. Swoboda:

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

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

Effective November 15, 2017 the above facility is certified for:

35 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 35 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

Electronically delivered
December 19, 2017

Ms. Krista Swoboda, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, MN 55307

RE: Project Number S5598028

Dear Ms. Swoboda:

On October 20, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on October 5, 2017. 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 November 27, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on November 30, 2017 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on October 5, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of November 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on October 5, 2017, effective November 15, 2017 and therefore remedies outlined in our letter to you dated October 20, 2017, 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 related to this letter.

Sincerely,

Mark Meath

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: O99K

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(L3) **GOOD SAMARITAN SOCIETY - ARLINGTON**
(L4) **411 SEVENTH AVENUE NORTHWEST**
(L5) **ARLINGTON, MN** (L6) **55307**

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1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **10/05/2017** (L34)

8. ACCREDITATION STATUS: __ (L10)
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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)
12/31

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

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13.Total Certified Beds (L17)

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A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	35			
(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 :
Magdalene Jares, HFE NE II 10/27/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 12/06/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
10/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
October 20, 2017

Ms. Krista Swoboda, Administrator
Good Samaritan Society - Arlington
411 Seventh Avenue Northwest
Arlington, MN 55307

RE: Project Number S5598028

Dear Ms. Swoboda:

On October 5, 2017, 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 a "F" tag), i.e., the plan of correction should be directed to:

Gloria Derfus, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: gloria.derfus@state.mn.us
Phone: (651) 201-3792
Fax: (651) 215-9697

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 November 14, 2017, 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 November 14, 2017 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 January 5, 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 April 5, 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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@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
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 10/2/17, through 10/5/17, a recertification survey was completed by surveyors from the Minnesota Department of Health (MDH) to determine compliance with requirements at 42 CFR Part 483, subpart B, requirements for Long Term Care Facilities. The facility's electronic Plan of Correction (ePoC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePoC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the PoC will be used as verification of compliance.	F 000		
F 157 SS=D	483.10(g)(14) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) (g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is,	F 157		11/14/17

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

Electronically Signed | 10/27/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 157	Continued From page 1 a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to notify the physician regarding for 1 of 1 resident (R9) reviewed for notification of change, who experienced a significantly low blood pressure. Findings include: R9 had a Physician's Order dated 5/10/16 to take	F 157	1. R9 vital signs were assessed are currently stable. 2. All residents who have a diagnosis of hypertension were reviewed to ensure abnormal values were addressed with their physician. No other residents were identified. 3. All nursing staff will be provided with re-education on GSS policy and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 157	Continued From page 2 Lisinopril (used to treat high blood pressure) 10 milligrams by mouth every day. A health status Progress Note dated 5/26/17, indicated R9 had informed staff at 4:00 p.m. that she'd been outside in the court yard longer than normal and didn't feel well. At that time, R9's vital signs were documented as: temperature: 100.0, pulse 57, oxygen 97%, respirations 18, blood pressure 56/32. The Progress Note further indicated R9 had informed staff she had a condition that increased her risk of dehydration and heat stroke and R9 had informed staff she didn't think she'd been drinking an adequate amount of fluids. R9's Weights and Vitals Summary printed 10/5/17, indicated R9's blood pressure readings for the month of May 2017 had been documented as ranging between 95/55 to 123/67. In addition, five of the seven blood pressures taken for the month of May 2017 indicated a -10% change from baseline. The medical record lacked documentation of whether the physician had been notified to provide direction regarding the resident's low blood pressure reading of 56/32 and the resident's reported symptoms of not feeling well, and history of dehydration/heat stroke. R9's Diagnoses List printed 10/5/17, indicated R9 had diagnoses including atrial fibrillation, mild cognitive impairment, and hypertension (high blood pressure). On 10/5/17, at 7:20 a.m. registered nurse (RN)-A was interviewed and stated a blood pressure of 56/32 was quite low and abnormal for R9. RN-A also stated the physician should have been called	F 157	procedure and Interact Change in condition cards for notifying physician of abnormal BP values for resident receiving Hypertensive. Interact Change of condition cards will be posted at the nursing station for easy access after the education occurs. This education will be completed by the DNS November 7, 2017. 4. Audits of medical records to ensure any abnormal BPs are communicated to physician timely will be conducted for R9 and random other residents by DNS or designee weekly X 4 then monthly X 3 with findings taken to quality committee for further recommendations. 5. Date of completion November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 157	Continued From page 3 to report the unusually low blood pressure reading. The interim director of nursing (DON) was interviewed on 10/5/17 at 7:43 a.m. and acknowledged a blood pressure of 56/32 was unusually low and abnormal for R9. The DON stated she would have expected staff to call and notify the physician of the low blood pressure. The facility's policy titled Notification of Change dated 11/16, directed staff to notify the physician when there was a significant change in the resident's physical, mental, or psychosocial status.	F 157		
F 164 SS=E	483.10(h)(1)(3)(i); 483.70(i)(2) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS 483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. (h)(3)The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. §483.70 (i) Medical records. (2) The facility must keep confidential all	F 164		11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 164	Continued From page 4 information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility staff failed to ensure 4 of 4 residents reviewed for activities of daily living (ADLs) (R7, R3, R15 and R19), and 1 randomly observed resident (R11) were afforded privacy during care. The findings include: R11 was observed on 10/3/17, at 7:54 a.m. R11 was in bed and covered, cares were being observed for roommate R19. R11 got up and ambulated to the bathroom. R11 was observed moving in the room between the bathroom and her bedside four times between 7:54 and 8:33 a.m. Both NA-A and TMA-A separately went into	F 164	1. R7 has expired. Staff caring for R3, R15 and R19 and R11 were provided with education regarding providing privacy with cares. 2. All residents have the potential to be affected. 3. All staff will be provided re-education on GSS policy and procedure and Resident rights for privacy by DNS or designee on November 7 4. Observation audits for Privacy with cares will be conducted for R3, R15, R19, and R11 and for random other residents by DNS or designee weekly x4 and monthly x3. Findings will be taken to Quality Committee for further	

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F 164	Continued From page 5 the bathroom to wash their hands, while R11 used the bathroom. R11 was not afforded privacy while using the bathroom nor was R11 asked by the staff if they could enter the bathroom while R11 was in there, until after the staff had entered the bathroom and started washing their hands. R11's record was reviewed and indicated the resident had been admitted to the facility on 10/21/16, with diagnoses of osteoarthritis, amnesia, hypothyroidism, overactive bladder and muscle weakness. R11's admission Care Area Assessment (CAA) dated 11/1/16, indicated R11 was confused at times, was working with PT (physical therapy) and OT (occupational therapy), sometimes refused activities of daily living cares. R11's back and hip pain were causing need for more assistance, at times refused to toilet or allow staff to change her. In addition the CAA indicated R11's dementia had increased and R11 would make unsafe choices at times. Staff were aware and watchful to assure safety. The CAA directed staff to use adult protection for incontinence and at times R11 refused to allow staff to help her after incontinence, re-approach, reassurance and instruction attempted repeatedly. R11's quarterly MDS dated 7/13/17, indicated R11 had significant cognitive loss, required supervision and encouragement or cueing from one staff for bed mobility and eating. In addition, the MDS indicated R11 required limited assistance of one staff for transfers, locomotion in room and on unit, dressing, toilet use and personal hygiene and R11 was frequently incontinent of urine. R15's impaired cognitive function care plan dated	F 164	recommendations. 5. Date of completion November 14, 2017	

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F 164	Continued From page 6	F 164		

12/3/16, instructed staff to ensure the resident had hearing aides in. R15's quarterly Minimum Data Set (MDS) dated 6/15/17, indicated R15 wore hearing aids and experienced minimal difficulty hearing in some environments when wearing hearing aids. The care plan printed 10/5/17, indicated R15 was to wear bilateral hearing aids when up.

During observations in the dining room on 10/2/17, at 12:16 p.m. registered nurse (RN)-A approached the dining room table where five residents, including R15, were seated and said to R15, "I have your hearing aids." RN-A then put hearing aids into R15's ears. RN-A did not ask R15 if it was ok to put the hearing aids in at the table in front of the other residents.

R3's communication plan dated 4/18/17, instructed staff to ensure hearing aids were in. R3's quarterly MDS dated 7/13/17, indicated R3 wore hearing aids and experienced moderate difficulty hearing.

During observations in the dining room on 10/3/17, at 8:57 a.m. RN-B stated to R3, "Do you want me to grab your hearing aids?" RN-B put hearing aids in R3's right and left ear without asking R3 if it was ok to put the hearing aids in at the table in front of the other residents.

R7's quarterly MDS dated 8/22/17, indicated the resident required extensive physical assistance of two staff with toileting and personal hygiene which included oral hygiene and pericares. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 9:25 a.m. RN-B approached with hearing aides, stood to R7's right and showed

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F 164	Continued From page 7	F 164		

them to R7 and applied put them to both ears as resident sat there looking at the food and other resident in the table ate. RN-B did not ask R7 if it was ok to put the hearing aids at the table in front of the other residents.

During dining room observation on 10/2/17, at 12:24 p.m. R19 was sitting at the dining room table with four other residents, the trained medication aide (TMA)-B and nursing assistant (NA)-A. RN-A was standing in the doorway of the dining room at the medication cart. R19 was attempting to feed herself using a fork. NA-A and TMA-B were discussing the need for R19 to have an assessment and possible different silverware because she kept missing her mouth when she tried to feed herself. This conversation occured in front of the other four residents. TMA-B stood up and went to R19 and repositioned the fork and stated to RN-A that R19 did better using a fork with her hand closer to the tines. TMA-B did not go to where RN-A was to speak about R19 privately. RN-A was approximately three and a half feet from the table.

R19's admission MDS dated 7/24/17, indicated R19 was severely cognitively impaired.

During interview on 10/2/17, at 3:37 p.m. TMA-B stated normally they were not supposed to discuss resident concerns in the dining room but stated she wanted the nurse to see the issue first hand.

During a dining room observation on 10/2/17, at 12:37 p.m. R1 was sitting at the dining room table with four other residents and the hospice nurse. RN-A was standing in the doorway of the dining room at the medication cart. The hospice nurse

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F 164	Continued From page 8 sat at the table which was three and a half feet away from RN-A and asked RN-A if R1 had and pain, what the pain level was, and if R1 had any break through pain. The hospice nurse did not go to where RN-A was to speak about R19 privately. R1's quarterly MDS dated 7/13/17, indicated R1 was severely cognitively impaired and was on hospice. During interview on 10/5/17 at 7:29 a.m., the DON stated it was unacceptable for staff to discuss resident's medical conditions where other residents and/or visitors could over hear.	F 164		
F 176 SS=D	483.10(c)(7) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE (c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to determine whether the practice of self administration of medications was safe for 2 of 2 residents (R1, R7) observed to have medications left in their room. Findings include: R1's room door was observed shut on 10/3/17, at 7:33 a.m. After knocking and being invited in, nursing assistant (NA)-A was observed to complete cares for R1. On the dresser next to resident bed was observed a 15 milliliter (ml) bottle of Liquitears 1.4% with directions to instill one drop to each eye two times a day. The eye	F 176	F176 1. R7 has expired. R1's eye drops were removed from her room and stored in the medication room. R1 was assessed for self-administration of medication and care plan/MAR was reviewed as appropriate. 2. All residents receiving nebulizer treatments and eye drops will be reviewed and assessed by nursing staff for self-administration and care plans updated as appropriate. These will be completed by 11/9/17. 3. All nurses/TMAs will be re-educated by DNS or designee on GSS Policy and Procedure for self-administration of	11/14/17

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F 176	Continued From page 9 drops remained on the bedside table while NA-A provided the care. The NA comleted the care at 7:49 a.m. During interview with registered nurse (RN)-A at 7:51 a.m., RN-A stated she had been in R1's room around 7:30 a.m. and had forgotten the eye drops on the bedside table. RN-A verified R1 did not have an order to self administer medications and stated she shouldn't have left the medication at the bedside. On 10/5/17, at 10:46 a.m. the interim director of nursing (DON) stated she would not expect eye drops to be left in a resident's room unless the resident had been assessed as appropriate to have medications in their room. The DON said the resident was supposed to be assessed, to make sure the resident was cognitively intact to have the medications in the room. The DON said to her recollection there was no resident in the facility with an order to self administer medications (SAM). R1's physician orders were reviewed. The physician order dated 6/6/17 revealed no order to self administer medications (SAM). R1's visual Care Area Assessment dated 4/19/17, identified R1 had a visual field deficit and had decreased visual acuity. The CAA also indicated R1 had severely impaired cognition and lacked information for R1 to self-administer the eye drops. During a medication pass observation on 10/3/17, at 7:47 a.m. RN-B retrieved an albuterol solution packet from the cart, went to R7's room and set	F 176	medications. 4. Audits will be conducted for R1 and random other residents by DNS or designee weekly X 4 then monthly X 3 to ensure residents receiving nebulizer treatments and eye drops. are being provided appropriate supervision or have been assessed as appropriate for self-administration of this medication. Results will be taken to quality committee for further recommendations. Date of completion November 14, 2017	

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F 176	Continued From page 10	F 176		

up and started nebulizer treatment via face mask. RN-B left the resident alone with the nebulizer being administered via the face mask. At 7:49 a.m., after recognizing the wrong medication had been used for the nebulizer, RN-B went in to remove the nebulizer treatment. When she returned to the medication cart, RN-B stated, "[R7] ended up pulling her mask off her face, so I do not think she got much."

R7's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 5/23/17, indicated "resident is disoriented, does not verbalize much though speech is clear when she does talk, nutritional intake is declining and she is somnolent much of the time. She is dependent in her mobility." The CAA also indicated R7 was on hospice. A quarterly Minimum Data Set (MDS) dated 8/22/17, indicated R7 had diagnosis of congestive heart failure and dementia.

R7's care plan review date 8/16/17, lacked evidence of any assessment/interventions to address whether the resident was safe to self-administer the nebulizer treatment.

R7's Medication Administration Record (MAR) and Treatment Administration Record (TAR) for 9/1/17 through 10/3/17, did not indicate directions for the resident to self administer the nebulizer treatment. A review of the resident's physician's orders, revealed a hand written order dated 10/2/17, "continue with Duoneb scheduled BID switch over to mask instead of hand held." There was no evidence of any direction for the resident to be able to safely self administer the nebulizer treatment. In addition, review of the electronic medical record lacked evidence indicating R7 had been assessed to safely administer the nebulizer.

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F 176	Continued From page 11 On 10/5/17, at 7:24 a.m. the interim DON was interviewed and stated R7 was not cognitively intact, could not self-administer medication, and should not be left alone during the duration of the nebulizer treatment. The DON confirmed there had been no assessment or identification on the care plan for SAM, because R7 was unable to self-administer medications. The DON also stated she would expect staff to stay with R7 during the nebulizer treatment. The DON reiterated there were currently no residents capable of self-administering medication residing in the facility. A Self-Administration of Medication policy was requested but not received.	F 176		
F 241 SS=E	483.10(a)(1) DIGNITY AND RESPECT OF INDIVIDUALITY (a)(1) A facility must treat and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life recognizing each resident's individuality. The facility must protect and promote the rights of the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 5 of 14 residents (R15, R3, R7, R19 and R1) in the stage two sample observed during dining, were treated in a dignified manner during dining. Findings include: During dining room observation on 10/2/17, at 4:51 p.m. nursing assistant (NA)-D was observed	F 241	F241 1. R7 has expired. Seating arrangements for R1, 3, 15 and 19 were reviewed and changes made to provide dignity with dining. . 2. All residents requiring dining assistance have been reviewed to ensure their location/position in the dining room affords them dignity while being assisted. 3. The facility will utilize larger square	11/14/17

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F 241	Continued From page 12 to stand while feeding R15 jello and sips of water. NA-D was observed to assist R7 with eating at the same time. At 5:07 p.m. NA-E, standing next to R15 and gave him a bite and a drink. Then proceeded to stand next to R1 to give her bites of food before going back to R15 and offering him bites. NA-E also stood next to R7 and offered R7 a drink. The administrator and interim director of nursing (DON) were in the dining room talking with surveyors and walked past staff standing and feeding without saying anything. At 5:18 p.m. NA-E, who stood next to R19, stated she was helping four people eat and did not have time to sit. NA-D came in and sat between R19 and R7 to assist with feeding. At 5:36 p.m. NA-E stated staff usually have to feed two to three residents and move between the residents. NA-E stated, "There was nobody else there so I had to go back and forth. Everyone was feeding at another table." On 10/3/17, at 9:07 a.m. dietary aide (DA)-A brought R1 to the dining room and placed R1 next to R3 at the table. DA-A said, "This table is not big enough for five wheel chairs." R3 started saying, "that's too close, that's too close." DA-A moved R3 by lifting on the wheelchair and moving the wheelchair. R3 became upset and said, "She moved the chair and the whole works, that woman is not supposed to be here. She does not know up from down." RN-B stopped what she was doing and talked to R3 and encouraged her to eat toast. During interview on 10/5/17 at 7:29 a.m., the DON stated it was unacceptable for staff to stand over residents while feeding them, and that staff were expected to sit and converse with residents. In addition, the DON stated staff need to inform a	F 241	tables for those that need assistance to ensure they have enough space and all residents needing assistance are sitting at the appropriate table based on their needs. Food and Nutrition staff and nursing staff will be re-educated on GSS policy and procedures for providing dignity and respect in the dining room by the DNS or designee on November 7, 2017 4. Observation audits will be conducted for R1,3,15 & 19 as well as random other residents to ensure residents are experiencing dining with dignity. The DNS or designee will conduct these audits weekly x 4 or monthly x3 with findings taken to Quality Committee for further recommendations. 5. Date of completion November 14, 2017	

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F 241	Continued From page 13 resident prior to moving their wheelchair to a different placement and it was not approrpiate to tip/lift a wheelchair off of the back wheels for staff convience of placing a resident in a different place at the table.	F 241		
F 282 SS=E	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow the care plan to provide assistance with eating, toileting, oral hygiene, repositioning, Range of Motion (ROM), and assistive devices for 7 of 8 residents (R1, R7, R19, R15, R11, R3, R2). Findings include: R1 was observed on 10/2/17, at 2:04 p.m. seated in a Broda wheelchair (specialized wheelchair) at the bedside in the bedroom. The bedroom was noted to have a strong odor of urine. R1 remained in the room until 3:45 p.m. At 3:46 p.m. an activity staff was observed to wheel R1 into the dining room for an activity until 4:02 p.m. At 4:06 p.m. staff was observed to wheel R1 to the aviary room and parked the wheelchair in front of the aviary. At 4:11 p.m. R1 was wheeled out of the aviary and sat outside the medication room	F 282	1. R 7 is expired. R1, 19, 15, 11, 3, and 2's care givers were re-educated on the care planned interventions for eating, toileting, oral hygiene, repositioning, ROM, and assistive devices. 2. All residents care planned interventions for these above mentioned ADLs have been reviewed with staff to ensure cares are being provided appropriately. 3. All CNAs will be provided re-education by the DNS or designee on accessing the resident Kardex and Policy and procedure for following the care planned interventions. This education will be provided on November 7, 2017 4. Observation audits for R1,19,15,11,3,and 2 and random other residents will be conducted by DNS or designee to ensure care planned	11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 282	Continued From page 14 across from the dining room. At 4:20 p.m. family member (F)-A came to visit R1 and wheeled R1 back to the resident's room. At 4:21 p.m. FM-A was interviewed about the help and assistance R1 needed with activities of daily living (ADLs) such as getting dressed, toileting, or cleaning teeth, F-A stated, "I question her oral hygiene." On 10/2/17, at 4:56 p.m. F-A was observed to wheel R1 into the dining room. When asked if the staff had offered to toilet R1 before coming to the dining room, F-A stated only the nurse had been to the room to give R1 medications. Between 5:00 p.m. and 6:00 p.m., R1 remained in the dining room where staff were observed seated next to her cuing her to eat. Throughout the resident observations, no staff offered R1 assistane with toileting nor did any staff offer, or provide assistance to check and change the resident. On 10/3/17, between 7:33 a.m. and 7:41 a.m., R1 was observed to receive assistance from NA-A with peri care, bed mobility and dressing, however staff did not offer nor provide oral hygiene/care assistance. On 10/3/17, trained medication aide (TMA)-A and nursing assiistant (NA)-A were observed at 9:04 a.m. to transfer R1 out of the bed to the Broda wheelchair using a Hoyer (mechanical) lift. The staff were observed to adjust R1's clothing, combed the resident's hair, but staff did not offer or provide oral hygiene/care. During continuous observations between 9:04 a.m.-11:55 a.m. on 10/3/17, the following was observed: At 9:06 a.m., NA-A wheeled R1 into the dining room. R1 remained in the dining for until 10:10 a.m., R1 ate breakfast slowly as staff cued her to	F 282	interventions for the above mentioned ADLs are being followed and findings will be taken to Quality Committee for further recommendations. 5. Date of completion: November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 282	Continued From page 15	F 282		

eat. At 10:07 a.m. NA-A approached resident and asked R1 if she done eating. At 10:10 a.m. NA-A then took a sheet of Kleenex and wiped around R1's mouth then tossed the soiled Kleenex then without washing their hands, NA-A wheeled resident out of dining room to the Chapel. At 10:33 a.m. R1 was wheeled out of the Chapel by staff and was assisted to sit outside the medication room. At that time NA-A was observed in the area but never offered to assist R1 to the toilet or to assist with any other ADLs. At 11:04 a.m. the activity staff approached R1 and asked if there was anything she wanted her to do for her. R1 stated "I don't have the ambition." R1 remained in the same area looking through a paper and some coloring sheets. At 11:55 a.m. after two hours and 51 minutes, the surveyor intervened and asked facility staff to reposition and toilet R1. At 11:57 a.m. the licensed practical nurse (LPN)-C and NA-A were observed to transfer R1 with a Hoyer lift into bed. At 11:59 a.m. LPN-A assessed R1's skin which was noted to be blanchable. NA-A and LPN-A were then observed to change R1's incontinent pad which was wet with urine, and NA-A was observed to provide perineal cleansing. The reisident was noted to have had a small of incontinent stool as well.

R1's care plan dated 10/2/16, indicated the resident had an ADL self-care performance deficit related to dementia and arthritis as evidenced by inability to transfer or ambulate and the need for help with activities of daily living (ADLs). R1's care plan indicated resident wore adult protection for incontinence, required staff assistance to perform toileting hygiene and was to check and change every two hours with morning cares, before or after meals, with evening cares and as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 282	Continued From page 16	F 282		

needed. In addition, the care plan directed staff for oral care resident had own teeth and staff was to assist with oral care, staff was to cue R1 to do what she can, then finish.

On 10/3/17, at 12:42 p.m. the interim director of nursing (DON) stated she would expect the nursing assistant to ask for assistance if they were running behind repositioning, toileting, checking and changing residents. DON stated the staff was supposed to follow the care plan for all residents.

R7 was observed on 10/3/17, at 7:53 a.m. NA-A was observed in R7's room and was getting supplies ready to get resident ready for the day. NA-A stated she was going to get R7 upper body cleaned and was going to need assistance with the lower body and pericare because resident grab bars had been taken off and was not able to help now. At 7:54 a.m. to 8:03 a.m. NA-A washed R7's upper body, applied shirt and then lowered the bed and stated she would come back with another staff to finish the cares. At 8:42 a.m. to 8:51 a.m. NA-A and TMA-A came to room with the Hoyer lift and both applied gloves and TMA-A approached R7 and stated they were going to get her up for breakfast. NA-A provided pericare and transferred R7 never offered oral hygiene.

On 10/3/17, at 8:53 a.m. the following was observed during a continuous observation for (two hours and 46 minutes). At 8:54 a.m. NA-A wheeled R7 to dining room never offered oral hygiene. At 9:10 a.m. dietary staff brought R7 a bowl of cereal with bananas, a plate with sausage and French toast and set it in front of resident after cutting it up in small pieces. The plate had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 17	F 282		

guard on one side and R7 sat there looked at the food. At 9:16 a.m. R7 picked up the glass of water and was observed drink out of it. At 9:21 a.m. R7 sat at the table no assistance offered at that time as she sat there looking at the food and was observed attempt to grab the fork but noted with tremors in both hands and set the fork on the plate. At 9:25 a.m. registered nurse (RN)-B sat between R1 and R7 stated she was going to help. At 9:27 a.m. RN-B stood up spoke briefly with the interim DON who then sat between R1 and R7 as RN-B went to the medication cart parked outside the dining room. At 9:28 a.m. almost immediately DON left and went to the medication cart and RN-B returned to the table at then asked R7 "Do you want food." At 9:30 a.m. (which was 20 minutes after the food was set in front of R7), RN-B then picked the fork gave a bit of French toast and R7 refused to open her mouth. At 9:33 a.m. RN-B was overheard ask the activities director "can you feed?" and the activities director stated "no I can't." RN-B then left the table never re-approached R7 or offer another bite of food. At 9:34 a.m. as NA-A wheeled another resident to the assistance table RN-B stated "I need someone to fed people I have meds and treatments to do." NA-A stated "We are still getting people up." At 9:41 a.m. which was 11 minutes since R7 had been offered a bite of food TMA-A approached the table spoke to NA-A none of the staff offered R7 another bite as R7 sat there. At 9:43 a.m. the activities director approached and cued R7 to drink and offered to bring her to church then left. At 9:46 a.m. R7 continued to stare at the plate of food no staff to that point had re-approached or sat with her since RN-B left. At 9:51 a.m. TMA-A approached R7 offered a bite of banana pieces while standing and that time R7 opened her mouth took the bite.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 18	F 282		

At 9:52 a.m. to 10:05 a.m. TMA-A sat next to R7 and assisted with eating and R7 ate all the French toast and cereal with banana with approximately 240 milliliters of fluids. At 10:08 a.m. RN-B wheeled R7 to the room and covered her with a blanket and left. At 10:15 a.m. resident observed in her room and the tooth brush on top of sink in a sealed wrap.

On 10/3/17, at 11:38 a.m. when surveyor approached and asked R7's toilet needs RN-B stated R7 was supposed to be checked and changed every two hours as she had been identified at risk for skin issues. At the same time when NA-A was asked about toileting R7 she stated "we are running really late today." At 11:40 a.m. after surveyor brought concern to facility attention then NA-A and RN-B transferred R7 to bed. NA-A provided pericare and stated R7 was barely wet and had a bowel movement. During the cares no oral care was offered.

R7's care plan dated 8/16/17, indicated resident had a self-care deficit related to terminal illness of end stage dementia and congestive heart failure as evidenced by inability to perform ADL's and sat in the assistance table for meals. The care plan directed staff to provide prompting verbal cueing to eat, to provide assistance to eat, for oral care R7 required total assist. In addition, the care plan directed staff for toilet use R7 was incontinent of bowel and bladder and staff was to provide check and change every 2 hours and as needed.

R7's diagnoses included Alzheimer's, dementia, depression, anxiety and diabetes mellitus obtained from the quarterly MDS dated 8/22/17. The MDS indicated resident required extensive physical assistance of two staff with toileting and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 19	F 282		

personal hygiene which included oral hygiene and pericare. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 1:57 p.m. NA-A verified she had not provided oral hygiene for residents because of stretched help. She indicated she would usually use the toothettes instead of the tooth brush and had not had time to do it. She indicated one of the staff that was supposed to work had indicated she was not coming to work and the director of nursing did not know until around noon. NA-A acknowledged R1 and R7 were at risk for skin breakdown and verified R1 and R7 were supposed to be repositioned at least every two hours. NA-A acknowledged R1's and R7's care plans for oral hygiene, eating, repositioning and toileting had not been followed.

Toileting/repositioning:
R19's significant change MDS dated 9/12/17, noted R19 to be occasionally incontinent and frequently incontinent of bowel. R19's Urinary Care Area Assessment (CAA) dated 7/28/17, indicated R19 was "not incontinent." R19's ADL care plan revised 9/18/17, for toileting noted R19 required assistance to use the bathroom. Offer toileting before/after meals and at bedtime due to forgetfulness and dementia.

On 10/3/17, at 7:54 a.m. R19 remained in bed, the wheelchair was next to bed. At 8:16 a.m. NA-A and NA-B entered room. R19 had defected in bed, removed her incontinent product and had been laying in feces. NA-A and NA-B performed morning cares. At 8:34 a.m. R19 was brought to dining room and remained there until 9:50 a.m. At 9:50 a.m. R19 was just removed from dining room. TMA-A took her to door and then asked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 20	F 282		

another staff to take her to church. At 10:33 a.m. R19 returned from chapel to day room outside of dining room, had portions of newspaper in her hands, and a coloring paper, had not been toileted. At 11:09 a.m. R19 was asleep with paper in front of her. Then R19 woke up and was gazing across table. At 11:16 a.m. R19 was asleep at table again. At 11:42 a.m. R219 received her pills by TMA-A. R19 attempted to put her glasses in her mouth instead of swallowing water. R19 went to eat lunch was not toileted prior to the meal service. At 2:08 p.m. R19 had attended an activity and still not been toileted or repositioned.

On 10/4/17, at 10:31 a.m. the DON stated staff was to follow the written care plan.

Oral care:
On 10/3/17, at 8:34 a.m. R19 was brought to dining room. No oral care was provided. At 9:50 a.m. R19 ate some French toast, and some meat. R19 was removed from dining room (was removed from the table without saying anything to her) TMA-A took her to door and then asked another staff to take her to church. At 10:33 returned from chapel to day room outside of dining room, had portions of newspaper in her hands, and a coloring paper, had not had oral care nor was R19 offered oral care. At 11:09 a.m. was asleep with paper in front of her. Then R19 woke up and was gazing across table. At 11:16 a.m. R19 was asleep at table again. At 11:42 a.m. received her pills by TMA-A. Oral care had not been provided for R19.

R19's care plan dated 7/17/17, noted R19 had her own teeth, broken teeth, will set up and encourage daily oral care. R19 did not receive staff assist with oral care.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 21	F 282		

Feeding assist:
On 10/3/17, at 8:34 a.m. R19 was brought to dining room. At 9:50 a.m. R19 ate some French toast, and some meat, but was slow to eat and was not encouraged or assisted. R19 was just removed from dining room (was removed from the table without saying anything to her). TMA-A took her to door and then asked another staff to take her to church.

On 10/4/17, at 7:33 a.m. R19 was sitting at table in day room, in front of dining room, paging through a magazine. At 8:03 a.m. R19 was moved into dining room. At 8:09 a.m. beverages were offered and R19 was assisted by dietary aide (DA)-A to get a sip of coffee. Orange juice and milk small glasses are filled in front of her. At 8:13 a.m. R19 continued to hold the coffee cup in her hand, but was staring off into space and the cup was held at a slight angle toward her body. At 8:19 a.m. R19 was now attempting to drink her orange juice, but held the cup up by her mouth, and then set it down. At 8:20 a.m. R19 was offered menu choices. At 8:26 a.m. R19 was holding coffee cup up, LPN-C got up from helping R7, and helped R19 lift the cup up to her mouth. At 8:28 a.m. R19 began feeding herself, but it took two or three attempts to get the spoon into her mouth. R19 was easily distracted by other residents entering the dining room. At 8:36 a.m. R19 took another bit, it took her two tries to get the spoon into her mouth. At 8:39 a.m. continued to attempt to feed self, Cream of Wheat. R19 over loaded the spoon, and then dropped some of the food on clothing protector. R19 did occasionally get in a rhythm and could find her mouth with the spoon for five continuous bites.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 22	F 282		

R19 then got distracted and had trouble finding her mouth again. At 8:44 a.m. LPN-C went around table and moved fruit bowl in front of R19. At 9:11 a.m., R19 was now asleep at table. At 9:16 a.m. R19 was woken up by NA-B to ask if she wanted to finish her coffee. She held the cup up to her mouth, but did not drink. At 9:25 a.m. NA-A asked R19 if she was still hungry, was given applesauce and had eaten all of that.

R19 was admitted to the facility on 7/17/17, with anxiety, diabetes mellitus, chronic congestive heart failure (poor heart function) and hypothyroidism (low levels of thyroid lead to weakness tires more easily, feel colder, become depressed and forgetful) per the Admission Face Sheet.

On 9/26/17, R19's Progress Notes indicated R19 needed more assistance with eating due to difficulty and was placed a table where staff could assist more.

R19's care plan revised 10/5/17, after surveyor intervention, noted the facility revised the feeding assist interventions and noted required assistance with eating and that the facility was trialing a two-handled cup to enable self-independence with drinking beverages. In addition, occupational therapy would be working with R19 for other adaptive equipment.

On 10/4/17, at 10:31 a.m. the DON stated staff was to follow the written care plan for oral care and feeding assisat for R19.

Repostioning/pressure relieving devices:
R15 was admitted to the facility on 6/6/16, with diagnoses of Parkinson's disease (chronic and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 23	F 282		

progressive movement disorder), history of falling, history of traumatic brain injury (TBI), and pressure ulcer per Admission Face Sheet. R15 had a physician order dated 8/11/16, for an air bed to help with skin. Pressure and breakdown.

R15's MDS dated 6/19/15, indicated R15 was totally dependent on two staff for bed mobility, transfers, and locomotion in and out of room, dressing, and toilet use.

The skin interruption care plan dated 9/24/16, noted Skin check every shift (watch for pressure points e.g. heels, calves, hips, shoulders, back, etc.) Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc. The nutritional care plan revised on 9/24/16, directed staff to lay R15 after meals. The care plan revised on 7/5/17, for skin interruption, indicated R15 had a history of open area on left posterior thigh (ischium) and potential for other skin Interruption related to immobility and incontinence. On 9/25/17, the care interventions for skin interruptions noted, staff were directed to turn and reposition at least every two hours as he allowed. Attempt to adjust position slightly if he allowed. Used sling with repositioning and assist of two.

The CAA dated 9/29/17, indicated R15 had a right outer ankle wound currently 100% epithelialized. R15 had a pressure relieving mattress, cushion in wheelchair, pressure relieving boots, and was repositioned every two hours.

On 10/3/17, at 7:41 a.m. R15 was observed in bed, R15 was rolled to right, with pillow slightly underneath back, knees were drawn up and right knee extended slightly over the right hand side of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 24	F 282		

bed. R15 was under continuous observation from 7:41 a.m. until the NA and TMA entered the room at 9:19 a.m. Morning ADL cares (washing of face, chest, armpits and peri area) were observed for R15. At 9:31 a.m. R15 was lifted into the reclining wheelchair. TMA-A asked why the heel protectors (Velcro boots) were not put on and NA-A stated "I need to be honest, the Velcro doesn't work and so there is no reason to put them on". NA-A further stated she had asked for them to be replaced but they hadn't been. NA-A could not remember how long it had been. NA-A stated "last year when you were here, his butt was open and it is really hard to heal it up; it's his left leg we're having trouble with now." At 10:07 a.m. nurse put in his hearing aids and R15 was taken to church. At 10:57 a.m. R15 remained seated in the wheelchair, sitting in room. At 12:03 p.m. R15 was taken into dining room for lunch. R15 went from 7:41 a.m. to 12:03 p.m. without being repositioned out of the Broda chair. In addition, R15 did not have the boots applied while up in the wheelchair to minimize pressure and R15 was not returned to bed after meals as directed by the care plan.

The care plan for skin interruptions revised during the survey on 10/4/17, read, pressure relieving /reducing device and or skin protective device on heels. Boots when up in wheelchair, and heel protectors in bed as he allows. Alternating pressure reducing mattress with edges. Barrier cream to buttocks with incontinent cares.

Nursing assistant charting was requested for prior 14 days, from 9/22/17 through 10/5/17, the charting was blank, "no data found."

On 10/5/17, at 12:49 p.m. the interim director of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 25	F 282		

nursing (DON) stated "I tell them all the time" the heel protectors [Velcro boots] should be on, if she had been told the Velcro did not work she would have ordered new boots.

ROM/PROM:
On 10/3/17, at 7:41 a.m. R15 was observed in bed, R15 was rolled to right, with pillow slightly underneath back, knees were drawn up and right knee extended slightly over the right hand side of bed. R15 was under continuous observation from 7:41 a.m. until the nursing assistant (NA) and trained medication aide (TMA) entered the room. At 9:19 a.m. NA-A and TMA-A entered the room. Morning ADL cares (washing of face, chest, armpits and peri area) were observed for R15, NA-A used gloves and provided pericare, then removed the gloves but did not wash her hands or use hand sanitizer. ROM was not provided. At 2:18 p.m. NA-A stated she did not do ROM, nervous because he would yell out and so did not complete it.

On 10/5/17, at 7:18a.m. NA-B performed morning cares on R15 and no PROM was provided.

R15 had a Physician Order dated 6/15/17, for PT: for ROM as contractures worsening (knee contracture noted).

R15's Minimum Data Set dated 6/15/17, indicated the resident was severely cognitively impaired.

The Therapy Documentation Notes dated 7/17/17, directed staff that R15 was to be stretched/PROM to both lower extremities, with hip abducted. "1. Slowly pull both legs at knees apart to tolerance, then put hip abductor bolster between legs at thigh level, times 20 reps

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 26	F 282		

[repetitions]. 2. Both ankles to be flexed down/up times 20 reps. 3. As best as possible stretch both knees to extension slowly with hand on knee and ankle to stretch slowly times 20 reps. R15 sometimes pulls both legs back, ask him to relax to do lower extremity stretching to tolerance."

The Care Plan printed 10/5/17, indicated R15 had contractures, staff were to perform ROM exercises per treatment plan in patient's room twice a day.

Nursing assistant charting was requested for prior 14 days, from 9/22//17 through 10/5/17, the charting was blank, "no data found."

On 10/5/17, at 12:49 p.m. the interim director of nursing (DON) stated R15 should be receiving ROM twice a day according to his care plan.

R11 was observed on 10/3/17, at 7:54 a.m. and was in bed and covered, cares were being observed for roommate R19. R11 got up and ambulated to the bathroom without her walker, even though it was next to the bed. NA-A asked R11 if she was okay, but did not encourage R11 to use her walker and did not physically bring the walker to her. R11 was observed between 7:54 and 8:33 moving about the room, between the bathroom and her bedside four times without using her walker. At 8:33 a.m. R11 started to ambulate toward the room door without her walker, then said "Oh no" and rushed into the bathroom.

On 10/2/17, at 3:57 p.m. the DON was interviewed and stated on 9/24/17, a fall report indicated R11 missed toilet went to sit down.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 27 missed and slid down to floor. No injuries were noted. R11's admission Care Area Assessment (CAA) dated 11/1/16, indicated R11 was confused at times, was working with PT (physical therapy) and OT (occupational therapy), sometimes refused ADL cares. Back and hip pain was causing need for more assistance, at times refused to toilet or allow staff to change her. R11's dementia had increased, R11 would make unsafe choices at times. Staff are aware and watchful to assure safety. The care plan revised on 10/4/17, after surveyor intervention, directed staff to ensure R11 had her walker in place to use while ambulating. The care plan was requested and not provided. On 10/4/17, at 10:31 a.m. the DON stated the care plan was revised to be sure walker beside bed, so she will use it, she is impulsive. R11 should be assisted to or reminded to complete her oral care. R3's care plan revised 4/24/17, indicated R3 was at risk for pressure ulcer development because of history of previous pressure ulcers, incontinence and diabetes. The care plan instructed staff to turn and reposition R3 at least every two hours using two staff members and a mechanical lift and that staff were to notify the nurse immediately of any new areas of skin break down, redness, blisters, bruises, and discoloration noted during bath or daily care. R3's care plan indicated R3 had deficit in self-performance of activities of daily living including toileting and instructed staff to check R3 for incontinence every two hours and change R3 as needed.	F 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 28	F 282		

R3's quarterly MDS dated 7/13/17, indicated R3 was severely cognitively impaired and mildly depressed. R3's MDS indicated R3 required assistance with all activities of daily living including bed mobility, transfers and toileting and was incontinent of bladder and at risk for pressure ulcer development. R3's MDS indicated R3 had diagnosis of insulin dependent diabetes, anemia and Alzheimer's.

R3's October 2017 Medication Administration Record (MAR) was reviewed and revealed R3 had an order dated 5/11/17, instructing staff to give R3 a house diabetic supplement twice a day for pressure ulcer and low food intake. October MAR indicated the supplement was not available from 10/2/17, evening shift through 10/4/17, morning shift.

R3's Skin Observation dated 10/3/17, indicated R3 had a 1 centimeter (cm.) by 0.1 cm crack on R3's buttock fold towards sacrum, and skin color was the same as surrounding skin "purple."

R3's Admission Record dated 10/5/17, indicated R3 had a diagnosis of a pressure ulcer left buttock Stage 2 (partial-thickness loss of skin with exposed dermis. The wound bed is viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) dated 7/3/17.

R3 was continuous observed on 10/3/17, from 7:55 a.m. until 12:27 p.m. At 8:06 a.m. R3 was wheeled to their room for medications and blood glucose check. At 8:07 a.m. RN-B entered R3's room and checked blood sugar and gave R3 insulin. At 8:12 a.m. RN-B took R3 to the dining room. At 8:26 a.m. R3 was sitting at the dining

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 29	F 282		

room table with a glass of water and a glass of milk and a cup of coffee in front of her. DA-A brought a plate with a bowl of hot cereal, two half slices of toast and a piece of ham and placed it on the table in front of R3. DA-A cut the ham up and told R3 to start eating. DA-A put the fork with a piece of ham on it into R3's hand. At 9:25 a.m. R3 started speaking loudly saying, "They do not know what they are doing." The DON spoke with R3. LPN-C stopped at R3's side and started to rub R3's back. DON and LPN-C provided reassurance to R3 and took R3 to her room. They placed a blanket around R3 without making significant change in R3 position, gave R3 a call light and dimmed the room lights. The DON stayed with R3 until R3 was calm. At 9:37 a.m. DON exited room and stated sometimes R3 needs a quiet place. The DON stated she was going to have staff lay R3 down in bed. At 10:44 a.m. NA-A was interviewed about R3's toileting routine. NA-A stated R3 had been changed when staff got R3 up in the morning and R3 would be checked before lunch, and when R3 was laid down, between 1:00 p.m. and 1:30 p.m. Surveyor asked NA-A to lay R3 down and check R3 for incontinence. NA-A said, "my co-worker is on break." The surveyor asked NA-A to lay R3 down when co-worker was back from break. NA-A said, "When she is done, I go on break." Surveyor asked NA-A to please transfer resident and check R3 because R3 had been up a long time and notify surveyor. At 10:54 a.m. NA-A entered R3's room with a water pitcher, straw, and glass. R3 remained sitting in the same position in wheelchair with eyes closed. R3 remained in the room from 10:54 a.m. until 12:06 p.m. unchanged and no repositioning had been done. At 12:06 p.m. RN-B entered R3's room and told R3, she was going to help her to the bathroom. RN-B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 30	F 282		

called on walkie-talkie and requested help to R3's room. At 12:11 p.m. RN-B stated the NAs should have repositioned and check and change R3 every two hours. RN-B offered R3 water. R3 refused. NA-A entered R3's room. Using a mechanical lift RN-B and NA transferred R3 from the wheelchair to R3's bed. NA-A lowered R3's blue jeans and stated R3 was not wet because color strip had not changed color. Surveyor requested incontinence brief be opened because there was an odor of urine. NA-A stated R3 always had a slight odor of urine. NA-A opened the incontinence brief. RN-B and NA-A verified the front of the brief was a little bit wet and that the back of the brief was very wet, soaking the bottom of R3's sweatshirt. R3 had also been incontinent of a small amount of black sticky stool. NA-A placed a clean incontinence brief on R3. NA-A then dressed R3 in a clean shirt. RN-B was standing on the right side of R3 helping R3 to stay on her right side while NA-A cleaned R3's bottom. RN-B was asked to check R3 buttocks if red area on buttock was blanchable. RN-B touched the area which blanched. Observation of R3's perirectal area noted redness. RN-B was asked to spread R3's buttock cheeks to be able see coccyx area. RN-B lifted left R3's buttock cheek from above. The observation noted slit between R3's left and right buttock cheek on coccyx immediately above rectum. NA-A verified there was an open area there. NA-A said "I did not see anything when I gave her a shower this morning." Requested RN-B and NA-A to change positions. RN-B verified slit present and when requested estimated size as an approximately 3 cm by 0.1 cm open area between the buttocks. She stated the surrounding tissue was intact, pink and blanchable. RN-B and NA-A switched places and NA-A placed a clean incontinence brief on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 31	F 282		

R3. NA-A then dressed R3 in a clean shirt. At 12:22 p.m. RN-B left R3's room when RN-C arrived. RN-C assisted NA-A to transfer R3 using a mechanical lift into R3's wheelchair.

During interview on 10/3/17, at 12:41 p.m. the DON stated she would have hoped staff would have asked for help if they needed help. DON stated she would expect staff to check and change residents according to their care plan. The DON stated she would have expected staff to reposition residents in accordance to their care plan. DON reviewed R3's care plan and Bedside Kardex Report printed 10/3/17, and verified R3's toileting plan was for R3 to be checked and changed every two hours as needed. DON stated staff were to reposition R3 every 2 hours. DON stated staff were to check R3 every two hours and if incontinent change R3. The DON was told that R3 was observed to have an open area on R3's coccyx. DON stated she would look at area and measure the area. Requested copy of documentation when completed.

Facility policy for repositioning was requested but not provided.

R2 was observed on 10/2/17, at 5:10 p.m. to be coughing as she got took a bite of the soup. The soup appeared to be regular consistency. When R2 coughed R2 would turn red on her face and then would clear up. At 5:18 p.m. observed R2 picked the bowl of soup up and was drinking it out of the bowl and no coughing at that time. At 5:19 p.m. R2 started coughing and that time the other residents in the table looked at her as she turned red. The soup was observed to be thin and not thickened. At 5:20 p.m. resident again coughed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 32	F 282		

At 5:21 p.m. the cook was interviewed and stated the soup was thin consistency. When asked if she had thickened any soup for the resident's the cook stated for R2 she knew she had to have thickened liquids however for the soup resident wanted regular consistency soup. Cook did not indicate if resident had been offered nectar thick soup prior to the regular consistency being given. At 5:45 p.m. R2 coughed three times after she drink out of the bowl soup. At 5:48 p.m. when approached and asked about the soup resident stated the second hot bowl was good and when asked about the coughing resident stated she sometimes coughed and had been told by the staff of the risk of not having the soup or other liquids thickened. At no time during the observation did the staff offer the nectar consistency soup to R2.

On 10/4/17, at 3:54 p.m. R2 stated she ate snacks and drank thin liquids while in her room. R2 stated staff did not inform her otherwise and R2 denied staff coming into her room while she was snacking and drinking thin liquids. R2 verified she was able to independently eat in her room and did not need staff assistance to open packages/obtain snacks. R2 confirmed she had two baskets of fruit (two oranges and six apples), three muffins, three tomatoes, rice Krispy treats, graham crackers, and pretzels. LPN-A was interviewed right after the R2's interview and confirmed the snacks in R2's room. LPN-A acknowledged there was no monitoring system in place for R2's snack consumption in her room.

The Admission Face Sheet dated 2/4/15, indicated R2 had a diagnoses of Parkinson's as of 2/4/15, and dysphagia (difficulty swallowing. It is usually a sign of a problem with your throat and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 33	F 282		

the muscular tube that moves food and liquids from the back of your mouth to your stomach) as of 9/15/15.

R2's physician had ordered a diet of regular diet with regular textured food. The liquids were to be of nectar consistency (nectar-thick liquids have a nectar consistency like an apricot nectar) as of 6/11/15.

The physician's Patient Encounter note dated 3/2/17, indicated R2 had diagnoses of Parkinson's induced dementia (a decline in thinking and reasoning that develops in someone diagnosed with Parkinson's disease at least a year earlier. Common symptoms include: Changes in memory, concentration and judgment, trouble interpreting visual information, muffled speech, visual hallucinations, delusions, especially paranoid ideas, depression, irritability and anxiety, and sleep disturbances, including excessive daytime drowsiness and rapid eye movement (REM) sleep disorder) and was to continue with thickened liquids.

A Speech Therapy Plan of Care (Evaluation Only) note conducted 6/21/17, indicated the resident had moderate cognitive impairment and the discharge plan for nursing to continue with regular textured food diet and nectar consistency fluids and soup. Staff were to monitor R2's snack consumption and free water intake while in her room.

R2's care plan printed on 10/4/17, for dysphagia interventions noted R2 was to be offered nectar-thickened liquids during meals and follow the Frazier free water protocol between meals (the facility provided a hand out dated 1/16, which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 34	F 282		

identified the Frazier free water protocol allowed residents to have ice chips and/or water in between meals who are on thickened liquids. The protocol advised residents were allowed to drink water between meals and 30 minutes after meals and directed residents should not consume food with thin liquids while on the Frazier free water program). Furthermore, the care plan identified staff was to monitor and discourage R2 from sneaking regular fluids.

R2's care plan printed on 10/4/17, for self-care directed staff to provide supervision after set-up. R2 required nectar thickened liquids and had the Frazier water protocol in place. The care plan also noted R2 had been educated on the risks versus benefits of drinking thin liquids. The medical record lacked evidence regarding R2's intake while in the room and consuming liquids and food concurrently according to the plan of care.

R2's care plan printed 10/5/17, after it was brought to the facility's attention, the intervention for the dysphagia focus had been updated and revised to indicate staff was monitor the respiratory status daily and report to R2's physician any changes. Staff were to continue to discourage the use of thin liquids. The instructions for staff to follow R2's nectar consistency were in consistent as the dysphagia care plan directed to offer yet the self-care deficit care plan directed staff that the resident required nectar fluids. It could not be determined which care interventions the staff were to follow as dysphagia interventions indicated staff was offer nectar consistency fluids and the self-care interventions informed it was required.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 35	F 282		

On 10/4/17, at 11:59 a.m. the rehabilitation director stated the Frazier free water protocol was implemented for R2 approximately one year ago. R2 was able to have thin liquids in her room but was not to be concurrently eating food with intake due to high risk of aspiration.

On the same day, at 12:57 p.m. RN-B stated staff were currently monitoring R2 for signs and symptoms of pneumonia. RN-B stated R2 should not be drinking thin liquids at all and was unaware what Frazier free water protocol was. RN-B stated there was not a monitoring system in place to observe when and what type of fluids R2 consumed.

On 10/4/17, at 1:01 p.m. NA-A was interviewed and stated R2 can have all of the thin liquids she wanted in her room and was delivered at least three pitchers of water per day. NA-A was unaware what the Frazier free water protocol was. NA-A stated R2 always had snacks in her room and believed to be able to eat and drink thin liquids in her room at the same time. NA-A verified there was not a monitoring system in place when R2 was in her room eating and drinking thin liquids.

On 10/4/17, at 2:43 p.m. the interim dietary manager (DM) stated R2 can have thin liquids in her room but was unable to consume food concurrently. The DM stated the dietary department does not monitor R2's intake while in her room.

At 2:52 p.m. the DON stated R2 did not have food in her room and staff do not offer food in her room. The DON stated there was not a monitoring system in place.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 282	Continued From page 36 On 10/5/17, at 10:05 a.m. speech therapist (ST) was familiar with R2 and stated she had difficulty remembering safe swallowing tips and therefore, her diet was modified to thickened liquids. ST stated R2's memory was inconsistent as far as recall of the rationale for her ordered diet. Further, ST stated R2 was on the Frazier free water protocol but had difficulty understanding the details of the program since her carryover of education was poor. ST stated the BIMS assessment tests more of short term memory which R2 was better with since her memory faded as the day went on. ST stated the facility should have a monitoring system in place while R2 was in her room drinking thin liquids and was not to have food at the same time. ST verified if R2 drank thin liquids and consumed food concurrently it increased her risk of choking and aspiration. The facility's policy titled Care Plan revised 11/16, identified residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. The facility's policy titled Comprehensive Care Plan and Care Conferences revised 9/17, directed staff to provide an ongoing method of assessing, implementing, and evaluating to meet the highest level of functioning.	F 282		
F 312 SS=E	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) A resident who is unable to carry out activities of daily living receives the necessary	F 312		11/15/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 312	Continued From page 37 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 provided assistance with eating, toileting, and oral hygiene for 5 of 8 residents (R1, R7, R3, R15, R19) reviewed for activities of daily living. Findings include: R1 was observed on 10/2/17, at 2:04 p.m. seated on the Broda wheelchair (specialized wheelchair) at the bedside in the room and was noted to have a strong odor of urine. R1 remained in the room until 3:45 p.m. At 3:46 p.m. the activity staff was observed wheel R1 into the dining room for an activity until 4:02 p.m. At 4:06 p.m. staff was observed wheel R1 to the bird room and parked the wheelchair in front of the bird house. At 4:11 p.m. R1 was wheeled out of the bird room and sat outside the medication room across from the dining room. At 4:20 p.m. family member (F)-A came to visit R1 and wheeled R1 to the room. At 4:21 p.m. when asked if R1 got the help and assistance she needed with getting dressed, toileting, or cleaning teeth F-A "I question her oral hygiene." On 10/2/17, at 4:56 p.m. F-A was observed wheel R1 into the dining room. When asked if the staff had offered to toilet R1 when in the room, F-A stated only the nurse had been to the room to give R1 medications. At 5:00 p.m. to 6:00 p.m. R1 remained in the dining room observed staff seated next to her and cuing her to eat however, no staff offered toileting or to check and change. On 10/3/17, at 7:33 a.m. to 7:41 a.m. R1 was	F 312	1. R 7 is expired. R1, 19, 15, 3,'s care givers were re-educated on the care planned interventions for eating, toileting, oral hygiene. 2. All residents care planned interventions for these above mentioned ADLs have been reviewed with staff to ensure cares are being provided appropriately. 3. All CNAs will be provided re-education by the DNS or designee on accessing the resident Kardex and Policy and procedure for following the care planned interventions. This education will be provided on November 7, 2017. 4. Observation audits for R1,19,15, & 3 and random other residents will be conducted by DNS or designee to ensure care planned interventions for the above mentioned ADLs are being followed and findings will be taken to Quality Committee for further recommendations. 5. Date of completion: November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 38	F 312		

observed lying in bed as nursing assistant (NA)-A was observed provide R1 pericare, bed mobility and getting dressed for the day however did not offer oral hygiene/care. On 10/3/17, at 9:00 a.m. to 9:04 a.m. trained medication aide (TMA)-A and NA-A were observed transfer R1 out of the bed to the Broda wheelchair using a Hoyer lift adjusted the clothing, combed hair but staff did not offer or provide oral hygiene/care.

On 10/3/17, at 9:04 a.m. to 11:55 a.m. during a continuous observation (2 hours and 51 minutes) the following was observed. At 9:06 a.m. NA-A wheeled R1 into the dining room. At 9:08 a.m. to 10:06 a.m. R1 remained in the dining for breakfast ate breakfast slowly as staff cued her to eat. At 10:07 a.m. NA-A approached resident and asked R1 if she was done eating. At 10:10 a.m. NA-A then took a sheet of Kleenex and wiped around R1's mouth then tossed the soiled Kleenex then without washing their hands, NA-A wheeled resident out of dining room to the Chapel. At 10:33 a.m. R1 was brought out of the Chapel and was wheeled and parked outside the medication room. At that time NA-A was observed come around the area but never offered to toilet resident or do oral hygiene. At 11:04 a.m. the activity staff approached R1 and asked if there was anything she wanted her to do for her and R1 stated "I don't have the ambition." R1 remained in the same area looked through the paper and coloring sheets. At 11:55 a.m. after two hours and 51 minutes' surveyor intervened and requested the facility staff to reposition the resident and check R1 for toileting. At 11:57 a.m. the licensed practical nurse (LPN)-C and NA-A were observed use a Hoyer lift to transfer R1 to bed. At 11:59 a.m. LPN-A assessed the skin noted to be blanchable. NA-A and LPN-A then

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 39	F 312		

were observed change R1's incontinent pad which was wet and NA-A was observed clean a small bowel movement when providing pericare.

R1's care plan dated 10/2/16, indicated the resident had an ADL self-care performance deficit related to dementia and arthritis as evidenced by inability to transfer or ambulate and the need for help with activities of daily living (ADLs). R1's care plan indicated resident wore adult protection for incontinence, required staff assistance to perform toileting hygiene and was to check and change every two hours with morning cares, before or after meals, with evening cares and as needed. In addition, the care plan directed staff for oral care resident had own teeth and staff was to assist with oral care, staff was to cue R1 to do what she can, then finish.

R1's urinary incontinence Care Area Assessment (CAA) dated 4/12/17, indicated resident required extensive assist with all toileting and was frequently incontinent of bladder and bowel. The CAA identified R1 required assist with all toileting.

R1's diagnoses included dementia with behaviors, major depression, anxiety and cerebrovascular accident obtained from the quarterly Minimum Data Set (MDS) dated 7/13/17. The MDS indicated resident required extensive physical assistance of two staff with toileting and personal hygiene which included oral hygiene and pericare. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 12:42 p.m. the interim director of nursing (DON) stated she would expect the nursing assistant to ask for assistance if they were running behind repositioning, toileting,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 312	Continued From page 40 checking and changing residents. DON stated the staff was supposed to follow the care plan for all residents. R7 was observed on 10/3/17, at 7:53 a.m. NA-A was observed in R7's room and was getting supplies ready to get resident ready for the day. NA-A stated she was going to get R7 upper body cleaned and was going to need assistance with the lower body and pericare because resident grab bars had been taken off and was not able to help now. At 7:54 a.m. to 8:03 a.m. NA-A washed R7's upper body, applied shirt and then lowered the bed and stated she would come back with another staff to finish the cares. At 8:42 a.m. to 8:51 a.m. NA-A and TMA-A came to room with the Hoyer lift and both applied gloves and TMA-A approached R7 and stated they were going to get her up for breakfast. NA-A provided pericare and transferred R7 never offered oral hygiene. On 10/3/17, at 8:53 a.m. the following was observed during a continuous observation for (two hours and 46 minutes). At 8:54 a.m. NA-A wheeled R7 to dining room never offered oral hygiene. At 9:10 a.m. dietary staff brought R7 a bowl of cereal with bananas, a plate with sausage and French toast and set it in front of resident after cutting it up in small pieces. The plate had a guard on one side and R7 sat there looked at the food. At 9:16 a.m. R7 picked up the glass of water and was observed drink out of it. At 9:21 a.m. R7 sat at the table no assistance offered at that time as she sat there looking at the food and was observed attempt to grab the fork but noted with tremors in both hands and set the fork on the plate. At 9:25 a.m. registered nurse (RN)-B sat between R1 and R7 stated she was going to help.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 312	Continued From page 41 At 9:27 a.m. RN-B stood up spoke briefly with the interim DON who then sat between R1 and R7 as RN-B went to the medication cart parked outside the dining room. At 9:28 a.m. almost immediately DON left and went to the medication cart and RN-B returned to the table at then asked R7 "Do you want food." At 9:30 a.m. (which was 20 minutes after the food was set in front of R7), RN-B then picked the fork gave a bit of French toast and R7 refused to open her mouth. At 9:33 a.m. RN-B was overheard ask the activities director "can you feed?" and the activities director stated "no I can't." RN-B then left the table never re-approached R7 or offer another bite of food. At 9:34 a.m. as NA-A wheeled another resident to the assistance table RN-B stated "I need someone to fed people I have meds and treatments to do." NA-A stated "We are still getting people up." At 9:41 a.m. which was 11 minutes since R7 had been offered a bite of food TMA-A approached the table spoke to NA-A none of the staff offered R7 another bite as R7 sat there. At 9:43 a.m. the activities director approached and cued R7 to drink and offered to bring her to church then left. At 9:46 a.m. R7 continued to stare at the plate of food no staff to that point had re-approached or sat with her since RN-B left. At 9:51 a.m. TMA-A approached R7 offered a bite of banana pieces while standing and that time R7 opened her mouth took the bite. At 9:52 a.m. to 10:05 a.m. TMA-A sat next to R7 and assisted with eating and R7 ate all the French toast and cereal with banana with approximately 240 milliliters of fluids. At 10:08 a.m. RN-B wheeled R7 to the room and covered her with a blanket and left. At 10:15 a.m. resident observed in her room and the tooth brush on top of sink in a sealed wrap.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 312	Continued From page 42 On 10/3/17, at 11:38 a.m. when surveyor approached and asked R7's toilet needs RN-B stated R7 was supposed to be checked and changed every two hours as she had been identified at risk for skin issues. At the same time when NA-A was asked about toileting R7 she stated "we are running really late today." At 11:40 a.m. after surveyor brought concern to facility attention then NA-A and RN-B transferred R7 to bed. NA-A provided pericare and stated R7 was barely wet and had a bowel movement. During the cares no oral care was offered. R7's care plan dated 8/16/17, indicated resident had a self-care deficit related to terminal illness of end stage dementia and congestive heart failure as evidenced by inability to perform ADL's and sat in the assistance table for meals. The care plan directed staff to provide prompting verbal cueing to eat, to provide assistance to eat, for oral care R7 required total assist. In addition, the care plan directed staff for toilet use R7 was incontinent of bowel and bladder and staff was to provide check and change every two hours and as needed. R7's diagnoses included Alzheimer's, dementia, depression, anxiety and diabetes mellitus obtained from the quarterly MDS dated 8/22/17. The MDS indicated resident required extensive physical assistance of two staff with toileting and personal hygiene which included oral hygiene and pericare. In addition, the MDS indicated R7 did not reject cares. On 10/3/17, at 1:57 p.m. NA-A verified she had not provided oral hygiene for residents because of stretched help. She indicated she would usually use the toothettes instead of the tooth brush and had not had time to do it. She indicated	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 43	F 312		

one of the staff that was supposed to work had indicated she was not coming to work and the director of nursing did not know until around noon. NA-A acknowledged R1 and R7 were at risk for skin breakdown and verified R1 and R7 were supposed to be repositioned at least every two hours. NA-A acknowledged R1's and R7's care plans for oral hygiene, eating, repositioning and toileting had not been followed.

On 10/4/17, at 8:21 a.m. to 8:58 a.m. LPN-C was assist R7 with breakfast. At 8:59 a.m. when asked how much R7 had eaten LPN-C stated 80% and 14 ounces of fluids she indicated "R7 was hungry this morning."

On 10/4/17, at 1:08 p.m. when asked about what assistance R7 required NA-A stated the resident R7 was on hospice and had lost a lot of weight in the last few weeks because resident was not eating well anymore and did not seem to have a good appetite. NA-A stated R7 required staff assistance with eating as before R7 was able to eat independently with a plate guard however resident was not able to feed herself now. NA-A further stated R7 required total cares for other cares.
R3's care plan revised 4/24/17, indicated R3 had deficit in self performance of activities of daily living including toileting and instructed staff to check R3 for incontinence every two hours and change R3 as needed.

R3's quarterly MDS dated 7/13/17, indicated R3 was severely cognitively impaired and mildly depressed. R3's MDS indicated R3 required assistance with all activities of daily living including bed mobility, transfers and toileting and was incontinent of bladder at all times and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 44	F 312		

continent of bowel at all times. R3's MDS indicated R3 had diagnosis of insulin dependent diabetes, anemia and Alzheimer's.

During continuous observation of R3 on 10/3/17, from 7:55 a.m. until 12:27 p.m. it was observed; at 7:55 a.m. R3 was sitting in a wheelchair at the table in the dayroom. At 8:06 a.m. staff wheeled R3 to room for medications and blood glucose check. At 8:07 a.m. RN-B entered R3's room and checked blood sugar and gave R3 insulin. At 8:12 a.m. RN-B took R3 to the dining room. At 8:26 a.m. R3 was sitting at the dining room table with a glass of water and a glass of milk and a cup of coffee in front of her. Dietary aide (DA)-A brought a plate with a bowl of hot cereal, two half slices of toast and a piece of ham and placed it on the table in front of R3. DA-A cut the ham up and told R3 to start eating. DA-A put the fork with a piece of ham on it into R3's hand. At 9:25 a.m. R3 started speaking loudly saying, "They do not know what they are doing." The DON spoke with R3. LPN-C stopped at R3's side and started to rub R3's back. DON and LPN-C provided reassurance to R3 and took R3 to her room. They placed a blanket around R3 without making significant change in R3 position, gave R3 a call light and dimmed the room lights. The DON stayed with R3 until R3 was calm. At 9:37 a.m. DON exited room and stated sometimes R3 needs a quiet place. The DON stated she was going to have staff lay R3 down in bed. R3 had not been checked or changed.

During interview at 10:44 a.m. NA-A stated R3 had been changed when staff got R3 up in the morning and R3 would be checked before lunch, and when R3 was laid down, between 1:00 p.m. and 1:30 p.m. Surveyor asked NA-A to lay R3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 312	Continued From page 45	F 312		

down and check R3 for incontinence. NA-A said, "my co-worker is on break." Surveyor asked NA-A to lay R3 down when co-worker was back from break. NA-A said, "When she is done, I go on break." The surveyor asked NA-A to please transfer resident and check R3 because R3 had been up a long time and notify surveyor. At 10:54 a.m. NA-A entered R3's room with a pink water pitcher and straw and glass. R3 remained sitting in the same position in wheelchair with eyes closed.

At 12:06 p.m. RN-B entered R3's room and told R3, she was going to help her to the bathroom. RN-B called on walkie talkie and requested help to R3's room.

At 12:11 p.m. RN-B stated the nursing assistants should have repositioned and check and change R3 every two hours. RN-B offered R3 water. R3 refused. NA-A entered R3's room. Using a mechanical lift RN-B and NA transferred R3 from the wheelchair to R3's bed. NA-A lowered R3's blue jeans and stated R3 was not wet because color strip had not changed color. Surveyor requested incontinence brief be opened because there was an odor of urine. NA-A stated R3 always had a slight odor of urine. NA-A opened the incontinence brief. RN-B and NA-A verified the front of the brief was a little bit wet and that the back of the brief was very wet soaking the bottom of R3's sweatshirt. R3 had also been incontinent of a small amount of black sticky stool. NA-A placed a clean incontinence brief on R3. NA-A then dressed R3 in a clean shirt.

During interview on 10/3/17, at 12:41 p.m. the DON stated she would have hoped staff would have asked for help if they needed help. DON

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 46	F 312		

stated she would expect staff to check and change residents according to their care plan. DON reviewed R3's care plan and Bedside Kardex Report printed 10/3/17, and verified R3's toileting plan was for R3 to be checked and changed every two hours as needed. DON stated staff were to check R3 every two hours and if incontinent change R3.
R15 was observed on 10/2/17, at 12:00 p.m. R15 was observed being taken into the dining room, he was in a tilt in space wheelchair, which had to be tilted forward to get his knees under the dining table. R15 required assistance to eat, although he lifted his cup to drink once, after it was put into his hands.

On 10/3/17, at 9:34 a.m. R15 was brought to dining room. NA-A cut up R15's food, then attempted to get him to feed himself. NA-A then sat down next to him and started to fed R15, then moved to another resident. At 9:41 a.m. TMA-A was now feeding R15. TMA-A asked him why he was not feeding himself. TMA-A offered apple juice and said, "Do you want to hold it?" TMA-A put the apple juice in front of him. R15 picked it up the glass with both hands and was feeding himself for a few minutes.

On 10/4/17, at 7:32 a.m. R15 was brought into dining room and placed at table. At 8:24 a.m. beverages were put in front of R15. At 8:30 a.m. DA-A brought food over, and put spoon into R15's hand, the DA-A left the table, then R15 was able to bring food to his mouth, he completed one bit of food. At 8:33 a.m. LPN-C prompted him to take another bite. R15 did not. At 8:34 a.m. LPN-C got up to wipe his mouth with clothing protector, offered R15 a drink, but he did not accept. At 8:38 a.m. LPN-C sat next to R15 and gave him two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 47	F 312		

bites of cereal, then moved back to R7 who was being assisted.

On 10/5/17, at 8:08 a.m. R15 was moved into dining room. At 8:19 a.m. beverages have been put in front of him, he was sitting with his eyes closed. R15's cereal has been put in front of him, his eyes remained closed. No one sat down to assist R15 with meal assistance. At 8:29 a.m. LPN-C sat down to feed R15. At 8:48 a.m. LPN-C got up and moved to feed R7, then cleaned her hands and went back to R15. At 9:07 a.m. NA-A removed R15 from dining room, he had eaten approximately 50% of his meal assisted by LPN-C who was also feeding R7 around the table from R15. R15 was encouraged to feed self when R15 had an order not to feed self and staff placed food in front of R15 with no assistance present.

R15 was admitted to the facility on 6/6/16, with diagnoses of Parkinson's disease (chronic and progressive movement disorder), history of falling, history of traumatic brain injury (TBI), and pressure ulcer per the Admission Face Sheet.

The nutritional care plan revised on 9/24/16, noted R15 had a potential nutritional problem related to need for mechanically altered textures and thickened liquids, provide adequate eating time with cueing and available assistance. R15 needed 1:1 assist, slow feeding time between bites to ensure he has time to chew and swallow before the next bite.

R15's MDS dated 9/13/17, indicated R15 required extensive assistance of one person for eating and had a poor oral intake.

The CAA dated 9/29/17, indicated R15 could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 48 partially feed self, but needs assistance to finish, two-handled cups and plate guard. R15 received supplement twice a day to maintain skin integrity/aid healing. Occasional vomiting and coughing, family declined thickened liquids. R15 had a physician order dated 9/30/17, for feeding recommendations. The order noted R15 required one to one assistance with eating. Staff were slow feeding time between bites and insure the resident had adequate time to chew and swallow before the next bite. Staff were to check for pocketing of food every eight hours. On 10/5/17, at 12:49 p.m. the DON verified staff should have provided more assistance in the dining room. R19 Oral care: On 10/3/17, at 8:34 a.m. R19 was brought to dining room. No oral care was provided. At 9:50 a.m. R19 ate some French toast, and some meat. R19 was removed from dining room (was removed from the table without saying anything to her) TMA-A took her to door and then asked another staff to take her to church. At 10:33 returned from chapel to day room outside of dining room, had portions of newspaper in her hands, and a coloring paper, had not had oral care nor was R19 offered oral care. At11:09 a.m. was asleep with paper in front of her. Then R19 woke up and was gazing across table. At 11:16 a.m. R19 was asleep at table again. At 11:42 a.m. received her pills by TMA-A, BP and pulse oximetry were taken. Oral care had not been provided for R19.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 312	Continued From page 49	F 312		

R19's care plan dated 7/17/17, noted R19 had her own teeth, broken teeth, will set up and encourage daily oral care. R19 did not receive staff assist with oral care.

On 10/4/17, at 10:31 a.m. the DON stated staff was to follow the written care plan for oral care.

Feeding assist:
On 10/3/17, at 8:34 a.m. R19 was brought to dining room. At 9:50 a.m. R19 ate some French toast, and some meat, but was slow to eat and was not encouraged or assisted. R19 was just removed from dining room (was removed from the table without saying anything to her). TMA-A took her to door and then asked another staff to take her to church.

On 10/4/17, at 7:33 a.m. R19 was sitting at table in day room, in front of dining room, paging through a magazine. At 8:03 a.m. R19 was moved into dining room. At 8:09 a.m. beverages were offered and R19 was assisted by dietary aide (DA)-A to get a sip of coffee. Orange juice and milk small glasses are filled in front of her. At 8:13 a.m. R19 continued to hold the coffee cup in her hand, but was staring off into space and the cup was held at a slight angle toward her body. At 8:19 a.m. R19 was now attempting to drink her orange juice, but held the cup up by her mouth, and then set it down. At 8:20 a.m. R19 was offered menu choices. At 8:26 a.m. R19 was holding coffee cup up, LPN-C got up from helping R7, and helped R19 lift the cup up to her mouth. At 8:28 a.m. R19 began feeding herself, but it took two or three attempts to get the spoon into her mouth. R19 was easily distracted by other residents entering the dining room. At 8:36 a.m. R19 took another bit, it took her two tries to get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 50	F 312		

the spoon into her mouth. At 8:39 a.m. continued to attempt to feed self, Cream of Wheat. R19 over loaded the spoon, and then dropped some of the food on clothing protector. R19 did occasionally get in a rhythm and could find her mouth with the spoon for five continuous bites. R19 then got distracted and had trouble finding her mouth again. At 8:44 a.m. LPN-C went around table and moved fruit bowl in front of R19. At 9:11 a.m., R19 was now asleep at table. At 9:16 a.m. R19 was woken up by NA-B to ask if she wanted to finish her coffee. She held the cup up to her mouth, but did not drink. At 9:25 a.m. NA-A asked R19 if she was still hungry, was given applesauce and had eaten all of that.

R19 was admitted to the facility on 7/17/17, with anxiety, diabetes mellitus, chronic congestive heart failure (poor heart function) and hypothyroidism (low levels of thyroid lead to weakness tires more easily, feel colder, become depressed and forgetful) per the Admission Face Sheet.

On 9/26/17, R19's Progress Notes indicated R19 needed more assistance with eating due to difficulty and was placed a table where staff could assist more.

R19's care plan revised 10/5/17, after surveyor intervention, noted the facility revised the feeding assist interventions and noted required assistance with eating and that the facility was trialing a two-handled cup to enable self-independence with drinking beverages. In addition, occupational therapy would be working with R19 for other adaptive equipment.

On 10/4/17, at 10:31 a.m. the DON stated staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 312	Continued From page 51 was to provide assistance with eating. Toileting: On 10/3/17, at 7:54 a.m. R19 remained in bed, the wheelchair was next to bed. At 8:16 a.m. NA-A and NA-B entered room. R19 had defected in bed, removed her incontinent product and had been laying in feces. NA-A and NA-B performed morning cares. At 8:34 a.m. R19 was brought to dining room and remained there until 9:50 a.m. At 9:50 a.m. R19 was just removed from dining room. TMA-A took her to door and then asked another staff to take her to church. At 10:33 a.m. R19 returned from chapel to day room outside of dining room, had portions of newspaper in her hands, and a coloring paper, had not been toileted. At 11:09 a.m. R19 was asleep with paper in front of her. Then R19 woke up and was gazing across table. At 11:16 a.m. R19 was asleep at table again. At 11:42 a.m. R219 received her pills by TMA-A. R19 attempted to put her glasses in her mouth instead of swallowing water. R19 went to eat lunch was not toileted prior to the meal service. At 2:08 p.m. R19 had attended an activity and still not been toileted or repositioned. R19's significant change MDS dated 9/12/17, noted R19 to be occasionally incontinent and frequently incontinent of bowel. R19's Urinary Care Area Assessment dated 7/28/17, indicated R19 was "not incontinent." R19's ADL care plan revised 9/18/17, for toileting noted R19 required assistance to use the bathroom. Offer toileting before/after meals and at bedtime due to forgetfulness and dementia. R19 was not provided the services for toileting. On 10/4/17, at 10:31 a.m. the DON stated staff was to follow the written care plan.	F 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314 SS=E	483.25(b)(1) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES (b) Skin Integrity - (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 reposition timely and pressure relieving devices applied 4 of 4 residents (R1, R7, R3, R15) who had been identified at risk for pressure ulcers reviewed for pressure ulcers. Findings include: R1 was continuously observed for two hours and 51 minutes on 10/3/17, at 9:04 a.m. to 11:55 a.m. the following was observed. At 9:06 a.m. nursing assistant (NA)-A wheeled R1 into the dining room. From 9:08 a.m. to 10:06 a.m. R1 remained in the dining for breakfast ate breakfast slowly as staff cued her to eat. At 10:07 a.m. NA-A approached resident and asked R1 if she was done eating. At 10:10 a.m. NA-A wheeled	F 314	1. R7 expired. R1 and 3 were provided immediate repositioning upon notification from surveyor. R15 was provided with new boots immediately upon notification. 2. All residents at risk for pressure ulcers will be reviewed to ensure care planned interventions for repositioning and use of pressure reducing devices are in place and being followed. 3. Nursing staff will be re-educated on the importance of following the care plan for timely repositioning and use of pressure reducing devices by the DNS or designee on November 7, 2017. 4. R1, 3 and 15 and random other residents will have observation audits to ensure care planned interventions for repositioning and use of pressure	11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 53 resident out of dining room to the Chapel. At 10:33 a.m. R1 was brought out of the Chapel and was wheeled and parked outside the medication room. At that time NA-A was observed come around the area. At 11:04 a.m. the activity staff approached R1 and asked if there was anything she wanted her to do and R1 stated "I don't have the ambition." R1 remained in the same area looked through the newspaper and coloring sheets. At 11:55 a.m. after 2 hours and 51 minutes' the surveyor intervened and requested the facility staff to reposition R1. At 11:57 a.m. the licensed practical nurse (LPN)-C and NA-A were observed use a Hoyer lift to transfer R1 to bed. At 11:59 a.m. LPN-A assessed the skin noted to be blanchable. NA-A and LPN-A then were observed change R1's incontinent pad which was wet and cleaned a small bowel movement when providing pericare. At 12:05 p.m. both staff transferred R1 back to the Broda wheelchair. R1's care plan dated 11/6/16, indicated the resident had potential for skin issues related to immobility, incontinence and poor nutrition. The care plan directed staff to offer to lie down in bed after meals as resident wished and to turn and reposition resident every two hours. R1's pressure ulcer Care Area Assessment (CAA) dated 4/19/17, identified R1 was at risk due to immobility, poor nutrition, incontinence and altered mental status. R1's diagnoses included dementia with behaviors, major depression, anxiety and cerebrovascular accident obtained from the quarterly Minimum Data Set (MDS) dated 7/13/17. The MDS indicated resident required extensive physical assistance of two staff with bed mobility which include turning side to side	F 314	reducing devices is being followed. These audits will be conducted by the DNS or designee weekly x4 and monthly x3 to ensure timely repositioning per their care plan. Findings will be taken to Quality Committee for further recommendations. 5. Date of completion November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 54	F 314		

and total dependence for transfers. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 12:42 p.m. the interim director of nursing (DON) stated she would expect the nursing assistants to ask for assistance if they were running behind repositioning. DON stated the staff was supposed to follow the care plan for all residents.

R7 was observed on 10/3/17, at 7:53 a.m. NA-A was observed in R7's room and was getting supplies ready to get resident ready. NA-A stated she was going to get R7 upper body cleaned and was going to need assistance with the lower body and pericare because resident grab bars had been taken off and was not able to help now. At 7:54 a.m. to 8:03 a.m. NA-A washed R7's upper body, applied shirt and then lowered the bed and stated she would come back with another staff to finish the cares. At 8:42 a.m. NA-A and trained medication aide (TMA)-A came to room with the Hoyer lift and both applied gloves and TMA-A approached R7 and stated they were going to get her up for breakfast. At 8:45 a.m. to 8:51 a.m. both staff were observed to provide assistance with getting R7 dressed and provide pericare. At 8:52 a.m. both NA's observed transfer R7 to the Broda wheelchair. R7 continued to be continuously observed for another two hours and 46 minutes. At 8:54 a.m. NA-A wheeled R7 to dining room and remained in the dining form until 9:52 a.m. At 10:08 a.m. RN-B wheeled R7 to the room and covered her with a blanket and left. At 10:15 a.m. to 11:38 a.m. resident observed in her room covered with blanket asleep. At 11:38 a.m. RN-B was interviewed regarding R7's repositioning. RN-B stated R7 was supposed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 55	F 314		

be repositioned every two hours as she had been identified at risk for skin issues. At the same time when NA-A was asked about repositioning R7 she stated "we are running really late today." At 11:40 a.m. NA-A and RN-B transferred R7 to bed then at 11:42 a.m. after laying R7 down RN-B checked the skin and was noted blanchable. NA-A was observed clean a bowel movement and stated the pad was barely wet and then transferred resident to the Broda wheelchair. R7 went from 7:54 a.m. to 11:40 a.m. with being repositioned.

R7's pressure ulcer CAA dated 5/23/17, indicated R7 was at risk for pressure ulcers due to immobility, diabetes, was incontinent of bowel and bladder and had currently a unstageable ulcer on her right heel. The care plan directed staff to reposition every two hours. R7's care plan dated 6/1/17, identified R7 had a pressure ulcer on the right heel and was at risk for developing pressure ulcers related to immobility, incontinence, poor nutrition and altered mental status. The care plan directed staff to turn/reposition R7 every two hours and with two staff.

R7's diagnoses included Alzheimer's, dementia, depression, anxiety and diabetes mellitus obtained from the quarterly MDS dated 8/22/17. The MDS indicated resident required extensive physical assistance of two staff with bed mobility which include turning side to side and total dependence for transfers. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 1:57 p.m. NA-A stated she had not provided R1 and R7 repositioning because of stretched help. NA-A acknowledged both

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 56	F 314		

residents were at risk for skin breakdown and verified R1 and R7 were supposed to be repositioned at least every two hours. NA-A then asked surveyor if it tilting the Broda wheelchair back would count for repositioning and surveyor directed her to check with the facility policy and the director of nursing. NA-A acknowledged R1's and R7's care plans for repositioning had not been followed.
R3's care plan revised 4/24/17, indicated R3 was at risk for pressure ulcer development because of history of previous pressure ulcers, incontinence and diabetes. The care plan instructed staff to turn and reposition R3 at least every two hours using two staff members and a mechanical lift and that staff were to notify the nurse immediately of any new areas of skin break down, redness, blisters, bruises, and discoloration noted during bath or daily care. R3's care plan indicated R3 had deficit in self-performance of activities of daily living including toileting and instructed staff to check R3 for incontinence every two hours and change R3 as needed.

R3's quarterly MDS dated 7/13/17, indicated R3 was severely cognitively impaired and mildly depressed. R3's MDS indicated R3 required assistance with all activities of daily living including bed mobility, transfers and toileting and was incontinent of bladder and at risk for pressure ulcer development. R3's MDS indicated R3 had diagnosis of insulin dependent diabetes, anemia and Alzheimer's.

R3's October 2017 Medication Administration Record (MAR) was reviewed and revealed R3 had an order dated 5/11/17, instructing staff to give R3 a house diabetic supplement twice a day for pressure ulcer and low food intake. October

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 57	F 314		

MAR indicated the supplement was not available from 10/2/17, evening shift through 10/4/17, morning shift.

R3's Skin Observation dated 10/3/17, indicated R3 had a 1 centimeter (cm.) by 0.1 cm crack on R3's buttock fold towards sacrum, and skin color was the same as surrounding skin "purple."

R3's Admission record dated 10/5/17, indicated R3 had a diagnosis of a pressure ulcer left buttock Stage 2 (partial-thickness loss of skin with exposed dermis. The wound bed was viable, pink or red, moist, and may also present as an intact or ruptured serum-filled blister) dated 7/3/17.

R3 was continuous observed on 10/3/17, from 7:55 a.m. until 12:27 p.m. At 8:06 a.m. R3 was wheeled to their room for medications and blood glucose check. At 8:07 a.m. RN-B entered R3's room and checked blood sugar and gave R3 insulin. At 8:12 a.m. RN-B took R3 to the dining room. At 8:26 a.m. R3 was sitting at the dining room table with a glass of water and a glass of milk and a cup of coffee in front of her. Dietary aide (DA)-A brought a plate with a bowl of hot cereal, two half slices of toast and a piece of ham and placed it on the table in front of R3. DA-A cut the ham up and told R3 to start eating. DA-A put the fork with a piece of ham on it into R3's hand. At 9:25 a.m. R3 started speaking loudly saying, "They do not know what they are doing." The DON spoke with R3. LPN-C stopped at R3's side and started to rub R3's back. DON and LPN-C provided reassurance to R3 and took R3 to her room. They placed a blanket around R3 without making significant change in R3 position, gave R3 a call light and dimmed the room lights. The

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 58	F 314		

DON stayed with R3 until R3 was calm. At 9:37 a.m. DON exited room and stated sometimes R3 needs a quiet place. The DON stated she was going to have staff lay R3 down in bed. At 10:44 a.m. NA-A was interviewed about R3's toileting routine. NA-A stated R3 had been changed when staff got R3 up in the morning and R3 would be checked before lunch, and when R3 was laid down, between 1:00 p.m. and 1:30 p.m. Surveyor asked NA-A to lay R3 down and check R3 for incontinence. NA-A said, "my co-worker is on break." The surveyor asked NA-A to lay R3 down when co-worker was back from break. NA-A said, "When she is done, I go on break." Surveyor asked NA-A to please transfer resident and check R3 because R3 had been up a long time and notify surveyor. At 10:54 a.m. NA-A entered R3's room with a water pitcher, straw, and glass. R3 remained sitting in the same position in wheelchair with eyes closed. R3 remained in the room from 10:54 a.m. until 12:06 p.m. unchanged and no repositioning had been done. At 12:06 p.m. RN-B entered R3's room and told R3, she was going to help her to the bathroom. RN-B called on walkie-talkie and requested help to R3's room. At 12:11 p.m. RN-B stated the NAs should have repositioned and check and change R3 every two hours. RN-B offered R3 water. R3 refused. NA-A entered R3's room. Using a mechanical lift RN-B and NA transferred R3 from the wheelchair to R3's bed. NA-A lowered R3's blue jeans and stated R3 was not wet because color strip had not changed color. Surveyor requested incontinence brief be opened because there was an odor of urine. NA-A stated R3 always had a slight odor of urine. NA-A opened the incontinence brief. RN-B and NA-A verified the front of the brief was a little bit wet and that the back of the brief was very wet, soaking the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

(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 314	Continued From page 59	F 314		

bottom of R3's sweatshirt. R3 had also been incontinent of a small amount of black sticky stool. NA-A placed a clean incontinence brief on R3. NA-A then dressed R3 in a clean shirt. RN-B was standing on the right side of R3 helping R3 to stay on her right side while NA-A cleaned R3's bottom. RN-B was asked to check R3 buttocks if red area on buttock was blanchable. RN-B touched the area which blanched. Observation of R3's perirectal area noted redness. RN-B was asked to spread R3's buttock cheeks to be able see coccyx area. RN-B lifted left R3's buttock cheek from above. The observation noted slit between R3's left and right buttock cheek on coccyx immediately above rectum. NA-A verified there was an open area there. NA-A said "I did not see anything when I gave her a shower this morning." Requested RN-B and NA-A to change positions. RN-B verified slit present and when requested estimated size as an approximately 3 cm by 0.1 cm open area between the buttocks. She stated the surrounding tissue was intact, pink and blanchable. RN-B and NA-A switched places and NA-A placed a clean incontinence brief on R3. NA-A then dressed R3 in a clean shirt. At 12:22 p.m. RN-B left R3's room when RN-C arrived. RN-C assisted NA-A to transfer R3 using a mechanical lift into R3's wheelchair.

During interview on 10/3/17, at 12:41 p.m. the DON stated she would have hoped staff would have asked for help if they needed help. DON stated she would expect staff to check and change residents according to their care plan. The DON stated she would have expected staff to reposition residents in accordance to their care plan. DON reviewed R3's care plan and Bedside Kardex Report printed 10/3/17, and verified R3's toileting plan was for R3 to be checked and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 314	Continued From page 60	F 314		

changed every two hours as needed. DON stated staff were to reposition R3 every two hours. DON stated staff were to check R3 every two hours and if incontinent change R3. The DON was told that R3 was observed to have an open area on R3's coccyx. DON stated she would look at area and measure the area. Requested copy of documentation when completed.

R15 was admitted to the facility on 6/6/16, with diagnoses of Parkinson's disease (chronic and progressive movement disorder), history of falling, history of traumatic brain injury (TBI), and pressure ulcer per Admission Face Sheet. R15 had a physician order dated 8/11/16, for an air bed to help with skin. Pressure and breakdown.

R15's MDS dated 6/19/15, indicated R15 was totally dependent on two staff for bed mobility, transfers, and locomotion in and out of room, dressing, and toilet use.

The skin interruption care plan dated 9/24/16, noted Skin check every shift (watch for pressure points e.g. heels, calves, hips, shoulders, back, etc.) Notify nurse immediately of any new areas of skin breakdown, redness, blisters, bruises, discoloration, etc. The nutritional care plan revised on 9/24/16, directed staff to lay R15 after meals. The care plan revised on 7/5/17, for skin interruption, indicated R15 had a history of open area on left posterior thigh (ischium) and potential for other skin Interruption related to immobility and incontinence. On 9/25/17, the care interventions noted, staff were directed to turn and reposition at least every two hours as he allowed. Attempt to adjust position slightly if he allowed. Used sling with repositioning and assist of two.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 314	Continued From page 61	F 314		

The 9/29/17, Wound Data Collection, noted the right outer ankle to measure 2 x 1 x 0.25 cm, dressing intact with drainage, the surrounding tissue was red, pain only with touch, and had minimum serosanguineous drainage. The margins were denuded and were erythematous. Wound was cleansed and dried per facility protocol. Mepilex (an absorbent, atraumatic self-adhesive island dressing) applied. In addition, the "pressure ulcer sage 1. Surrounding tissue is red and denuded. Redness spans 6 cm x 7 cm."

The CAA dated 9/29/17, indicated R15 had a right outer ankle wound currently 100% epithelialized. R15 had a pressure relieving mattress, cushion in wheelchair, pressure relieving boots, and was repositioned every two hours.

On 10/2/17, the physician ordered Mepilex to be applied to the right ankle until healed and the dressing was to be changed every 72 hours.

The 10/2/17, Wound data collection Right outer ankle no measurements, dressing intact, drainage on dressing, clean, intact, maceration, pain with touch only, Drainage None: intact pink, macerated. Cleansed/dried per facility protocol and Mepilex applied. clean, dry, intact, macerated. pain with touch minimum purulent drainage. intact, macerated. Wound cleansed and dried per facility protocol. Mepilex applied.

On 10/3/17, at 7:41 a.m. R15 was observed in bed, R15 was rolled to right, with pillow slightly underneath back, knees were drawn up and right knee extended slightly over the right hand side of bed. R15 was under continuous observation from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 314	Continued From page 62	F 314		

7:41 a.m. until the NA and TMA entered the room at 9:19 a.m. Morning ADL cares (washing of face, chest, armpits and peri area) were observed for R15. At 9:31 a.m. R15 was lifted into the reclining wheelchair. TMA-A asked why the heel protectors (Velcro boots) were not put on and NA-A stated "I need to be honest, the Velcro doesn't work and so there is no reason to put them on". NA-A further stated she had asked for them to be replaced but they hadn't been. NA-A could not remember how long it had been. NA-A stated "last year when you were here, his butt was open and it is really hard to heal it up; it's his left leg we're having trouble with now." At 10:07 a.m. nurse put in his hearing aids and R15 was taken to church. At 10:57 a.m. R15 remained seated in the wheelchair, sitting in room. At 12:03 p.m. R15 was taken into dining room for lunch. R15 went from 7:41 a.m. to 12:03 p.m. without being repositioned out of the Broda chair. In addition, R15 did not have the boots applied while up in the wheelchair to minimize pressure and R15 was not returned to bed after meals as directed by the care plan.

On 10/4/17, the Wound Data Collection noted a "pressure ulcer stage 1. Redness around ulcer is 5 cm x 6cm."

The care plan for skin interruptions revised during the survey on 10/4/17, read, pressure relieving /reducing device and or skin protective device on heels. Boots when up in wheelchair, and heel protectors in bed as he allows. Alternating pressure reducing mattress with edges. Barrier cream to buttocks with incontinent cares.

R15's right ankle pressure ulcer was observed on 10/5/17, at 11:50 a.m. RN-A stated the wound

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 314	Continued From page 63 care nurse was coming today to give education. RN-A set up wound care for R15, washed hands, applied gloves, removed old dressing and disposed of appropriately. RN-A then removed gloves and cleaned hands. RN-A said wound looks smaller, but was more red with the surrounding skin. The resident pulled away when the wound was touched and cleansed. RN-A palpated reddened area. RN-A again changed gloves and cleaned hands. RN-A indicated the wound was open, Stage 2, with reddened, brownish slightly swollen area surrounding the wound. Nursing assistant charting was requested for prior 14 days, from 9/22/17 through 10/5/17, the charting was blank, "no data found." On 10/5/17, at 12:49 p.m. the interim director of nursing (DON) stated "I tell them all the time" the heel protectors [Velcro boots] should be on, if she had been told the Velcro did not work she would have ordered new boots. At 1:00 p.m. the DON reviewed conflicting documentation on the pressure ulcers and stated need ownership on who's going to do the documentation. Facility policy for repositioning was requested but not provided.	F 314		
F 318 SS=D	483.25(c)(2)(3) INCREASE/PREVENT DECREASE IN RANGE OF MOTION (c) Mobility. (2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.	F 318		11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 318	Continued From page 64 (3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 3 resident (R15) was provided with Range of Motion (ROM) to prevent decline. Findings include: R15 was admitted to the facility on 6/6/16, with diagnoses of Parkinson's disease (chronic and progressive movement disorder), history of traumatic brain injury (TBI), and pressure ulcer. R15 had a Physician Order dated 6/15/17, for PT: for ROM as contractures worsening (knee contracture noted). R15's Minimum Data Set dated 6/15/17, indicated the resident was severely cognitively impaired. The Physical Therapy (PT) Therapist Progress and Discharge Summary dated 7/11/17, indicated the resident was able to tolerate stretching for 10 minutes without becoming agitated. The Therapy Documentation Notes dated 7/17/17, directed staff that R15 was to be stretched/PROM to both lower extremities, with hip abducted. "1. Slowly pull both legs at knees apart to tolerance, then put hip abductor bolster between legs at thigh level, times 20 reps [repetitions]. 2. Both ankles to be flexed down/up	F 318	1. R15 was re-evaluated 10/12/17 and is currently being seen by physical therapy 5 times a week and is not currently on a ROM program 2. All resident's on a ROM were reviewed on 10/24/2017 to ensure presence in the care plan and current R.O.M plans are being followed 3. Nursing staff will be re- educated by DNS or designee on the importance of performing and documenting ROM programs for each resident on a ROM program on XXX date 4. R15 and other random residents as appropriate will be audited by DNS or designee weekly x4 and monthly x3 to ensure completion of ROM tasks and documentation and findings will be reviewed by quality committee for further recommendations 5. Date of completion November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 318	Continued From page 65	F 318		

times 20 reps. 3. As best as possible stretch both knees to extension slowly with hand on knee and ankle to stretch slowly times 20 reps. R15 sometimes pulls both legs back, ask him to relax to do lower extremity stretching to tolerance."

The MDS of 9/13/17, revealed R15 and required extensive to total assist with all activities of daily living (ADLs). R15 also had bilateral functional impairment in the upper and lower extremities. The Care Plan printed 10/5/17, indicated R15 had contractures, staff were to perform ROM exercises per treatment plan in patient's room twice a day.

On 10/2/17, at 12:00 p.m. R15 was observed being taken into the dining room, he was in a tilt in space wheelchair, which had to be tilted forward to get his knees under the dining table. R15 required assistance to eat, although he lifted his cup to drink once, after it was put into his hands.

Nursing assistant charting was requested for prior 14 days, from 9/22 through 10/5/17, the charting was blank, "no data found."

On 10/3/17, at 7:41 a.m. R15 was observed in bed, R15 was rolled to right, with pillow slightly underneath back, knees were drawn up and right knee extended slightly over the right hand side of bed. R15 was under continuous observation from 7:41 a.m. until the nursing assistant (NA) and trained medication aide (TMA) entered the room. At 9:19 a.m. NA-A and TMA-A entered the room. Morning ADL cares (washing of face, chest, armpits and peri area) were observed for R15, NA-A used gloves and provided pericare, then removed the gloves but did not wash her hands

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 318	Continued From page 66	F 318		

or use hand sanitizer. ROM was not provided. At 2:18 p.m. NA-A stated she did not do ROM, nervous because he would yell out and so did not complete it.

On 10/5/17, at 7:18a.m. NA-B performed morning cares on R15 and no PROM was provided.

On 10/5/17, at 12:49 p.m. the interim director of nursing (DON) stated R15 should be receiving ROM twice a day according to his care plan.

A policy for Range of Motion dated September 2012, indicated: To provide the residents with as full a range of motion as possible. To improve or maintain joint mobility and functional independence. To prevent contractures. PROM Caregiver moves the joints without resident assistance.
ROM (2) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and / or to prevent further decrease in range of motion.

A policy titled Restorative Nurse Job Orientation and Training (JOT) dated September 2012 indicated: To ensure consistent and proper training for each new restorative nurse. The restorative nursing program is part of the interdisciplinary team that assess, plans and implements and evaluates the abilities/disabilities of the individual residents. The vision of the restorative nursing staff is to promote the highest potential for a resident's physical needs and functional independence and mental and psychosocial well-being. This comprehensive care will identify the specific needs of each resident with a planned intervention to assist in prevention of further disability, maintain strengths

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 318	Continued From page 67 and restore any loss of function. Every attempt will be made to assist the resident to achieve the independence necessary for discharge. However, if that goal is not obtainable because of chronic or terminal illness, the resident will continue to be treated and cared for with respect and dignity and assisted to attain/maintain his/her highest practicable level of independent function.	F 318		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents. (n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. (1) Assess the resident for risk of entrapment from bed rails prior to installation. (2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. (3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. This REQUIREMENT is not met as evidenced by:	F 323		11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 323	Continued From page 68 Based on observation, interview and document review, the facility failed to ensure adequate supervision and assistive device interventions were in place to prevent accidents for 2 of 3 residents (R9 and R11) reviewed for accidents. Findings include: R9's nutritional Care Area Assessment (CAA) dated 3/20/17 and quarterly Minimum Data Set (MDS) dated 6/22/17, indicated R9 had a poor memory and depression. The CAA indicated R9 frequently gave her friend, another resident at her table, thin liquids when the resident had orders to receive nectar thickened liquids. The CAA notes also indicated education had been provided to R9 by the staff. R9's care plan revised on 3/29/17, identified R9 gave another resident (R2) thin liquids which was usually soda. The care plan identified that R9 had been educated but had not changed her actions despite stating verbal understanding of the risks her actions could cause R2. On 10/4/17, at 3:02 p.m. during an interview family member (FM)-A, the family stated R2 was on thickened liquids. FM-A stated R2 was forgetful and does not always remember the education regarding her diet. FM-A stated R2 consented to thickened liquids because it was her benefit and protection. FM-A was unware of R2 drinking soda and stated R2 had never asked her for soda. On 10/4/17, at 4:22 p.m. the medical director (MD) stated he was unaware what other interventions were in place to ensure R9 didn't continue giving R2 the thin liquids, other than	F 323	1. DNS discussed accident prevention with R9. Immediate supervision was initiated upon findings. R11's care plan was updated to remind staff to intervene when resident is ambulating independently by offering her walker. Immediate education was provided to staff related to assistance device interventions. 2. All residents who utilize assistive devices and require assistance with ambulation have been reviewed and staff have been updated and reeducated on their needs for assist and assistive devices for these residents 3. All staff will be educated on accident hazards and the importance of utilizing appropriate support and assistance by DNS or designee on or by November 7, 2017 4. R9 and other random residents as appropriate will be audited by DNS or designee weekly x4 and monthly x3 to ensure completion of ROM tasks and documentation and findings will be reviewed by quality committee for further recommendations 4. Date of completion November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 323	Continued From page 69 education. On 10/5/17, at 10:05 a.m. the speech therapist (ST) stated she was aware R9 had given R2 regular soda. The ST was also aware R9 had been educated but was unaware of any specific supervision provided, or any other interventions. R9's progress notes were reviewed from 1/6/17 to present and revealed the following: On 1/16/17, at 10:21 p.m. it was documented that during dinner that evening R9 gave another resident pop and that R9 was educated. The note indicated R2 had stated that she did not want the pop and that R9 was encouraging her to drink it. The note indicated the pop was then thickened and R2 complied with it while R9 stated "that's nasty, she should drink what she wants ...yuck." On 3/13/17, a 10:44 p.m. entry indicated R9 had given R2 soda. The note indicated R9 was educated but had responded that she did not care what she could or could not give people and had shrugged her shoulders. On 3/15/17, at 12:32 p.m. the note indicated R9 had given another resident a pop and was educated, however, R9 responded with shrugging her shoulders. On 3/26/17, at 11:08 p.m. it was noted R9 had given R2 soda at dinner and R2 had begun coughing and turning. The notes indicated R9 had been educated and had responded R2 "is fine she always turns red when she eats and drinks."	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 323	Continued From page 70	F 323		

On 3/29/17, at 11:24 a.m. a care conference note identified the registered dietician (RD) educated R9 on why she cannot give R2 thin liquids (choking/aspiration/pneumonia risks). The note indicated R9 was unhappy with the subject and had stated she "only gives her a little glass" and R2 "doesn't cough when I give it to her" "she coughs with everything, it's not the soda I give her."

On 5/30/17, at 10:18 p.m. an entry indicated a licensed practical nurse (LPN) had educated R9 about not giving other residents food that are not a part of their diet. The note indicated that R9 smiled and shrugged her shoulders during the education.

On 6/1/17, at 7:21 a.m. a note indicated R9 had been educated to not give R2 soda and that the facility might have to move her table if it continued. The note indicated R9 had responded by shrugging her shoulders and stating, "I do what I want and if you move tables I will eat in my room."

On 6/19/17, at 9:35 a.m. it was documented R9 had given R2 thin liquids even though R9 had been educated countless times about how it was hazardous to R2's health. The note continued to indicate R9 stated she understood but continued to give R2 thin liquids.

On 7/15/17, at 5:47 p.m. the note indicated R9 was witnessed to be giving R2 pop and staff intervened as R2 was coughing. The note further indicated R9 was screaming at the nursing assistant (NA) who intervened. R9 was re-educated at that time regarding resident safety and R2's history of coughing and becoming

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 71	F 323		

cyanotic due to pop.
No other interventions were recorded as being implemented.

On 10/4/17, at 11:47 a.m. R2 was interviewed and confirmed she was on a regular diet and thickened liquids. At 12:18 p.m., R2 was at the lunch table and was compliant with thickened liquids. R9 was not observed at the table during the meal. Another resident at the table was drinking soda, but there was no exchange/request regarding it.

During interview on 10/4/17, at 1:01 p.m. nursing assistant (NA)-A confirmed R9 gives R2 pop. NA-A stated staff check on R2 when they hear her cough increasing and "we know [R9] gave it to her." NA-A stated R9 had been educated but that R9 had responded that she did not care. NA-A was unaware of any other interventions having been attempted.

On 10/4/17, at 1:14 p.m. NA-B stated R2 was tolerant to thickened liquids. NA-B stated R9 gave R2 pop and felt R9 poured it into a cup and set it in front of R2. NA-B stated R9 had been educated but she continued to do it. NA-B was unaware of other interventions put into place.

On 10/4/17, at 2:27 p.m. the administrator and director of nursing (DON) were interviewed and stated R9 had been educated, and that was documented in the Progress Notes. The DON and administrator stated they had not personally talked to R9 but were aware of the situation.
On 10/3/17, at 7:54 a.m. R11 was observed to be in bed while cares were being provided to her roommate (R19). R11 got up and ambulated to the bathroom without her walker, even though it

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 323	Continued From page 72	F 323		

was next to the bed. NA-A asked R11 if she was okay, but did not encourage R11 to use her walker and did not physically bring the walker to her. R11 was observed between 7:54 and 8:33 moving about the room, between the bathroom and her bedside four times without using her walker. At 8:33 a.m. R11 started to ambulate toward the room door without her walker, but returned back to the bathroom.

R11's record indicated she had been admitted to the facility on 10/21/16, with diagnoses of osteoarthritis, amnesia, hypothyroidism, overactive bladder and muscle weakness.

R11's admission Care Area Assessment (CAA) dated 11/1/16, indicated R11 was confused at times, was working with PT (physical therapy) and OT (occupational therapy), and sometimes refused ADL (activities of daily living) cares. Back and hip pain was causing need for more assistance, at times refused to toilet or allow staff to change her. The CAA further indicated R11's dementia had increased and that R11 would make unsafe choices at times. The CAA indicated staff were to be aware and watchful to assure safety.

R11's Minimum Data Set (MDS) dated 7/13/17, indicated R11 had significant cognitive loss, required supervision and encouragement or cueing from one staff for bed mobility and eating, limited assistance of one staff for transfers, locomotion in room and on unit, dressing, toilet use and personal hygiene and was frequently incontinent of urine.

On 10/4/17, at 10:31 a.m. the director of nursing (DON) stated R11's care plan had been revised

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

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GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 323	Continued From page 73 that morning to be sure R11's walker was beside the bed so she would use it since she is impulsive. The DON confirmed R11 should be assisted to or reminded to use the walker.	F 323		
F 353 SS=F	483.35(a)(1)-(4) SUFFICIENT 24-HR NURSING STAFF PER CARE PLANS 483.35 Nursing Services The facility must have sufficient nursing staff with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). [As linked to Facility Assessment, §483.70(e), will be implemented beginning November 28, 2017 (Phase 2)] (a) Sufficient Staff. (a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. (a)(2) Except when waived under paragraph (e) of	F 353		11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 353	Continued From page 74 this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. (a)(3) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care. (a)(4) Providing care includes but is not limited to assessing, evaluating, planning and implementing resident care plans and responding to resident's needs. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure adequate staffing was available to meet the daily care needs for 7 of 14 residents in the sample (R1, R3, R7, R9, R11, R15, R19), with the potential to affect all residents in the facility. The facility census was 20 residents at the time of survey. Findings include: Refer to F312: the facility failed to provided assistance with eating, toileting, and oral hygiene for 5 of 8 residents (R1, R7, R3, R15, R19) reviewed for activities of daily living. Refer to F314: the facility failed to reposition timely and pressure relieving devices applied 4 of 4 residents (R1, R7, R3, R15) who had been identified at risk for pressure ulcers reviewed for pressure ulcers. Refer to F318: the facility failed to ensure 1 of 3 resident (R15) was provided with Range of	F 353	1. R 7 has expired. R1, 3, 9, 11, 15, and 19 are being provided with services per their care plan. The Scheduling Coordinator was provided with immediate education in communicating scheduling changes to the DNS or Administrator to allow Leadership to implement schedule change processes to ensure resident needs are met. 2. All residents have the potential to be affected. 3. Staffing patterns have been reviewed and processes for scheduling changes have been developed to ensure resident care needs are met. Education on processes for staffing will be provided to the Scheduling Coordinator and GSS nursing staff on XXX date. 4. Audits will conducted weekly X 4 and then monthly X 3 to ensure staffing pattern is in place. These audits will be completed by the Administrator or designee with findings taken to Quality	

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F 353	Continued From page 75 Motion (ROM) to prevent decline. Refer to F323: the facility failed to ensure that effective supervision and assistive devices were implemented for 1 of 1 resident (R9) who provided another resident with liquids that did not meet residents dietary restrictions, and failed to ensure R11 had an assistive device in place for 1 of 3 residents (R11). On 10/5/17, at approximately 11:00 a.m. during an interview with the director of nursing (DON) and staff scheduler, they stated if they were short a staff, the registered nurse (RN) or licensed practical nurse (LPN) would work 12 hour shifts to cover if short. They also stated staff are very good about picking up half shifts. The staff scheduler stated "we obviously have open holes [in the schedule], we try not to let negative out in environment and community, and try to keep it positive." However, the staff scheduler said they work to fill openings but verified it was fair to say the facility was short staffed. She further added, they had created a new trained medication aide (TMA) position assigned from 7:00 a.m. through 1:00 p.m. because their census was starting to climb. She said if the facility was short staffed the TMA position would be able to help on the floor. On 10/5/17, at 1:15 p.m. during an interview with the administrator, the administrator acknowledged the facility had experienced staff turnover from 1/1 through 8/31/17, and that they had hired 18 nursing assistants (NAs). She stated they currently had 15 active NA staff. The administrator said they had hired two licensed nurses and currently had seven active licensed nurses. She further confirmed the facility continued to have open positions including the	F 353	Committee for further recommendations. 5. Date of completion November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 353	Continued From page 76	F 353		

DON, an RN charge nurse, an LPN charge nurse, and TMA and NA positions.
On 10/2/17, at 4:20 p.m. family member (FM)-A was interviewed about the facility's staffing adequacy. FM-A stated "I am concerned about this. Staff work double shifts and yesterday there was only one nursing assistant and one nurse.Yesterday I came to visit and found [resident's name] in bed and then when I asked the nursing assistant to get her up she stated she was the only one in the facility and had to get a nurse to help. The only one in the facility? for how many residents? I am concerned when I come and find food remaining in her mouth and dried around the mouth."

R1's quarterly MDS dated 7/13/17 indicated the resident required extensive physical assistance of two staff with toileting and personal hygiene, which included oral hygiene and pericare.

On 10/3/17, at 2:20 p.m. nursing assistant (NA)-A verified staff did not follow the plan of care and provide services of oral cares for R19 or R15, did not do PROM (Passive Range of Motion) on R15, and did not ensure or encourage R11 to use her walker while ambulating back and forth from the bathroom to her bedside four times in her room as care planned.

During interview on 10/2/17, at 3:20 p.m. licensed practical nurse (LPN)-A laughed and shook her head (in the "No" direction) when asked if there was enough staff. LPN-A stated there was not enough staff to get the work done, but that do their best. LPN-A told the surveyors showers get missed, charting was not always done and if a resident refused a treatment there might not be time to go back and talk them into it. LPN-A said

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 353	Continued From page 77	F 353		

the, "dining room is difficult."

During interview on 10/2/17, at 3:37 p.m. TMA-B said, "I have been here almost 12 hours." TMA-B stated she'd been asked to stay over from the morning shift. TMA-B stated she was unsure if someone had called in. TMA-B stated many of the residents required two people for cares but that staff were normally able to get everything done except for charting. TMA-B confirmed that call lights might be on longer if they were providing other care. TMA-B stated it was not typical to miss a resident's bath, but it happened on occasion if really desperate for staff.

During interview on 10/3/17, at 10:44 a.m. NA-A stated there was one other aide on but sometimes they would also have a TMA. NA-A said, "We are usually done with cares by 8 a.m., today has not been good. Everyone is constantly asking us to do stuff today." NA-A stated staff would normally be in the dining room about 8:30 a.m.

During interview on 10/3/17, at 7:51 a.m. RN-B stated she had not passed medications in a month, but today the TMA was pulled to be an aide because there was only one aid. RN-B said, "Everything is so stressful."

On 10/3/17, at 1:57 p.m. NA-A verified she had not provided oral hygiene, check, change, repositioning and eating for residents because of being stretched for help. NA-A stated one of the staff that was supposed to work had indicated she was not coming to work and the director of nursing didn't know until around noon. When asked about resident cares, NA-A stated usually there were two nursing assistants in the facility

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F 353	Continued From page 78	F 353		

with a nurse however, sometimes it was hard to get it done with staff and the residents who either required two staff assistance and used a mechanical lift to get in and out of bed which took a lot of time.

During interview on 10/3/17, at 12:41 p.m. the DON stated she would hope staff would asked for help if they needed it.
R9's quarterly Minimum Data Set (MDS) dated 6/22/17, identified R9 had moderate impaired cognition, was frequently incontinent of bladder and always continent of bowel. R9's MDS indicated R9 had diagnoses of generalized muscle weakness, anxiety and depression.

R9 stated on 10/2/17 at 2:05 p.m. that sometimes there were not enough staff requiring a wait of 20-30 minutes for the call light to be answered. R9 stated this had caused her to be incontinent and stated she wished she wouldn't be incontinent. R9 stated that being short staffed didn't occur on a particular day or time, just often.

R10's significant change MDS dated 7/25/17, identified that R10 was cognitively intact and indicated it was very important to her to choose between a shower and tub bath. R10's MDS indicated R10 had diagnoses of arthritis and Parkinson.

R10 was interviewed on 10/2/17, at 2:22 p.m. and was asked about her preference for a shower, tub or bed bath. R10 said she would normally get a shower but if the staff had the time, they would give her a bath which was her preference. R10 further stated the staff do not often have the time to do baths as showers were faster. R10 stated it was okay to take a shower. R10 also said

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 353	Continued From page 79 "sometimes I have to wait 30 minutes when I use my call light. I have fallen getting up by myself." R10 pointed to the sign on wall and stated it was there to remind her to use her call light and wait for help. During an interview on 10/2/17, at 4:41 p.m. the DON verified R10 had fallen twice in the 30 days prior to the start of the survey. R22's quarterly MDS dated 6/18/17, indicated R22 was cognitively intact and had diagnoses of diabetes and history of a stroke. During an interview with R22 on 10/2/17 at 3:06 p.m. R22 was asked whether there was enough staff. R22 said, "No" and stated if he did not ask for the evening snack he would not get it. R22 stated that the facility was very short of staff and that he did not get his scheduled shower last night or last week. R22 said he would like a shower one to two times a week. He stated, "The staff will say they will see what they can do, but they do not have the help to give me showers when I want." R13's quarterly MDS dated 7/3/17, indicated R13 was cognitively intact and had diagnoses of anxiety and depression. On 10/2/17, at 3:51 p.m. when was asked if there was enough staff, R13 said, "I think that staffing is a problem. I think it is more of a problem on the weekends. There are others who have to wait. I can do most things myself. I do not use the call light."	F 353		
F 356 SS=C	483.35(g)(1)-(4) POSTED NURSE STAFFING INFORMATION	F 356		11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 356	Continued From page 80 483.35 (g) Nurse Staffing Information (1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law) (C) Certified nurse aides. (iv) Resident census. (2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. (3) Public access to posted nurse staffing data.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 356	Continued From page 81 The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. (4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to have an accurate staff posting for 3 of 3 days reviewed. This had the potential to affect all 20 residents, family members and visitors. Findings include: On 10/2/17, at 2:01 p.m. the Daily Staffing for Monday October 2nd, 2017, printed 9/29/17, was located on the column across from the charting room. The Daily staffing 10/2/17, indicated the census was 21 residents. The census was inaccurrate as there were 20 residents in the facility. In addition, the staff posting did not reflect the changes for trained medication aide (TMA)-B as TMA-B worked 12 hours and nursing aide (NA)-E was working as a dietary aide. During interview on 10/2/17, at 3:37 p.m. TMA-B stated she had been working at the facility almost 12 hours today. and was not sure if someone had called in. During interview on 10/2/17, at 4:57 p.m. NA-E stated she was the resource aide and was working as a dietary aide that evening not as a NA. NA-E stated an aide had called in. NA-C and	F 356	1. Staff posting was corrected. 2. All residents have the potential to be effected by inaccurate staff and census postings 3. To prevent further incident staff were reeducated on the importance of ensuring daily staffing and census postings are changed to reflect current staffing levels and census within the facility. The facility has implanted a process to ensure staffing level postings are up to date and accurate. 4. Staffing levels and census postings will audited by Scheduling Coordinator weekly x4 and monthly x3 to ensure accuracy and brought to the quality committee for further review and recommendation. 5. Date of completion November 14, 2017	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 356	Continued From page 82 NA-D were observed in the dining room at that time. At 6:10 p.m. on 10/2/17, the Daily Staffing posted for the day had not been updated to reflect actual census or staffing for nursing assistants. On 10/3/17, at 7:50 a.m. and 2:01 p.m., the Daily Staffing posted for the day indicated a census of 21, which was inaccurate as the census was actually 20. In addition, staff had been hand written onto the actual schedule, but their shifts were not reflected on the Daily Staffing posted. During interview on 10/3/17, at 7:49 a.m. (RN)-B stated TMA was pulled to be an aide because there was only one nursing assistant working. On 10/4/17, at 2:01 p.m. the Daily Staffing post identified nine staff. However, review of the staff schedule indicated additional staff had been added that were not identified on the Daily Staffing post. On 10/5/17, at approximately 11:00 a.m. the director of nursing and staffing scheduler were interviewed about the Daily Staffing postings. They reviewed the postings identified above with the actual schedules. The staffing scheduler stated she usually printed staff postings for Thursday thru Monday before the weekend, and Printed Monday-Thursday at the beginning of the week. The Staffing scheduler stated the charge nurse was then responsible to update the posting with any changes.	F 356		
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN	F 367		11/14/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 367	Continued From page 83 (e) Therapeutic Diets (e)(1) Therapeutic diets must be prescribed by the attending physician. (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to implement nutritional interventions for 1 of 1 resident (R2) who had dysphagia and who ate independently in their room. Findings include: On 10/2/17 at 5:10 p.m., R2 was observed to be coughing as she got took a bite of soup. The soup appeared to be regular consistency. When R2 coughed her face would turn red. At 5:18 p.m. R2 was observed to pick up the bowl of soup and was drinking out of the bowl with no coughing. However, at 5:19 p.m. R2 started coughing and that time the other residents in the table looked at her as she turned red. The soup was observed to be thin and not thickened. At 5:20 p.m. resident again coughed. At 5:21 p.m. the cook was interviewed and stated the soup was thin consistency. When asked if she had thickened any soup for the resident's the cook stated for R2 she knew she had to have thickened liquids however for the soup resident wanted regular consistency soup. Cook did not indicate if resident had been offered nectar thick soup prior to the regular consistency being given. At 5:45	F 367	1. The Frazier protocol was reviewed with the resident and his Dr. and discontinued for R2 on October 9, 2017. R2's care plan was updated to indicate new diet orders. 2. All residents with a diagnosis of dysphagia will be reviewed to ensure interventions are in place as appropriate. 3. Dietary and Nursing staff will be educated by DNS or designee regarding dysphagia and nutritional interventions in place on November 7, 2017. 4. Both record and observation audits for R2 and random other residents will be conducted by the DNS or designee to ensure nutritional interventions are in place and being followed. These audits will be done weekly x4 and monthly x3. Findings will be taken to the Quality Committee for further recommendations. 5. Date of completion November 14, 2017	

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F 367	Continued From page 84	F 367		

p.m. R2 coughed three times after she drink out of the bowl of soup. At 5:48 p.m. when approached and asked about the soup resident stated the second hot bowl was good and when asked about the coughing resident stated she sometimes coughed and had been told by the staff of the risk of not having the soup or other liquids thickened. R2 was not offered nectar consistency soup prior to being served the regular consistency soup.

On 10/4/17, at 3:54 p.m. R2 stated she ate snacks and drank thin liquids while in her room. R2 stated staff did not inform her otherwise and R2 denied staff coming into her room while she was snacking and drinking thin liquids. R2 verified she was able to independently eat in her room and did not need staff assistance to open packages/obtain snacks. R2 confirmed she had two baskets of fruit (two oranges and six apples), three muffins, three tomatoes, rice Krispy treats, graham crackers, and pretzels. Licensed practical nurse (LPN)-A was interviewed right after the R2's interview and confirmed the snacks in R2's room. LPN-A acknowledged there was no monitoring system in place for R2's snack/fluid consumption in her room.

The Admission Face Sheet dated 2/4/15, indicated R2 had a diagnoses of Parkinson's as of 2/4/15, and dysphagia (difficulty swallowing. It is usually a sign of a problem with your throat and the muscular tube that moves food and liquids from the back of your mouth to your stomach) as of 9/15/15.

R2's physician had ordered a diet of regular diet with regular textured food. The liquids were to be of nectar consistency (nectar-thick liquids have a

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F 367	Continued From page 85 nectar consistency like an apricot nectar) as of 6/11/15. The physician's Patient Encounter note dated 3/2/17, indicated R2 had diagnoses of Parkinson's induced dementia (a decline in thinking and reasoning that develops in someone diagnosed with Parkinson's disease at least a year earlier. Common symptoms include: Changes in memory, concentration and judgment, trouble interpreting visual information, muffled speech, visual hallucinations, delusions, especially paranoid ideas, depression, irritability and anxiety, and sleep disturbances, including excessive daytime drowsiness and rapid eye movement (REM) sleep disorder) and was to continue with thickened liquids. R2's Care Area Assessment (CAA) for nutritional status dated 3/8/17, indicated R2 was on a mechanically altered diet, had swallowing issues, dementia, and poor memory. A quarterly Minimum Data Set (MDS) dated 6/8/17, indicated the resident's cognitive status was moderately impaired. A Physician Encounter Note dated 6/20/17, indicated the resident had a diagnoses of chronic Parkinson's with dementia, but had normal ability to recall person, place and time. A Speech Therapy Plan of Care (Evaluation Only) note conducted 6/21/17, indicated the resident had moderate cognitive impairment and the discharge plan for nursing to continue with regular textured food diet and nectar consistency fluids and soup. Staff were to monitor R2's snack consumption and free water intake while in her room. R2's quarterly MDS dated 9/8/17, revealed R2's	F 367		

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F 367	Continued From page 86	F 367		

cognition had not been assessed. However, when concern was brought to the facility's attention, the facility completed a brief interview of mental status (BIMS - a tool used to denote cognitive status) assessment on 10/4/17, which indicated R2 had intact cognition. The MDS identified R2 needed supervision, oversight, and encouragement with set up assistance for eating. The medical record lacked evidence regarding R2's intake while in the room and consuming liquids and food concurrently.

R2's care plan printed on 10/4/17, for dysphagia interventions noted R2 was to be offered nectar-thickened liquids during meals and follow the Frazier free water protocol between meals (the facility provided a hand out dated 1/16, which identified the Frazier free water protocol allowed residents to have ice chips and/or water in between meals who are on thickened liquids. The protocol advised residents were allowed to drink water between meals and 30 minutes after meals and directed residents should not consume food with thin liquids while on the Frazier free water program). Furthermore, the care plan identified staff was to monitor and discourage R2 from sneaking regular fluids.

R2's care plan printed on 10/4/17, for self-care directed staff to provide supervision after set-up. R2 required nectar thickened liquids and had the Frazier water protocol in place. The care plan also noted R2 had been educated on the risks versus benefits of drinking thin liquids.

R2's care plan printed 10/5/17, after it was brought to the facility's attention, the intervention for the dysphagia focus had been updated and revised to indicate staff was monitor the

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F 367	Continued From page 87	F 367		

respiratory status daily and report to R2's physician any changes. Staff were to continue to discourage the use of thin liquids. The instructions for staff to follow R2's nectar consistency were in consistent as the dysphagia care plan directed to offer yet the self-care deficit care plan directed staff that the resident required nectar fluids. It could not be determined which care interventions the staff were to follow as dysphagia interventions indicated staff was offer nectar consistency fluids and the self-care interventions informed staff it was required.

On 10/4/17, at 11:59 a.m. the rehab director stated the Frazier free water protocol was implemented for R2 approximately one year ago. R2 was able to have thin liquids in her room but was not to be concurrently eating food with intake due to high risk of aspiration.

On the same day, at 12:57 p.m. registered nurse (RN)-B stated staff were currently monitoring R2 for signs and symptoms of pneumonia. RN-B stated R2 should not be drinking thin liquids at all and was unaware what Frazier free water protocol was. RN-B stated there was not a monitoring system in place to observe when and what type of fluids R2 consumed.

On 10/4/17, at 1:01 p.m. nursing assistant (NA)-A was interviewed and stated R2 can have all of the thin liquids she wanted in her room and was delivered at least three pitchers of water per day. NA-A was unaware what the Frazier free water protocol was. NA-A stated R2 always had snacks in her room and believed to be able to eat and drink thin liquids in her room at the same time. NA-A verified there was not a monitoring system in place when R2 was in her room eating and

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F 367	Continued From page 88 drinking thin liquids. On 10/4/17, at 2:43 p.m. the interim dietary manager (DM) stated R2 can have thin liquids in her room but was unable to consume food concurrently. The DM stated the dietary department does not monitor R2's intake while in her room. At 2:52 p.m. the director of nursing (DON) stated R2 did not have food in her room and staff do not offer food in her room. The DON stated there was not a monitoring system in place. On 10/5/17, at 10:05 a.m. speech therapist (ST) was familiar with R2 and stated she had difficulty remembering safe swallowing tips and therefore, her diet was modified to thickened liquids. ST stated R2's memory was inconsistent as far as recall of the rationale for her ordered diet. Further, ST stated R2 was on the Frazier free water protocol but had difficulty understanding the details of the program since her carryover of education was poor. ST stated the BIMS assessment tests more of short term memory which R2 was better with since her memory faded as the day went on. ST stated the facility should have a monitoring system in place while R2 was in her room drinking thin liquids and was not to have food at the same time. ST verified if R2 drank thin liquids and consumed food concurrently it increased her risk of choking and aspiration. The facility's policy titled Comprehensive Care Plan and Care Conferences revised 9/17, directed staff to provide an ongoing method of assessing, implementing, and evaluating to meet the highest level of functioning.	F 367		

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F 367	Continued From page 89 The facility's policy titled Care Plan revised 11/16, identified residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.	F 367		
F 441 SS=E	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (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: (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 (facility assessment implementation is Phase 2); (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;	F 441		11/14/17

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F 441	Continued From page 90 (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (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 adequate hand hygiene for 6 of 8 residents (R15, R11, R7,	F 441	F441 1. R7 is expired. R1, R3, R11, R15, R32 are being provided cares with proper hand	

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F 441	Continued From page 91 R3, R32, R1) observed with cares. In addition, the facility failed to conduct a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system. This had the potential to affect all 20 residents residing at the facility. Findings include: Dining room: R15's quarterly Minimum Data Set (MDS) dated 6/15/17, indicated R15's diagnoses included dementia, and depression. The MDS indicated resident required extensive physical assistance of one staff with eating. R11's quarterly MDS dated 7/13/17, indicated R11's diagnoses included arthritis and anemia. The MDS indicated resident required supervision with eating. R7's quarterly MDS dated 8/22/17, indicated R7's diagnoses included Alzheimer's, dementia, depression, anxiety and diabetes. The MDS indicated resident required extensive physical assistance of one staff with eating. During observation of the lunch meal in the dining room trained medication aide (TMA)-B was observed on 10/2/17, at 12:18 p.m. carrying a plate of food to R15. TMA-B sniffed and then wiped her nose with her hand before putting R15's plate in front of R15 and without washing hands or using alcohol based sanitizer TMA-B then touched R15's red sweatshirt with the same hand used to wipe TMA-B's nose. At 12:24 p.m. TMA-B touched her nose with her right hand and then touched her hair. Without washing hands or	F 441	hygiene in place. Immediate education was provided with staff caring for the above residents. The facility risk assessment was completed on 8/25/2017 and sent to NALCO. The facility is currently working with EcoLab to determine a date on which they will come to the facility. 2. All residents have the potential to be affected by improper hand hygiene. The facility assessment for Legionella was completed on 8-25-2017. 3. All staff will be re-educated by DNS or designee on proper hand hygiene on XXX date. EcoLab has been contracted to conduct annual testing for Legionella. 4. Hand hygiene will be audited by observation for R1, 3, 11, 15 and 32 and random other residents weekly x4 and monthly x3 by DNS or designee to ensure proper hand hygiene is occurring and findings will be reviewed by quality committee for further recommendations. Ecolab testing results will be included In Tels and reviewed annually 5. Date of completion November 14, 2017 Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of facts alleg3ed or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is require by provisions of federal and state law. For the purpose of any allegation that the center is not in substantial compliance with federal	

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F 441	Continued From page 92 using alcohol based hand sanitizer, TMA-B sat down between R15 and R7 at the dining room table. TMA-B picked up R15's fork and fed R15 then switched fork and fed R7 alternating between both residents. At 12:28 p.m. TMA-B touched her nose with right and left hand then without washing hands or using alcohol based hand sanitizer, repositioned R7 in Broda chair to a more upright position. At 12:29 p.m. TMA-B wiped her nose with her right hand then fed R15 a forkful of food. TMA-B, without washing hands or using alcohol based hand sanitizer, went to the kitchen pass through window and picked up R11's plate. TMA-B brought R11's plate to the table with her right thumb touching the rim of the plate next to R11's biscuit. At 12:31 p.m. TMA-B touched her hair with her right hand and then opened R7's butter. TMA-B then fed R7 a forkful of food and then buttered R7's biscuit while holding biscuit with R7's napkin. During interview on 10/2/17, at 3:37 p.m. TMA-B stated she had bad allergies and normally would get up and wash her hands if she rubbed her nose or eyes. TMA-B said, "I forgot today." Blood sugar: R3's quarterly MDS dated 7/13/17, R3 indicated R3 had diagnoses of insulin dependent diabetes, anemia and Alzheimer. R3's MDS indicated R3 received daily insulin injections. R32's Admission Record printed 10/5/17, Indicated R32 had diagnoses of diabetes with long term usage of insulin. On 10/2/17, at 3:31 p.m. TMA-B entered R3's room and got a pair of gloves out of R3's bathroom and put the gloves on. TMA-B obtained	F 441	requirements of participation, this response and plan of correction constitutes the centers allegation of compliance in accordance with section 7305 of the State Operations Manual.	

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F 441	Continued From page 93	F 441		

supplies for checking R3 blood sugar form the plastic box in R3's room. TMA-B wiped R3's finger and used a lancet to obtain a drop of blood. Blood sugar was 74 (normal range 70-100) TMA-B disposed of soiled lancet, cotton ball and test strip in the sharps container. Without washing her hands TMA-B opened a plastic container of puff corn and gave it to R3. TMA-B left R3's room without washing hands or using alcohol based hand sanitizer.

At 3:34 p.m. TMA-B entered R32's room and told R32 shed needed to check his blood sugar. TMA-B put gloves on without having done any form of hand hygiene after completing R3's blood sugar. TMA-B wiped R32's third finger with alcohol and used a lancet to obtain a drop of blood. R32's blood sugar was 115. TMA-B removed gloves and did not wash hands or use alcohol based sanitizer. TMA-B straightened the covers on R32's bed and picked up dirty laundry from the floor and put it in basket. TMA-B left R32's room and walked back to the medication cart. TMA-B wiped her nose with the back of her hand then used alcohol based sanitizer to clean her hands.

During interview on 10/2/17, at 3:37 p.m. TMA-B stated she had used alcohol based sanitizer just prior to entering R3's room. TMA-B verified she did not wash hands or use alcohol based sanitizer after removing gloves in R3's room or before putting gloves on in R32's room. TMA-B verified did not clean her hands after doing R32's blood sugar until she got back to the medication cart. TMA-B said, "I have been here almost 12 hours, I forgot."

Incontinence cares:

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F 441	Continued From page 94	F 441		

R3's quarterly MDS dated 7/13/17, R3 indicated R3 had diagnosis of insulin dependent diabetes, anemia and Alzheimer. R3's MDS indicated R3 required extensive assistance of two staff members with dressing and toileting.

At 12:06 p.m. registered nurse (RN)-B entered R3's room and told R3, she was going to help her to the bathroom. RN-B called on walkie-talkie and requested help to R3's room. RN-B got the commode out of R3's bathroom then sanitized her hands with alcohol based sanitizer and put on gloves.

At 12:11 p.m. nursing assistant (NA)-A entered R3's room. Using a mechanical lift, RN-B and NA transferred R3 from the wheelchair to R3's bed. NA-A put gloves on and NA-A lowered R3's blue jeans and stated R3 was not wet because color strip had not changed color. Surveyor requested incontinence brief be opened because there was an odor of urine. NA-A stated R3 always had a slight odor of urine. NA-A opened the incontinence brief. RN-B and NA-A verified the front of the brief was a little bit wet and that the back of the brief was very wet soaking the bottom of R3's sweatshirt. R3 had also been incontinent of a small amount of black sticky stool. NA-A wiped R3's bottom, removed gloves and put clean gloves on without washing hands or using hand sanitizer. Without changing gloves NA-A placed a clean incontinence brief on R3 and then went to the closet and got a clean shirt. NA-A then removed R3's shirt and wet sweatshirt. NA-A removed the wet gloves and without washing hands or using sanitizer, put the clean shirt on R3.

At 12:27 p.m. NA-A gathered the garbage and

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ARLINGTON	411 SEVENTH AVENUE NORTHWEST ARLINGTON, MN 55307

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F 441	Continued From page 95	F 441		

bag of wet clothing and took them to the soiled utility room. NA-A washed her hands. NA-A verified she did not use sanitizer in R3's room or wash her hands after the glove changes. NA-A said, "She must have been stressed out."
R1's diagnoses included dementia with behaviors, major depression, anxiety and cerebrovascular accident obtained from the quarterly MDS dated 7/13/17. The MDS indicated resident required extensive physical assistance of two staff with toileting and personal hygiene which included oral hygiene and pericare. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 7:33 a.m. resident was observed lying in bed as NA-A washed under the breast, armpits and then applied deodorant. NA-A then removed gloves never washed hands then applied a long sleeved shirt on resident. NA-A then donned another pair of gloves got a clean incontinent pad rinsed a wash towel provided pericare in the front and she cued R1 she was doing pericare then pat dried the area after. NA-A then cued resident she was going to turn her to the wall and resident was observed assist to turn. NA-A then was observed provide pericare in the back and was noted with smears of bowel movement as she cleaned. NA-A then set the soiled wash towel on the floor on top of the pajama set that was laying on the floor. NA-A then pat dried the back pericare, then tucked the clean pad under resident and fastened it still using the same gloves. NA-A then touched resident shirt then removed her gloves and reached out for the wash basin went over to the sink and dumped the used water and washed her hands at that time. At 7:41 a.m. NA-A returned to the bedside and pulled R1's pants, adjusted the clothing and then told R1 she was coming back

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F 441	Continued From page 96	F 441		

as she covered R1 up. NA-A then collected the clothes/linen from the floor and put them in clear plastic bag then left the room went across the hall tossed the pajamas set in laundry then went down the hallway to the soiled room and tossed the incontinent pad then used hand sanitizer to cleanse.

On 10/3/17, at 11:57 a.m. the licensed practical nurse (LPN)-C and NA-A were observed use a Hoyer lift to transfer R1 to bed. At 11:59 a.m. LPN-A assessed the skin noted to be blanchable. NA-A and LPN-A then were observed change R1's incontinent pad which was wet and NA-A was observed clean a small bowel movement when providing pericare. NA-A with the same gloves used to clean the bowel movement continued to turn resident as she touched R1's clothing, skin and applied a clean pad then removed the gloves. NA-A then adjusted the pants applied the lift sheet under R1's body still with no hand washing then hooked R1 to the Hoyer lift and transferred R1 to the Broda wheelchair as she touched the Broda wheelchair as she coordinated with LPN-C. NA-A then pushed the Hoyer lift out of the room to the door where the administrator took it to the equipment storage area then at 12:05 p.m. used hand sanitizer foam to clean her hands. At 12:07 p.m. LPN-C stated she had not noticed NA-A had not changed gloves and done hand hygiene after providing pericare to R1. LPN-C stated NA-A was supposed to have washed her hands after removing the gloves she had used to wipe resident with pericare.

R7's diagnoses included Alzheimer's, dementia, depression, anxiety and diabetes mellitus

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	245598	A. BUILDING _____ B. WING _____	10/05/2017

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F 441	Continued From page 97	F 441		

obtained from the quarterly MDS dated 8/22/17. The MDS indicated resident required extensive physical assistance of two staff with toileting and personal hygiene which included oral hygiene and pericare. In addition, the MDS indicated R7 did not reject cares.

On 10/3/17, at 7:53 a.m. NA-A was observed in R7's room and was getting supplies ready to get resident ready. NA-A stated she was going to get R7 upper body cleaned and was going to need assistance with the lower body and pericare because resident grab bars had been taken off and was not able to help now. At 7:54 a.m. to 8:03 a.m. NA-A washed R7's upper body, applied shirt and then lowered the bed and stated she would come back with another staff to finish the cares.

On 10/3/17, at 8:42 a.m. NA-A and TMA-A came to room with the Hoyer lift and both applied gloves and TMA-A approached R7 and stated they were going to get her up for breakfast. At 8:45 a.m. both staff were observed apply the pants to the knee level then applied a shoe on the left foot and a foam boot on the right foot. At 8:46 a.m. NA-A was observed provided front pericare as TMA-A turned resident to the right and NA-A was observed wipe off loose green bowel movement using wet wipes then after used a wash towel. NA-A then pat dried R7's bottom then with same gloves applied the clean pad. NA-A then removed the right glove then assisted TMA-A to turned R7 fastened the pad then removed the left glove. NA-A still without washing hands donned another pair of gloves then applied InterDry Silver textile (antimicrobial cloth used to manage moisture and odor) on both abdominal folds, adjusted clothing and applied the lift sheet

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F 441	Continued From page 98 under R7. At 8:51 a.m. NA-A and TMA-A then washed hands. On 10/3/17, at 11:40 a.m. NA-A and RN-B transferred R7 to bed then at 11:42 a.m. both NA and RN applied gloves cued resident they were going to check her. NA-A then took the pad off stated R7 was barely wet and RN-A checked the skin and was noted blanchable. NA-A was observed clean a bowel movement never removed gloves turned R7 to apply a clean pad still using same gloves and did touch R7's clothing. NA-A then removed gloves cleansed with sanitizer foam and transferred resident to the Broda wheelchair. On 10/3/17, at 1:57 p.m. when asked about gloving NA-A acknowledged she had not removed the gloves after providing pericare and stated she was supposed to remove them and use hand sanitizer or wash hands. On 10/5/17, at 7:38 a.m. the DON was interviewed and stated she expected her staff to perform good hand hygiene practices. The DON stated staff should utilize hand sanitizer or soap and water to clean their hands after performing a blood sugar check. The DON expected staff to perform hand hygiene in between the change of dirty/soiled gloves to the change of a clean pair of gloves. Further, the DON expected staff to wash their hands after touching parts of their body prior to assisting a resident to decrease the spread of any potential infections. Hand Hygiene and Handwashing policy revised 3/16, instructed staff: "4. Wash hands with plain soap and water or anti-microbial soap and water: *if hands are	F 441		

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F 441	Continued From page 99 visible soiled (dirty), if hands are visible contaminated with blood or body fluids *before eating* after using the restroom. 5. If hands are not visible soiled or contaminated with blood or body fluids, use an alcohol based hand rub for routinely cleaning hands: *before having direct contact with residents, patients and children *After having direct contact with another person's skin *After having contact with body fluids, wounds or broken skin *After touching equipment or furniture near the resident/patient *After removing gloves." WATER MANAGEMENT POLICY: On 10/4/17, at 2:22 p.m. the Legionella policy was requested but was not provided until 10/16/17. During review of the policy it was revealed the policy was a corporate general policy and did not indicate if the facility had conducted a facility risk assessment to identify where Legionella and other opportunistic waterborne pathogens could grow and spread in the facility water system, if the facility had implemented a water management program that considered the American Society of Heating, Refrigerating and Air-Conditioning Engineers industry standard and the Centers for Disease Control toolkit, and included control measures such as physical controls, temperature management, disinfectant level control, visual inspections and environmental testing for pathogen. In addition, the policy did not specify testing protocols and acceptable ranges for control measures, and document the results of testing and corrective actions taken when control limits are not maintained.	F 441		

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F 441	Continued From page 100 The facility Legionella Disease and Water Management Program policy dated August 2017, indicated "All Good Samaritan Society rehab [rehabilitation]/skilled location will identify a water management team at their location that will annually, and with any major maintenance and water service change, identify where Legionella could grow."	F 441		

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	245598	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/04/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on December 13, 2016. At the time of this survey, Good Samaritan Society Arlington was found not to be 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 Occupancies. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St Paul, MN 55101-5145, or By email to: 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.	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		10/27/2017

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

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	245598	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**10/04/2017**

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K 000	Continued From page 1 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Arlington was constructed as follows: The original building was built in 1958, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 1st addition was built in 1963, is one story, has no basement, is fully fire sprinkler protected and is of Type V(111) construction; The 2nd addition was built in 1977, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 3rd addition was built in 1988, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction; The 4th addition was built in 1993, is one story, has no basement, is fully fire sprinkler protected and is of Type II(111) construction. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors which is monitored for automatic fire department notification. A two-hour fire wall with a labeled, self-closing, 90-minute fire rated door assembly separates the nursing home from an assisted living facility. The facility has a capacity of 35 beds and had a census of 19 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET.	K 000		
K 363 SS=D	NFPA 101 Corridor - Doors Corridor - Doors	K 363		11/14/17

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K 363	Continued From page 2 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable or combustible materials. Powered doors complying with 7.2.1.9 are permissible. 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 STANDARD is not met as evidenced by: Based on observation and staff interview the facility failed to provide two corridor doors with a means suitable for resisting the passage of smoke in accordance with the 2012 Life Safety Code (NFPA 101) section 19.3.6.3.1 & 19.3.6.3.5.	K 363	KTag – 363 1. New door that meets fire code regulations was ordered and will be installed by November 14, 2017. 2. Maintenance supervisor will be	

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K 363	Continued From page 3 This deficient practice could allow for smoke to enter the corridor making it difficult to exit in the case of fire, affecting 10 of the 19 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 9:30 am to 12:30 pm on 10/04/2017 observations and staff interview revealed the employee entrance utility room did not fit tight in the frame. This deficient condition was confirmed by the facility Maintenance Supervisor.	K 363	responsible for correction and monitoring to prevent recurrence. 3. Completion date Nov. 14, 2017	