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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL ID: PWS5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/07/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **106** (L18)
13.Total Certified Beds **106** (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
	106			
(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):

Reduction in the number of certified SNF/NF beds from 114 beds to 106 beds, effective May 30, 2018, in accordance with a change in licensure. Due to eight beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective May 30, 2018, all 106 facility beds are certified SNF/NF. After this change they currently have 22 beds on layaway.

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 06/13/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 06/13/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1988
(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
06/05/2018
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245500

June 13, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

Dear Mr. Cerney:

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

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

Effective May 30, 2018 the above facility is recommended for:

106 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 13, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: Project Number S5500028, H550040 and H550043

Dear Mr. Cerney:

On May 7, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 20, 2018 that included an investigation of complaint number H550040 and H550043. 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 June 7, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on June 7, 2018 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on April 20, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 30, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 20, 2018, effective May 30, 2018 and therefore remedies outlined in our letter to you dated May 7, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: PWS5

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00087

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245500**
2.STATE VENDOR OR MEDICAID NO.
(L2) **078040500**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BETHANY**
(L4) **804 WRIGHT STREET**
(L5) **BRAINERD, MN** (L6) **56401**

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 **04/20/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **114** (L18)
13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
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
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(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):

Reduction in the number of certified SNF/NF beds from 114 beds to 106 beds, effective May 30, 2018, in accordance with a change in licensure. Due to eight beds being placed in layaway status (in accordance with Minn. Stat. 144A.071, Subd. 4b., as amended by the Minnesota State Licensure) effective May 30, 2018, all 106 facility beds are certified SNF/NF. After this change they currently have 22 beds on layaway.

17. SURVEYOR SIGNATURE Date:
Lisa Carey, HFE NE II 05/22/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Douglas S. Larson, Enforcement Specialist 05/30/2018 (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
01/01/1988
(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

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
May 7, 2018

Mr. Ryan Cerney, Administrator
Good Samaritan Society - Bethany
804 Wright Street
Brainerd, MN 56401

RE: Project Number S5500028, H550040 and H550043

Dear Mr. Cerney:

On April 20, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. In addition, at the time of the April 20, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H550040.

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 attached CMS-2567 whereby corrections are required. In addition, at the time of the April 20, 2018 standard survey the Minnesota Department of Health completed an investigation of complaint number H550043 that was found to be unsubstantiated.

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

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

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

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

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

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

DEPARTMENT CONTACT

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

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

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 30, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by May 30, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the

Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by July 20, 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 October 20, 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,

Joanne Simon, Enforcement Specialist
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: 651-201-4161 Fax: 651-215-9697
Email: joanne.simon@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
	245500	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 4/16/18, through 4/20/18, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted and complaint investigations were also completed at the time of the standard survey on 4/16/18, through 4/20/18. Investigation of complaint #H550040 was completed and found to be substantiated at F686, F690, and F725. Investigation of complaint #H550043 was completed and found to be unsubstantiated. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2)	F 550		5/30/18

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

Electronically Signed | 05/16/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity 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. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	04/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide personal cares in a dignified manner for 1 of 5 (R63) residents observed to have unnecessary full body exposure during cares. Findings include: R63's quarterly Minimum Data Set (MDS) dated 3/16/18, indicated R63 was diagnosed with dementia and depression. The MDS also indicated R63 had moderate cognitive impairment and required extensive assistance with dressing and personal hygiene. On 4/19/18, at 7:08 a.m. nursing assistant (NA)-K and NA-L was observed to provide R63 morning cares. NA-K handed R63 a wet washcloth to wash his face. As R63 was washing his face, NA-K removed all of R63 blankets and placed them on a chair. R63 was noted to to have bilateral blue pressure reduction boots on along with an incontinent brief and a T-shirt. NA-K removed the boots and handed R63 a towel to dry his face. When R63 was done drying his face, NA-K removed his T-shirt and assisted to wash and dry under R63's arms. NA-K removed R63's brief which resulted in R63 being totally nude and proceeded to provide pericares. R63 remained nude and exposed until NA-K and NA-L started to dress him. - At 11:57 a.m. NA-K stated she had realized after the fact that she had left R63 totally nude while providing cares and should have kept areas not	F 550	Resident R63 has personal cares completed by staff will has the minimal amount of their body as possible exposed during cares to ensure dignity and maintaining comfort. All residents who receive personal cares performed by staff have the potential to be affected. All residents are receiving cares in a dignified manner. All nursing staff were re-educated on performing personal cares with exposing as little areas of the body as possible at one time for as little time as possible during education sessions on 5/10/18 and 5/11/18 presented by DNS and staff development. Audits of personal cares for resident 63 and other random residents will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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	245500	A. BUILDING _____ B. WING _____	04/20/2018

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F 550	Continued From page 3 being cleaned covered for his personal privacy and so he didn't get cold. - At 12:14 p.m. licensed practical nurse (LPN)-D stated during personal cares, only the area being washed should be exposed. -At 12:27 p.m. R63 stated most of the time during morning cares, the aids removed everything off of me and at times he got cold. - At 12:33 p.m. clinical manager (CM)-D stated during personal cares staff were expected to expose as little as possible for the shortest period of time to provide the resident with privacy and dignity A policy related to dignity was requested and not provided.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(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 comprehensively assess a residents ability to safely self administer medication for 1 of 1 resident (R12) who stored medication in their room. Findings include: R12's quarterly Minimal Data Set (MDS) dated 1/17/18, indicated R12 had intact cognition.	F 554	Resident R12's primary MD was contacted for orders of medications found in room. Assessment completed for self-administration and careplan updated as indicated. All residents have the potential of being affected. All residents rooms were checked for medications that were not stored appropriately on 5/26/18 and	5/30/18

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F 554	Continued From page 4 On 4/17/18, at 12:54 p.m. during interview with R12 and family member (FM)-A, R12 stated she currently had redness under her breasts. R12 also stated when FM-A assisted her with cares, FM-A would apply powders and ointments to the area and also under her abdominal folds, as needed. On 4/18/18, at 4:19 p.m. a plastic bag which contained tubes of creams/ointments with prescription pharmacy labels on them was observed on R12's bathroom counter. At 4:44 p.m. the creams/ointments remained on the counter. The prescription labels identified the tubes as Nystatin powder, Miconazole cream, Nystatin cream, and Vanicream. On 4/19/18, at 7:10 a.m. the bag of creams/ointments remained on R12's bathroom counter. R12's Medication Review Report (physican orders) dated 4/20/18, did not include orders for the aforementioned creams or powders. R12's Resident Self-Administration of Medications dated 2/8/17, indicated R12 was able to safely self-administer some medications and those medications for which R12 was deemed safe to self-administer would be stored in the medication cart. However, the assessment did not include the self administration of the aforementioned creams/ointments/powders. R12's quarterly Resident Self-Administration of Medications update dated 3/18/18, indicated no changes to R12's self administration since 2/8/17. R12's care plan dated 4/20/18, indicated R12	F 554	5/27/18. Medications found in room were removed until appropriate assessments completed, orders obtained, and careplan updated according GSS policy and procedure r/t self medication administration. All nursing staff were educated on the need for assessment and careplanning for self-administration of medication per GSS policy and procedure if the resident chooses to do so during education sessions by DNS and staff development on 5/10/18 and 5/11/18. Observation audits of resident self-administration of medication will be completed 3x/wk for 4 weeks with results submitted to the QAPI committee for further recommendation.	

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F 554	Continued From page 5 would self-administer nebulizers and oasis mouth wash per physician's order. The care plan did not address the creams/ointments or powders. On 4/20/18, at 11:10 a.m. clinical manager-A stated she was not aware of any ointments/powders being stored in R12's room and confirmed R12 did not have a physician's order to apply the medicated ointment/powder and had not been assessed for the safe application and storage of them.	F 554		
F 561 SS=D	Self-Determination CFR(s): 483.10(f)(1)-(3)(8) §483.10(f) Self-determination. The resident has the right to and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in paragraphs (f)(1) through (11) of this section. §483.10(f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. §483.10(f)(2) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident. §483.10(f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. §483.10(f)(8) The resident has a right to	F 561		5/30/18

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F 561	Continued From page 6 participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the failed to honor residents choices for rising times as requested for 1 of 5 residents (R63) reviewed for choices. Findings include: R63's quarterly Minimum Data Set (MDS) dated 3/16/18, indicated R63's diagnoses included dementia and depression. The MDS also indicated R63 had moderate cognitive impairment, required extensive assistance with dressing and personal hygiene, and was totally dependent with transfers. R63's admission MDS dated 9/29/17, indicated it was "very important" to R63 to choose his own bedtime. During interview on 4/18/18, at 1:09 p.m. R63 stated he liked to get up in the morning at 9:00 a.m. in which he had informed staff of his desired morning rising time. However, R63 stated the staff got him ready and out of bed every morning around 7:00 a.m. despite knowing his personal preference. R63's care conference note dated 1/2/18, indicated R63 did not wish to get up in the morning at 6:00 a.m. rather preferred to get up later such as 9:00 a.m. R63's care plan revised on 3/28/18, indicated R63 had a preference to get dressed for the morning after 8:00 a.m.	F 561	Resident R63's personal preference for rising time was communicated to staff to ensure his preferred waking time is being honored. All residents requiring assistance for dressing and hygiene have the potential to be awoken against their stated personal preference care plans were reviewed based on resident stated preferences. Staff to assist residents with waking based on their preferences. All nursing staff were re-educated on honoring the personal preference of waking/rising times for each resident during education sessions on 5/10/18 and 5/11/18 by DNS and staff development. Audits of honoring personal preferences of waking times for resident 63 and other random residents will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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F 561	Continued From page 7 On 4/19/18, at 7:04 a.m. R63 was observed lying in bed with his eyes closed. -At 7:06 a.m. nursing assistant (NA)-K and NA-L knocked and entered R63's room, turned on the overhead light, and asked if R63 if he was ready to get up and dressed for the day. R63 did not answer, however, NA-K and NA-L proceeded to assist R63 with personal hygiene, dressing and out of bed. -At 8:06 a.m. R63 was taken to the common area. On 4/19/18, at 11:57 a.m. NA-K stated even though she was aware R63 wanted to sleep in until 9:00 a.m., she would normally assist R63 to get up and ready for the day around 7:00 a.m.. NA-K stated R63 had never refused to get up at that time and was was usually ready to get up. -At 12:33 p.m. clinical manager (CM)-D stated R63's preference for getting up in the morning was between 8:00 a.m. and 9:00 a.m. which was noted on his care plan. CM-D stated the staff should not be waking R63 up any earlier than his desired time to rise. CM-D confirmed R63's personal preference was not honored and should have been. The facility Resident's Rights for Skilled Nursing Facilities revised 11/16, included "The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident,"	F 561		
F 583 SS=D	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		5/30/18

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F 583	Continued From page 8 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical 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. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(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. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize body exposure during the provision of morning cares for 1 of 5 (R63) residents observed to have	F 583	Resident R63's personal cares are completed by staff to have the minimal amount of his body as possible exposed during cares to ensure dignity and	

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F 583	Continued From page 9 unnecessary full body exposure during cares. In addition, the facility failed to ensure personal information was not posted and visible to all who entered the room for 1 of 1 resident (R55) who had personal care information posted on her bedroom wall. Findings include: R63's quarterly Minimum Data Set (MDS) dated 3/16/18, indicated R63 was diagnosed with dementia and depression. The MDS also indicated R63 had moderate cognitive impairment and required extensive assistance with dressing and personal hygiene. On 4/19/18, at 7:08 a.m. nursing assistant (NA)-K and NA-L was observed to provide R63 morning cares. NA-K handed R63 a wet washcloth to wash his face. As R63 was washing his face, NA-K removed all of R63 blankets and placed them on a chair. R63 was noted to to have bilateral blue pressure reduction boots on along with an incontinent brief and a T-shirt. NA-K removed the boots and handed R63 a towel to dry his face. When R63 was done drying his face, NA-K removed his T-shirt and assisted to wash and dry under R63's arms. NA-K removed R63's brief which resulted in R63 being totally nude and proceeded to provide pericares. R63 remained nude and exposed until NA-K and NA-L started to dress him. - At 11:57 a.m. NA-K stated she did not provide R63 personal bodily privacy during morning cares and noticed, after the fact she had left him totally nude during the process. She should have kept areas not being cleaned covered for his personal privacy and so he didn't get cold.	F 583	maintaining comfort. Resident R55's personal care information was removed from her bedroom wall. All residents who receive personal cares performed by staff have the potential to be affected by overexposure during cares. Residents are being provided cares limiting exposure to ensure dignity and maintaining comfort. Also, all residents have the potential to have their personal care information, that they do not want posted and visible to all. Nurse managers completed a whole house audit and moved signage to an appropriate area and/or removed signage as indicated. All nursing staff were re-educated on performing personal cares with exposing as little areas of the body as possible at one time for as little time as possible and ensuring resident's personal care information is not posted publically. Staff re-educated on HIPPA privacy and bathing and hygiene care per GSS policy and procedure during education sessions on 5/10/18 and 5/11/18 by DNS and staff development. Observation audits of personal cares and publically posted personal care information will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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F 583	Continued From page 10	F 583		

- At 12:14 p.m. licensed practical nurse (LPN)-D stated during personal cares, only the area being washed should be uncovered.

-At 12:27 p.m. R63 stated most of the time during morning cares, the aids removed everything off of me and at times he got cold.

- At 12:33 p.m. clinical manager (CM)-D stated during personal cares it was expected to expose as little as possible for the shortest period of time to provide the resident with privacy and dignity. R55's annual MDS dated 2/7/18, indicated R55 was diagnoses included Parkinson's disease and arthritis. The MDS also indicated R55 had intact cognition, required extensive assist of two staff for bed mobility and toileting, and was at risk for pressure ulcers.

On 4/18/18, at 4:09 p.m. a 8 x 11 inch piece of paper was observed posted on R55's bedroom wall which read: "If resident is placed on bedpan set timer at desk for 10 minutes. Return to check on resident every 10 minutes while on bedpan if she requests to stay on bedpan."

-At 2:34 p.m. CM-A stated she had placed the sign in R55's room after collaboration with the director of nursing and R55's daughter due to R55 having been left on the bedpan for an extended period of time. CM-A confirmed the sign identified personal information related to R55 which was visible to all who entered her room and should not have been.

The facility Resident's Rights for Skilled Nursing Facilities revised 11/16, indicated "The resident has the right to personal privacy."

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F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to accurately code the oral/dental status section of the Minimum Data Set (MDS) for 1 of 2 residents (R84) reviewed for dental services. Findings include: R84's admission MDS dated 3/30/18, identified R84 was cognitively intact and did not indicate R84 had any broken natural teeth. R84's Nursing Admit Re-Admit Data Collection-V 3 form dated 3/23/18, identified R84 had his own teeth and there were no broken natural teeth. On 4/16/18, at 11:47 a.m. R84 stated he needed to see a dentist for a chipped tooth he sustained from a fall prior to entering the facility. R84's front lower tooth was noted to be chipped. On 4/20/18, 10:19 a.m. registered nurse (RN)-B stated she did not personally do a visual oral assessment while completing the MDS unless she questioned the nursing admission assessment which was completed by nursing staff. RN-B confirmed the MDS was coded incorrectly due to the inaccuracy of the nursing admission assessment. The facility policy Dental/Oral Health Service and Assessments revised 10/17, indicated basic dental/oral health assessments could be	F 641	Nurse Manager re-assessed R 84's oral status and MDS was corrected to reflect the accurate assessment. All residents had oral assessments completed to ensure assessments were accurate this was completed by 5/18/2018. All nursing staff were re-educated on completion of the oral assessment and the nursing admission assessment to ensure accuracy at education sessions on 5/10/18 and 5/11/18. Education completed by DNS and staff development. Audits of oral assessments will be completed to ensure accuracy by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	5/30/18

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F 641	Continued From page 12 performed on residents by registered nurses following the guidance provided in section L of the Resident Assessment Instrument (RAI) Manual. These assessments would be conducted before initial, quarterly and annual MDS or with any oral changes.	F 641		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility also failed to provide edema management for 1 of 1 resident (R12) observed with significant edema which was not monitored. The facility also failed to identify black scabbed areas on toes for 1 of 2 (R45) residents reviewed for non-pressure related skin injuries. Findings include: R12's quarterly MDS dated 1/17/18, indicated R12 was alert and orientated and had diagnoses including of Renal insufficiency, diabetes mellitus, hyponatremia, and chronic obstructive pulmonary disease. The MDS indicated R12 required extensive assistance with bed mobility, transfers and ambulation.	F 684	R12's edema is being monitored daily. R45's skin check was completed upon notification and is accurate care plan updated and MD notified. MD assessed areas on 4/19/2018. The nurse was immediately educated on ensuring accuracy with the completion of the weekly skin check. All residents were reviewed and assessed by 4/22/2018 and the weekly skin checks were completed. Areas that were noted were documented to as appropriate. Residents with edema were reviewed to ensure edema management is appropriate. Licensed nursing staff educated on the	5/30/18

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F 684	Continued From page 13 R12's care plan dated 4/20/18, directed staff to inspect R12's feet daily for open areas, pressure areas, blisters, edema or redness and report to nurse. The nursing staff were to complete weekly skin observations. The care plan also indicated R12 was on a daily 3500 milliliter fluid restriction and had a behavior in which she would drink excessive amounts of fluids. The plan directed the staff to monitor R12's fluid intake and document the findings. R12's Medication Review Report dated 4/20/18, indicated Torsemide (diuretic medication) 20 milligrams (mg) twice daily was ordered for edema/renal insufficiency. R12's Skin observation dated 4/19/18, indicated no skin conditions observed. On 4/18/18, at 12:07 p.m. R12 was observed in the dining room, seated in an electric wheelchair. R12's legs were hanging down and not supported on the foot rests. R12's legs were noted to be swollen and pink from the knee down with taught skin. -At 4:19 p.m. R12 was observed in her room, seated in a recliner with legs elevated. Two plastic 20 ounce/500 ml soda bottles were on the overbed table next to R12. One bottle was filled with water, the other was empty. -At 04:44 p.m. NA-B assisted R12 to restroom and R12 requested NA-B fill the empty soda bottle with water and place on overbed table. NA-B followed R12's direction/request. -At 5:13 p.m. R12 stated her legs got swollen and tight (edema) on a daily basis. R12 stated she took a "water pill' to treat the edema. -At 5:36 p.m. R12 was at the dining room table,	F 684	need to monitor edema on a daily basis and to accurately complete the weekly skin checks. According to GSS policy and procedure for skin assessment and edema management. NAR's educated on the need to alert the licensed staff of areas of concern noted when completing cares. On 5/10/18 and 5/11/18 education completed by DNS and staff development. Skin observation audits will be completed for R12, R45, and other random residents to ensure accuracy of the documentation for weekly skin checks and edema monitoring will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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seated in the electric wheelchair, wearing shorts. R12's legs were not on the foot rests. R12's legs from the knee to the toes were observed pink, swollen and the skin was taught.

On 4/19/18, at 07:18 a.m. R12's son assisted R12 to ambulate from her bed to the bathroom. R12 opened the closet to get slippers and noted 2- 24 count packs of soda in R12's closet.
-At 7:22 a.m. R12 was observed seated in a manual wheelchair in the hallway next to the tub room. R12's feet and legs continued to be swollen and the skin was tight.
-At 8:02 a.m. NA-A assisted R12 out of tub, dried her lower legs/feet which appeared edematous with taught skin. NA-A applied regular socks and lotion to legs. NA-A stated R12's legs appeared more edematous.
-At 8:12 a.m. licensed practical nurse (LPN)-A completed a skin assessment for R12. LPN-A stated there were no concerns related to R12's lower legs.
-At 8:38 a.m. LPN-A stated R12's feet were edematous on a daily basis and R12 elevated her legs several times a day and also received diuretic medications. LPN-A stated R12 did not utilize compression stockings nor did the facility have a system to monitor R12's edema.

On 4/20/18, at 10:56 a.m. LPN-B stated R12's edema was managed by the use of diuretic medications and elevation of R12's legs. LPN-B stated R12 had compression stockings in the past but had refused to wear them. LPN-B stated she monitored R12's edema every day but did not document the findings in R12's clinical record.

Review of R12's clinical record lacked documentation related to the fluid intake.

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-At 11:10 a.m. CM-A confirmed R12 had a long history of edema in her lower legs. R12 wore shorts daily therefore the staff easily monitored R12's legs, however, they did not document any identified concerns. CM-A stated the facility was currently monitoring R12's edema through weekly weights and skin observations. R12 had a long history of being non-complaint with the fluid restriction, and had been offered compression stockings in the past however, R12 had refused them, however was willing to keep her feet elevated in the recliner, and also accepted the daily diuretic medications. Upon review of R12's clinical record, CM-A confirmed the record did not include a evidence of any type of monitoring for R12's lower extremity edema nor evidence R12 was educated on the risk/benefits of non-compliance with the prescribed fluid restriction. CM-A stated R12 had been identified with weight fluctuations due to fluid gains/losses, however, they had not been reported the fluctuations to the physician.

Requested progress notes from the physician and outside dietician and these were not provided. Good Samaritan Society Edema Checks policy dated 9/2012, indicated that any resident who showed signs of edema should have the area measured on a routine basis. Conditions that may contribute to edema may be congestive heart failure, the placement of casts, venous obstruction for various reasons, some medications, and renal disease. The policy indicated that it was a good general rule to measure weekly to detect swelling and daily to monitor swelling and any response to treatment. If the area was unable to be measured, the level of pitting edema could be measured by pressing

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two fingers or thumb firmly into area for 5-10 seconds and then check for indentation. The policy directed the staff to notify the physician of two plus pitting edema or more.
R45's Diagnoses Report dated 4/20/18, included diagnoses of dementia, end stage renal disease which required dialysis, diabetes type II, atherosclerotic heart disease, and chronic pain.

R45's annual MDS dated 2/21/18, indicated R45 had moderate cognitive impairment and required extensive assistance from two plus staff members for bed mobility, transfers, dressing, and hygiene.

R45's care plan was provided on 4/20/18, indicated R45 had impaired circulation related to edema with a history of refusing the foot support board which covered the wheelchair pedals, and history of refusals to elevate lower extremities. The staff were directed to observe fingers and toes for warmth and color routinely and notify nurse of any changes. The care plan also indicated R45 had diabetes and directed the staff to inspect feet daily for open areas, sores, pressure areas, blisters, edema, or redness, and report abnormalities to the nurse. Limited physical mobility related to history of falls evidenced by weakness and informed staff R45 had a history of removing feet from foot pedals, swinging feet, bumping on foot pedals and preferred the have the foot pedals down.

R45's physician orders dated 4/20/18, directed to cleanse the left foot daily and place gauze between the first and second toes every morning. R45's April 2018 treatment administration record (TAR) indicated the gauze treatment had been completed every morning except for April 1, 5, 12,

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and 15th.

R45's Skin Observation evaluation on 4/7/18, and 4/17/18, indicated R45's skin check was completed and no concerns were identified.

On 4/18/18, at 11:50 a.m. R45 was observed seated in her rock-n-go wheelchair without foot pedals, near the nursing station. R45's feet were dangling, both feet were bare, purplish in color, dry, and edematous (swollen, fluid filled). R45's left foot had scabs on her big and pinky toe. The right foot had a scabs on the second toe.

-At 1:09 p.m. R45 remained seated in the rock-n-go wheelchair. R45's bare feet continued to dangle without her feet touching the floor. Licensed practical nurse (LPN)-D approached R45 and asked if the foot pedals could be put on the chair so her feet would not dangle. R45 stated she did not want the foot pedals put on and continued to swing her feet back and forth.

-At 5:31 p.m. CM-D stated she was not aware of the scabs on R45's toes. CM-D stated the NAs were supposed to look at the residents' skin daily and report any concerns identified to the nurses. CM-D also stated the licensed nurses performed weekly skin evaluations and confirmed the most recent evaluation completed 4/17/18, had not identified the scabs on the toes.

-At 8:00 p.m. the DON stated R45's toe wounds were measured and a skin assessment was performed. The DON indicated the wounds appeared to be vascular in nature.

R45's Skin Observation evaluation dated 4/18/18, included the follow areas of impaired skin integrity

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F 684	Continued From page 18 -Right foot: 2nd toe blister area with edge scabbed measured 1.5 centimeters (cm) wide by 1.0 cm long, and 1.0 cm scab under toenail. -Left foot: great toe scabbed area that measured 0.8 cm wide by 1.0 cm long. Pinky toe scabbed area that measured 0.5 cm by 1.0 cm long. On 4/20/18, at 8:54 p.m. the DON stated the nurse who completed the Skin Observation on 4/17/18, had not identified the scabs on the toes because she had not removed R45's gripper socks when she completed the evaluation. The DON confirmed the socks should have been removed in order to evaluate the condition of the feet. A facility policy for non-pressure related skin injuries was requested and not received	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document	F 686	Resident R34 and 45 are being	5/30/18

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F 686	Continued From page 19 review, the facility failed to ensure timely repositioning/offloading was provided in order to minimize the risk and/or prevent pressure ulcers from developing for 2 of 2 (R34, R45) residents reviewed who were at risk for pressure ulcer development and required staff assistance for repositioning. Findings include: R34's annual Minimal Data Set (MDS) dated 1/30/18, identified R34 with severe cognitive impairment and diagnoses including heart failure, neurogenic bladder and Alzheimer's disease. The assessment indicated R34 required extensive assistance with all activities of daily living which included repositioning, and R34 was totally incontinent of bowel and bladder. R34's Pressure Ulcer Care Area Assessment (CAA) dated, 2/21/18, indicated R34 had impaired cognition and was at risk for skin breakdown. R34 was incontinent of bowel and bladder and staff were to assist with toileting, transfers and personal hygiene. The CAA indicated R34 did not have a pressure ulcer. R34's Braden Scale for Predicting Pressure Sore Risk dated 2/15/18, indicated R34 was at high risk for skin breakdown. R34's Care Plan dated 4/19/18, indicated R34 required extensive staff assistance with bed mobility and grab bars to boost up in bed and to reposition side to side. R34 preferred the head of the bed elevated due to feeling short of breath when lying flat. The plan directed staff to turn and reposition R34 every two hours when in the bed and and wheelchair and to utilize a air overlay	F 686	repositioned according to their individualized plan of care. All residents requiring staff assistance with repositioning were monitored to ensure they are being repositioned according to their individualized plan of care. All nursing staff were provided with re-education on GSS policy and procedure for following care planned interventions for repositioning to prevent pressure ulcers during education sessions by the DNS and staff development on 5/10/18 and 5/11/18. Observation audits for resident, 34, 45, and other random residents to ensure timely repositioning will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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pressure reducing device on the bed and a standard cushion in the wheelchair.

On 4/18/18, from 3:45 p.m. to 7:00 p.m. R34 was continuously observed resting in bed, positioned on her back. At no time during the continuous observations were the staff observed to enter R34's room to provide assistance with repositioning.
-At 7:00 p.m. NA-B stated she had not assisted R34 with any type of cares since the start of her shift at 2:00 p.m.
-At 7:01 p.m. NA-C stated she had not assisted R34 with any type of cares since the start of her shift at 2:00 p.m. At this time, NA-C entered R34's room and assisted her with repositioning. R34 was observed to be incontinent of urine.
- At 7:13 p.m. NA-C confirmed R34 had not received assistance with turning and repositioning from 2:00 p.m. to 7:00 p.m. for a total of five hours.

On 4/19/18, from 7:03 a.m. to 9:18 a.m. R34 was continuously observed in bed, positioned on her back with the head of bed elevated approximately 45 degrees. At no time during the continuous observations were the staff observed to assist R34 with repositioning.
-At 9:18 a.m. NA-E assisted R34 with morning cares. R34 was observed to be incontinent of urine. NA-E confirmed R34 had not been provided any assistance since her shift began at 6 a.m..
-At 9:20 a.m. NA-E stated she had not assisted R34 with repositioning/cares since her arrival at the facility at 6:00 a.m. for a a total of 3 hours and 18 minutes.

On 4/19/18, at 12:46 p.m. CM-A reviewed the

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NA's computerized documentation for the evening of 4/18/18, and confirmed R34 had not received assistance with turning and repositioning between 2:00 p.m. and 7:00 p.m. for a total of five hours. CM-A also confirmed the lack of assistance on the morning of 4/19/18, between 6:00 a.m. and 9:18 p.m. for at total of three hour and 18 minutes. CM-A stated R34 was to receive assistance with turning and repositioning every two hours, as directed by the care plan.
R45's Diagnoses Report dated 4/20/18, included diagnoses of dementia with behavioral disturbance, end stage renal disease that required dialysis, diabetes type II, atherosclerotic heart disease, and chronic pain.

R45's annual MDS dated 2/21/18, indicated R45 had moderate cognitive impairment and required extensive assistance from two plus staff for bed mobility, transfers, dressing, and hygiene. The MDS also indicated R45 was at risk for pressure ulcers and required a pressure reducing device for both chair and bed, and required a repositioning program.

R45's Pressure Ulcer CAA dated 2/26/18, indicated R45 was at risk for pressure related skin injury due to weakness and decreased mobility. Had diagnoses of tachycardia, seizures, pain, dementia, anxiety and chronic renal disease that required dialysis. The CAA also included R45 refused to lay down in bed and preferred to sit in wheelchair, required scheduled repositioning, and required assistance with repositioning.

R45's Braden Scale for Predicting Pressure Sore Risk dated 2/21/18, indicated R45 was at moderate risk for pressure ulcers.

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R45's Positioning Assessment and Evaluation dated 2/22/18, indicated R45 declined allowing staff to assist to lay down rather R45 preferred to sit in the wheelchair. Continue with every two hour repositioning as this was effective. R45 was at risk for pressure ulcer formation therefore required a pressure redistribution mattress and wheelchair cushion.

R45's care plan was provided on 4/20/18, and indicated two plus staff members and a stand aide was required for transfers and toileting, two staff assist to turn side to side, R34 utilized bilateral grab bars to aid in repositioning. The care plan also indicated R34 had a history of refusing repositioning or sleeping in bed. R34 utilized a rock-n-go wheelchair for locomotion, had impaired circulation related to edema, was at risk for pressure ulcer development and directed the staff to turn/reposition R34 every two hours. The plan also directed the use of pillows for support/comfort, float heels off bed, pressure redistribution mattress on bed and cushion in wheelchair, and to notify the nurse immediately of any new areas of skin breakdown.

On 4/16/18, at 5:54 p.m. family member (FM)-B indicated they spent a lot of time at the facility and were very involved in R45's care. FM-B stated during visits, they had not ever recalled offering or attempting to take R45 to the restroom and reposition.

On 4/17/18, at 11:45 a.m. R45 stated staff did not ask her if she wanted to be repositioned so she would yell out to go to the bathroom even when she didn't have to go just to get out of the wheelchair for a few minutes.

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On 4/18/18, at 11:43 a.m. R45 was observed at a table near the nursing station, seated in her rock-n-go wheelchair.
-At 11:53 a.m. NA-F wheeled R45 into the dining room to eat lunch.
-At 12:10 a.m. NA-M asked R45 is she wanted to return to the nursing in which R45 agreed. NA-M proceeded to assist R45 back to the area.
-At 12:26 p.m. R45 remained seated the same chair as she received a phone call on her cell phone.
-At 1:01 p.m. licensed practical nurse (LPN)-D walked over to R45 and informed she had one Lasix (diuretic medication) pill for her and administered the pill in applesauce to R45.
-At 1:16 p.m. R45 asked to use the restroom at which time, LPN-D replied she would get somebody to her assist her.
-At 1:26 p.m. rehabilitation aide (RA)-A wheeled R45 to her room and performed range of motion to both lower extremities. When RA-A completed the range of motion exercises, RA-A attached R45's foot rest to the wheelchair and placed the foot board over the pedals. RA-A did not offer to take R45 to the restroom or to reposition and proceeded to assist R45 back to the lobby/nursing area.
-At 1:48 p.m. R45's FM-B arrived and sat with R45 at the table near the nurses station.
-At 2:41 p.m. FM-B stated assisted R45 to the scheduled music activity.
-At 4:09 p.m. R45 returned from activities with FM-B and went for a walk around the facility.
-At 4:13 p.m. R45 was seated in her wheelchair, at the table by the nursing station.
-At 4:30 p.m. R45 continued to sit in her wheelchair at the table.
-At 4:48 p.m. surveyor requested NA-O reposition R45 as it had been 5 hours without any staff

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attempts to offer repositioning. NA-O asked R45 permission to reposition. NA-O proceeded to wheel R45 to her room. NA-O and NA-N assisted R45 onto the bedside commode with a standing aid. R45's skin was intact with a light pink area on the upper gluteal fold. R45 did not void at this time nor had she been incontinent.

-At 4:55 p.m. neither NA-O or NA-N could articulate R45's repositioning schedule and would have to check R34's care plan. NA-N stated the residents' positioning times were passed along during shift report or it could also be determined by looking it up on the computer. NA-N stated there was also an alert that came up on the computer when it was time to reposition a resident. When asked when the last time R45 had been offered or attempts made to reposition, neither NA-O or NA-N were aware. In addition, neither NA could articulate the time period required for a which a resident was to be offloaded (pressure relieved) in order for total reperfusion to occur.

-At 5:03 p.m. NA-N referenced historical documentation for R34's repositioning. NA-N confirmed the last time R45 had been repositioned was at 8:06 a.m. NA-N stated if repositioning had been offered and refused by R45, it was supposed to be documented at such and the refusal would have shown up in the history.

-At 5:15 p.m. CM-D stated the NAs should follow the care plan repositioning as directed and if a resident refused, the NA's were to document those refusals.

On 4/20/18, at 8:43 a.m. the DON stated

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GOOD SAMARITAN SOCIETY - BETHANY	804 WRIGHT STREET BRAINERD, MN 56401

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 686	Continued From page 25 offloading to allow sufficient tissue reperfusion should be for one minute. There DON stated staff should attempt repositioning as outlined in the care plan, and if the resident refused the staff needed to go back and offer again. The DON stated the staff were expected to document any refusals and to also alert the nurse of continued refusals. Facility policy Wound and Pressure Ulcer Management last revised 1/2017, indicated wound programs should include a comprehensive management program to prevent the development of a pressure ulcer or other skin conditions (Braden, following interventions identified on the care plan, nutritional intervention, and specialty surfaces, ect). Facility policy Pressure Ulcers last revised 1/2017, indicated the residents would receive appropriate assessments and services to promote and maintain skin integrity. Good Samaritan Society Pressure Ulcer Practice Guidelines dated September 2016, indicated staff should implement resident specific turning and repositioning programs based upon an individualized assessment.	F 686		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent	F 689		5/30/18

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F 689	Continued From page 26 accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to consistently utilize a gait belt during transfers with a stand aid for 1 of 7 (R45) residents observed to be transferred without a gait belt and had the directive to do so. Findings include: R45's Diagnosis Report dated 4/20/18, included diagnoses of dementia with behavioral disturbance, anxiety disorder, chronic pain, low back pain, and history of falls. R45's annual Minimum Data Set (MDS) dated 2/21/18, indicated R45 had moderate cognitive impairment, and required extensive assistance from two plus staff for bed mobility, toileting, transfers, dressing, and hygiene. R45's Activities of Daily Living Care Area Assessment (CAA) dated 2/26/18, indicated R45 required extensive assistance with transferring and stabilization when standing and transferring. R45's Mobilization Support Data Collection Tool dated 2/21/18, indicated R45 required one staff assist with stand aide for transfers. R45's care plan was provided on 4/20/18, which indicated R45 had decreased mobility, and impaired cognition. The care plan directed staff to two staff with use of the stand aide for transferring, and if R45 was weak/lethargic to use a total lift with a medium high back sling. On 4/18/18, the care plan was updated to include the use of a gait belt while using the stand aide.	F 689	Resident 45's care plan was updated to include use of transfer belt during transfers as resident will allow on 4/18/2018. Resident was also assessed to determine appropriate transfer status and CP was updated and changed to have resident assisted with a sit to stand lift vs the stand aid as resident could not consistently transfer without staff having to physically assist her. All residents who require assistance with transfers are at risk for not having gait belts utilized during transfers. All nursing staff were provided with re-education on GSS policy and procedure for resident transfers and to follow safe resident handling during education sessions by the DNS and staff development on 5/10/18 and 5/11/18. Observation audits to ensure staff are following the GSS policy and procedure for safe resident handling to prevent recurrence for resident 45 and random other residents will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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F 689	Continued From page 27	F 689		

R45's progress note dated 12/20/18, indicated R45 was transferred to toilet without difficulty. However, when transferring R45 from the toilet, R45 slumped forward and refused to help stand up. The staff informed R45 her assistance in standing was required when using the stand aid. The staff attempted to stand R45 up by grabbing underneath her arms and the other staff member guiding her bottom off the toilet. The note indicated during the transfer, a scab on R45's elbow peeled off and had started to bleed.

The facility incident spreadsheet indicated on 3/1/18, R45 stated during the night shift when she had to use the bathroom the aide hooked her up to the stand aid and pulled on her arms to get her to stand up. R45 scraped her chest across the stand aide. The intervention implemented was for staff to use a transfer belt and proper lifting techniques when transferring R45. R45's care plan was not updated to include this intervention until 4/18/18.

R45's clinical record lacked evidence of refusals of the use of the gait belt.

On 4/17/18, at 1:00 p.m. R45 was observed in her room, seated in her wheelchair. Nursing assistant (NA)-Q and NA-M positioned the stand aide in front of R45. NA-Q informed R45 of the gait belt placement in which R45 did not object to. NA-Q and NA-M stood off to R45's side and slightly behind her. The NA's instructed R45 where to place her hands on the stand aide and to pull herself up. As R45 came to a standing position, both aides held onto the gait belt and used extensive physical assistance to help R45 come to the standing position and positioned onto

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F 689	Continued From page 28 the commode. NA-Q and NA-M used the same technique to transfer R45 back to the wheelchair. On 4/18/18, at 4:48 p.m. NA-N and NA-O were observed to offload (stand/remove pressure) R45. R45 grabbed onto the stand aide. NA-N stood on R45's right side and NA-O on the left. Without applying a gait belt, NA-N proceeded to lace their arm under R45's left arm and NA-O placed her hand on R45's bottom. When R45 went to stand up, NA-O pushed up on R45's bottom while NA-N pulled up underneath R45's arm to bring R45 to a standing position. -At 7:37 p.m. NA-O verified they had not used a gait belt when transferring R45 and stated she did not use one because R45 complained about it all the time or would refuse it. -At 7:39 p.m. NA-N verified they had not used a gait belt to transfer R45 and stated he had missed the opportunity to use it. NA-N stated the gait belt was supposed to be offered and attempted when transferring R45. -At 7:40 p.m. the director of nursing (DON) stated if the gait belt was supposed to be used it should have been identified on the care plan and implemented.	F 689		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is	F 690		5/30/18

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F 690	Continued From page 29 not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure toileting assistance was provided for 2 of 2 (R45, R34) residents who required staff assistance for toileting. Findings include: R45's Diagnosis Report dated 4/20/18, indicated	F 690	Resident R34 and 45 are being toileted according to their individualized plan of care. All residents requiring staff assistance with toileting were monitored to ensure they are being toileted according to their individualized care plan.	

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F 690	Continued From page 30 R45's diagnoses included chronic renal disease requiring dialysis, dementia with behavioral disturbance, anxiety, and repeated falls. R45's annual Minimum Data Set (MDS) dated 2/21/18, indicated R45 had moderate cognitive impairment, required extensive assistance from two plus staff for bed mobility, toileting, transfers, dressing, and hygiene. The MDS further indicated R45 was occasionally incontinent of urine, was on a toileting program, and was frequently incontinent of bowel with no toileting program. R45's Urinary Incontinence Care Area Assessment (CAA) dated 2/26/18, identified R45 had occasional bladder incontinence and was frequently incontinent of bowel. The CAA also indicated R45 had restricted mobility, urinary urgency and required assistance in toileting. The CAA further indicated R45 took diuretics that could cause urge incontinence and anticholinergic that could lead to overflow incontinence. R45's care plan was provided on 4/20/18, and indicated two staff were to assist R45 with transfers with a transfer aid, and two staff were to assist with toileting. The care plan also indicated R45 had functional bladder incontinence and directed staff to offer toileting and check/change incontinent product with AM/HS (bedtime) cares, before meals, with repositioning and as needed. The care plan did not identify R45 had bowel incontinence. R45's Bladder Assessment dated 2/21/18, indicated R45 had functional incontinence and recommended a check and change program. The schedule included: offer toileting and	F 690	All nursing staff was provided with re-education on GSS policy and procedure for following care planned interventions for toileting during education sessions by the DNS and staff development on 5/10/18 and 5/11/18. Observation audits to ensure timely toileting of resident 34, 45 and other random residents will be completed by DNS or designee 3x/wk for 8 weeks with results reported to the QAPI committee for further recommendation.	

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F 690	Continued From page 31	F 690		

check/change with a.m./HS (bedtime) cares, before meals, with repositioning, and as needed per resident request. The Bowel Assessment dated 2/21/18, reflected the same toileting routine as the bladder assessment.

R45's nursing assistant documentation for April 2018, directed staff to document toilet use and transfers after each occurrence. Per the documentation, R45 was toileted three times a day on the following days:

-On 4/16/18, R45 was toileted at 5:31 a.m.,11:29 a.m., and at 10:14 p.m.
Transferred at 11:29 a.m. and 5:06 p.m.
-On 4/17/18, R45 was toileted at 6:14 a.m., 11:35 a.m., and at 10:06 p.m.
Transferred at 11:35 a.m. and 10:06 p.m.
-On 4/18/18, R45 was toileted at 6:14 a.m., 9:53 a.m., and 8:11 p.m.
Transferred at 9:53 a.m. and 4:58 p.m.
The documentation had not reflected any refusals by R45.

On 4/16/18, at 3:21 p.m. R45 was observed in her room seated in a rock-n-go wheelchair with family member (FM)-B present. R45 stated staff did not like to answer her call light timely or would say they would be right back but would never come back.

On 4/16/18, at 5:54 p.m. FM-B stated family had spent a lot of time at the facility and were very involved in R45's care. FM-B stated during family visits, they had not ever recalled staff offering or attempting to take R45 to the restroom and R45 had to always ask to go to the bathroom. FM-B also stated when R45 would ask to the use the restroom, staff would not come on time or staff

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would tell her just a minute but would never come back therefore R45 would be incontinent. FM-B stated when R45 was incontinent as a result of not being toileted on time, she would become upset and frustrated and would often become upset with staff when they couldn't get her to the bathroom room on time. FM-B stated last week during a visit, the cushion on her wheelchair was totally soaked with urine and FM-B had to alert staff to change the cushion.

On 4/17/18, at 11:38 a.m. R45 was observed in her room, seated in a tilt-n-space wheelchair waiting for dialysis. A Family member was present. R45's rock-n-go wheelchair was in the room and had a white towel on the seat cushion with a basketball sized yellowish wet spot in the middle of the towel.

On 4/18/18, at 11:43 a.m. R45 was observed seated in her rock-n-go wheelchair at a table near the nursing station.
-At 11:53 a.m. nursing assistant (NA)-P wheeled R45 into the dining room to eat lunch.
-At 12:10 a.m. NA-M wheeled R45 away from the dining room area after asking R45 if she wanted to return to the table in the nursing station area.
-At 12:26 p.m. R45 received a phone call on her cell phone and continued to sit in her wheelchair in the same location.
-At 1:01 p.m. licensed practical nurse (LPN)-D walked over to R45 and informed her she had one Lasix (diuretic medication) pill for her and proceeded to administer the medication.
-At 1:16 p.m. R45 asked to use the restroom. LPN-D replied she would get somebody to her assist her. After a few moments R45, pleaded "please, I have to go to the bathroom." LPN-D replied again that she would get somebody to

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help her. R45 repeated the request for help again, and LPN-D again stated she would get someone to help.
-At 1:26 p.m. rehabilitation aide (RA)-A wheeled R45 to her room and performed range of motion to both lower extremities. When RA-A completed range of motion, RA-A wheeled R45 back to the lobby area and did not ask of offer to take R45 to the bathroom nor did R45 request to use the bathroom.
-At 1:48 p.m. FM-B arrived and sat with R45 at the table near the nurses station.
-At 2:41 p.m. FM-B stated R45 had not been offered to use the bathroom. FM-B wheeled R45 to the scheduled music activity.
-At 4:09 p.m. R45 returned from activities with FM-B and then went for a walk around the facility.
-At 4:13 p.m. R45 was seated in her wheelchair at the table by the nursing station.
-At 4:30 p.m. R45 continued to sit in her wheelchair at the table.
-At 4:48 p.m. NA-O was approached by surveyor and requested R45 be offered the toileting as it had been five hours and 5 minutes observation without R45 recieving assistance. NA-O wheeled R45 to her room and NA-O and NA-N transferred R45 onto the bedside commode. R45 did not void at this time nor had she been incontinent.
-At 4:55 p.m. neither NA-O or NA-N could articulate R45's toileting schedule. NA-N stated they would have to check R45's care plan. NA-N indicated the time a resident was assist with toileting was passed along during shift report or it could be determined by looking it up on the computer. NA-N indicated there was an alert that came up on the computer when it was time to toilet a resident. When asked when the last time R45 had been offered or attempts made to toilet, neither NA-O or NA-N were aware of the last

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F 690	Continued From page 34	F 690		

time.
-At 5:03 p.m. NA-N referenced historical documentation for toileting and confirmed the last time R45 had been assisted to the toilet was at 9:53 a.m. NA-N stated if toileting had been offered and refused by R45, then it was supposed to be documented and it would show up in the history.
-At 5:15 p.m. clinical manager (CM)-D stated the NAs should have followed the care plan for toileting and if a resident refused, the NA's were supposed to document those refusals.

On 4/20/18, at 8:43 a.m. the director of nursing (DON) stated staff should have attempted to toilet R45 as directed by the care plan, and if R45 refused, the staff needed to go back and offer at a later time. The DON also stated staff should document any refusals and alert the nurse of continued refusals.
R34's annual MDS dated 1/30/18, identified R34 with severe cognitive impairment and diagnoses including heart failure, neurogenic bladder and Alzheimer's disease. The assessment indicated R34 required extensive assistance with all activities of daily living which included toileting, and was totally incontinent of bowel and bladder.

R34's Urinary Incontinence CAA dated 2/21/18, indicated R34 had impaired cognition, was diagnosed with neurogenic bladder, required assistance with transferring, received a daily diuretic, had mixed incontinence, was incontinent of bowel and bladder daily with no pattern noted, and wore an incontinent product. R34 was recently admitted to hospice services. Frequency of toileting needs was not identified.

R34's Care Plan dated 4/19/18, directed one staff

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to assist R34 with stand aid to toilet and per resident preference for privacy, R34 could be in the bathroom alone with the stand aid. The care plan also directed staff to toilet R34 upon rising/retiring and after meals. In addition, the care plan indicated R34 utilized incontinent briefs and directed staff to check the brief when repositioning R34, and as needed.

On 4/18/18, from 3:45 p.m. to 7:00 p.m. R34 was continuously observed resting in bed, positioned on her back. At no time during the continuous observations were the staff observed to enter R34's room to provide assistance with incontinence cares.
-At 7:00 p.m. NA-B stated she had not assisted R34 with any type of toileting/incontinence cares since the start of her shift at 2:00 p.m.
-At 7:01 p.m. NA-C stated she had not assisted R34 with any type of cares since the start of her shift at 2:00 p.m. At this time, NA-C entered R34's room and assisted her with incontinence cares. R34 was observed to be incontinent of urine.
- At 7:13 p.m. NA-C confirmed R34 had not received assistance with incontinence cares from 2:00 p.m. to 7:00 p.m. a total of five hours earlier.

On 4/19/18, from 7:03 a.m. to 9:18 a.m. R34 was continuously observed in bed, positioned on her back with head of bed elevated approximately 45 degrees. At no time during the continuous observations were the staff observed to assist R34 with incontinence cares.
-At 9:18 a.m. NA-E assisted R34 with morning cares. R34 was observed to be incontinent of urine. NA-E confirmed R34 had not been provided any assistance since her shift began at 6 a.m..

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F 690	Continued From page 36 -At 9:20 a.m. NA-E stated she had not assisted R34 with incontinence cares since her arrival at the facility at 6:00 a.m. A total of 3 hours and 18 minutes earlier. On 4/19/18, at 12:46 p.m. CM-A reviewed the NA's computerized documentation for the evening of 4/18/18, and confirmed R34 had not received assistance with incontinence cares between 2:00 p.m. and 7:00 p.m. a total of five hours. CM-A also confirmed the lack of incontinence cares on the morning of 4/19/18, between 6:00 a.m. and 9:18 p.m. at total of three hour and 18 minutes. CM-A stated R34 was to receive assistance with incontinence cares as directed by the care plan. The Bowel and Bladder Assessment Evaluation and Retraining policy dated September 2012, directed staff to ensure that each resident with bowel or bladder incontinence received appropriate treatment and services to restore as much normal bowel or bladder functioning as possible. Facility policy Toileting Programs last revised 2/2016, indicated the purpose was to assist in the selection of an appropriate toileting program for the resident, decrease or prevent urinary incontinence, and to minimize or avoid negative consequences for incontinence.	F 690		
F 698 SS=D	Dialysis CFR(s): 483.25(l) §483.25(l) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the	F 698		5/30/18

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 698	Continued From page 37 comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor, assess, and/or implement and evaluate interventions related to a prescribed fluid restriction and/or edema for 1 of 1 (R45) resident who received dialysis services, was on a daily fluid restriction and had edema. Findings include: R45's Diagnoses Report dated 4/20/18, included diagnoses of dementia, end stage renal disease that required dialysis, diabetes type II, atherosclerotic heart disease, and chronic pain. R45's annual Minimum Data Set (MDS) dated 2/21/18, indicated R45 had moderate cognitive impairment and required extensive assistance from two plus staff members for bed mobility, transfers, dressing, and hygiene. The MDS also indicated R45 required renal dialysis. R45's care plan revealed the following: -Dialysis related to renal failure dated 4/3/18, and indicated R45 was on a 1500 milliliter (ml) daily fluid restriction and directed staff to monitor and document peripheral edema and observe hydration status. -Nutrition problem evidenced by variable intakes, and therapeutic diet. At times, R45 would decline the therapeutic diet. The 1500 ml fluid restriction was delineated as such: 240 ml fluids per meal from dietary, 260 ml fluids per shift per day from nursing. No other fluids in room or at activities.	F 698	R45's fluid intake is being monitored on a daily basis. Residents on fluid restrictions have the risk of not having their intakes monitored. These residents are having their fluids monitored. Nursing orders placed to have licensed staff tally fluid intake at the end of each shift and this is reviewed by the dietitian/RN case manager on a weekly or as needed basis based on the individual resident's needs. Staff were educated to this process by DNS and staff development on 5/10/2018 and 5/11/2018 Audits of fluid intake monitoring for resident 45 and other random residents on fluid restrictions will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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F 698	Continued From page 38 Send snack to dialysis. -Activities of daily living dated 3/2/18, indicated self-care performance deficit related to decreased mobility, weakness, and impaired cognition. The bed mobility care plan indicated R45 had a history of refusing to reposition and sleep in bed. -Impaired circulation related to edema dated 8/10/17, and directed staff to keep foot/ankle support board on wheelchair when up in the wheelchair as resident would allow. History of refusing support board. Observe fingers and toes for warmth and color routinely and notify nurse of any changes. Elevate legs two times per day for one hour each time, if refusing to lie down, put legs up on a chair. Resident has history of refusing to elevate legs so encourage and re-approach. Support stockings to be worn 23 out of 24 hours a day. Change each morning after lotion applied to both calves. Resident has a history of refusing to have compression stockings. -Limited physical mobility related to falls evidenced by weakness dated 6/14/17, indicated R45 was to use a manual wheelchair only for dialysis transport and a rock-n-go wheelchair for locomotion. -inspect feet daily for open areas, sores, pressure areas, blisters, edema or redness and report to the nurse. The care plan lacked identification of R45's goal weight range. R45's physician orders dated 4/20/18, included an order for Lasix (diuretic) 40 milligrams (mg) twice per day (start date 2/25/17) for hypertensive chronic kidney disease and also dialysis treatments three days per week. The physician orders also included nursing orders which consisted of:	F 698		

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-complete clinical assessment dialysis upon return from each dialysis treatment
-keep track of fluid total per day due to 1500 milliliter (ml) daily fluid restriction
-monitor edema daily
-offer R45 to sit in recliner in station common area for comfort once per day at 1:00 p.m.
-offer snacks and fluids between meals every shift.

R45's April 2018, Medication Administration Record (MAR) revealed the following:

-complete clinical assessment dialysis upon return from dialysis. Documention revealed this was conducted four of eight opportunities.
-Monitor edema daily. The documentation was blank.
-offer R45 to sit in recliner in station common area for comfort, daily. Documention indicated this was offered daily.
-keep track of fluid total for day due to 1500 ml daily restriction. The documention was blank through 4/19/19, night shift.
-offer snack and fluids between meals, keep track of fluid total for day. The documentation from 4/1-18/18 revealed 18 shifts did not reflect any fluid intake and the daily totals were not calculated in order to determine compliance with the restriction.
-provide four ounces house supplement two times per day mixed in ice cream. Documentation indicated this was provided twice per day with ounces consumed indicated. However, it was undetermined if the total consumed was included in the 1500 ml fluid restriction.

R45's March 2018, MAR revealed the following:

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-4 ounces house supplement mixed with ice cream, twice day. The documentation reflected the amount consumed however, it was undetermined if the ounces consumed were included in the 1500 ml fluid daily fluid total.
-offer snacks and fluids between meals (keep track of fluid total for day ok for 1500 ml per day) every shift. The documentation reflected inconsistent offerings, however when offered, the amount of fluid was documented. It was undetermined if the amount consumed was included in the 1500 ml fluid restriction.
Daily fluid intake totals was not documented in order to monitor and determine whether R45 had an excess or deficit of fluid intake.

R45's nutritional status note dated 4/5/18, indicated R45 was at a nutritional risk and identified the diet type and fluid restriction. The note included the current weight of 124 lbs., one month ago was 122 lbs., and six months ago was 129 lbs with some weight fluctuations due to dialysis and Lasix use. The note also indicated R45's fluid amounts were within the restriction at most meals.

R45's Dialysis Overview report indicated R45's ideal body weight was 120 pounds (lbs.) and the duration of dialysis was three hours. The dialysis run sheet reflected an increase in pre and post weights:

3/29/18- pre weight=127 lbs. and post weight=121 lbs.
3/31/18 pre weight =128 lbs. and post weight= 122 lbs.
4/3/18 pre weight =130 lbs. and post weight=124 lbs.

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F 698	Continued From page 41 4/5/18 pre weight=129 lbs. and post weight=123 lbs. 4/7/18 pre weight=129 lbs. and post weight=122 lbs. 4/10/18 pre weight=130 lbs. and post weight=125 lbs. 4/12/18 pre weight=129 lbs. and post weight=122 lbs. 4/14/18 pre weight=130 lbs. and post weight=123 lbs. 4/17/18 pre weight=130 lbs. and post weight=124 lbs. On 4/16/18, at 11:12 a.m. R45 was observed in the lobby area, seated in her rock-n-go wheelchair with her head down, eyes closed, and feet dangling. R45 had gripper socks on and no compression socks. Both lower extremities were noted to be edematous (swollen, fluid filled). -at 3:21 p.m. R45 was observed in her room, seated in her rock-n-go wheelchair with both extremities dangling. R45 had gripper socks on and no compression stockings. On 4/17/18, at 8:11 a.m. R45 was observed seated in her rock-n-go wheelchair with her legs dangling. R45 had gripper socks on and no compression stockings. R45's family member (FM)-B stated family was frequently at the facility and very involved in R45's care. FM-B stated the doctor wanted R45 to elevate her feet and family had brought in a personal recliner so she could sit and elevate her feet, however, staff refused to use it because R45 could not get in and out of it by herself, therefore the recliner was considered a physical restraint. FM-B stated he had not witnessed staff offer or attempt to elevate R45's her feet, nor had he seen her seated in the lobby	F 698		

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area recliner.

-At 11:38 a.m. R45 was observed seated in her tilt-n-space wheelchair. Her feet were dangling, she had on gripper socks on but no compression stockings. Edema was noted in both lower extremities, more so in the right lower leg than the left. R45 stated the only time she ever put her feet up was at dialysis, and when a family member helped her. R45 explained a family member would move another chair over by her and lift her legs up onto the chair. R45 stated she would not use the recliner in her room to elevate her feet because staff would never come back and get her out of the chair. R45 stated she had dialysis today so she would be able to put her feet up while there.

On 4/18/18, at 11:43 a.m. R45 was observed in the lobby area, seated in her rock-n-go wheelchair. R45's feet were bare, purplish in color and both lower legs were edematous. R45 remained in the lobby until 11:53 a.m. at which tine she was assisted into the dining room. R45 remained in the dining room until 12:10 pm.
-At 12:10 p.m. R45 was assisted into the lobby area where she remained seated in her rock-n-go wheelchair until 1:26 p.m.
-At 1:26 p.m. rehabilitation aide (RA)-A wheeled R45 to her room to do range of motion exercises. RA-A asked R45 if she would be willing to use the foot rests, to which R45 agreed to. Both of R45's feet were remained edematous with the right foot being more edematous than the left. As RA-A performed range of motion, R45 stated her left knee was stiff. RA-A informed R45 there was a lot of fluid in her ankles and encouraged R45 to put her feet up. RA-A did not mention or encourage compression stockings.

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-At 1:48 p.m. RA-A connected the foot board over the foot rests of the wheelchair and returned R45 to the table in the lobby area. RA-A did not offer nor attempt to elevate R45's feet after the range of motion exercise session. R45 remained in the lobby area with a family member until 2:41 p.m. at which time the family member stated no staff had approached and offered R45 any care related services. R45's family member also stated he/she had put R45's gripper socks on after noticing she had nothing on to cover her feet. At this time, R45 was assisted to a scheduled activity program and returned to the lobby area at 4:09 p.m.

On 4/18/18, at 4:22 p.m. licensed practical nurse (LPN)-D stated R45 was non-compliant with the fluid restriction and family brought her in pop to drink almost every day. LPN-D stated she recorded the amount of fluids that was given to R45 with her medications, between meals. However, LPN-D stated she was unaware if R45 was meeting or exceeding her daily fluid restriction. LPN-D also stated R45 did not like wearing compressions stockings therefore would refuse to wear and those refusals should have been documented.

On 4/18/18, at 5:15 p.m. clinical manager (CM)-D stated R45 did not like to be left alone in her room therefore would not sit in her personal recliner. CM-D stated nursing had not always used recliners for residents who could not get in/out of them independently and would have to do an assessment in order to determine if the recliner would be considered a restraint for R45. CM-D confirmed R45 was on a 1500 ml a day fluid restriction and verified the documentation failed to include the daily fluid consumption totals in order to determine a fluid deficit or excess intake and

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stated R45's intake should have been documented, totaled, and evaluated. In addition, CM-D verified documentation related to R45's edema monitoring was lacking and state nursing should have been documenting R45's edema status daily. CM-D confirmed R45 refused to where compression stockings and stated the documentation did not reflect refusals to wear. CM-D stated if R45 refused to wear the compression stockings, a nurse should have been notified.

R45's clinical record lacked evidence of edema monitoring, evaluation, and management. The record also lacked reassessment of the edema interventions for effectiveness and/or assessment of refusals in order determine appropriate new interventions for edema management. In addition, R45's record lacked evidence the risk vs. benefits of refusing edema management interventions was explained to R45.

R45's nursing progress notes were reviewed from 3/1/18, through 4/18/18, which indicated R45 had "refused" to sit in her recliner on 3/7, 3/8, 4/3, 4/6, and 4/11.

On 4/19/18, at 7:05 a.m. R45 was observed in the common areas, seated in her rock-n-go wheelchair. R45's legs were not elevated, and she had gripper socks on and no compression stockings.

-At 7:15 a.m. LPN-D stated she monitored edema daily when she put special lotion on R45's feet, however did not measure or document the extent of the edema because there was no prompt on the computer software to do so. LPN-D stated R45's legs would get pretty firm, R45 never put

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her feet up, and only elevate her feet when she was at dialysis. LPN-D stated a lot of the time R45's feet wound dangle because R45 refused to use the foot rests and footboard for support.

-At 8:50 a.m. dialysis registered nurse (D-RN) stated R45's weight and edema had started to increase in the middle of March. RN-D stated there were some medication changes and R45 had been much more cognitively intact or more stable during the last few weeks. RN-D also stated the dialysis run time used to be three hours, with the maximum amounts of fluid being removed. However, because R45 was more stable, cognitively intact, and had increases in weight, the dialysis run times needed to be extended to 3.5 hours in order to get the excess fluid off. RN-D stated the first 3.5 hour run time was scheduled to start at the next scheduled visit. RN-D confirmed it was difficult to determine R45's dry weight because of the amount of lower extremity edema she had.

The facility's Dialysis Services agreement dated 10/2011, indicated the facility's nursing facility staff must have the ability to perform the following interventions for dialysis residents if necessary:

a. Monitoring of fluid gain and loss, including assessment of weight, blood pressure, pulse, respiration and intake and output.
d. provision of support services for emotion and social wellbeing of the patient upon identification of problems that included non-compliance with the regimen.

Good Samaritan Society Edema Checks policy dated 9/2012, indicated any resident who showed signs of edema should have the area measured

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F 698	Continued From page 46 on a routine basis. Conditions that may contribute to edema may be congestive heart failure, the placement of casts, venous obstruction for various reasons, some medications, and renal disease. The policy indicated it was a good general rule to measure weekly to detect swelling and to monitor swelling daily and any response to treatment. If the area was unable to be measured, the level of pitting edema could be measured by pressing two fingers or thumb firmly into area for 5-10 seconds and then check for indentation. The policy directed the staff to notify the physician of two plus pitting edema or more.	F 698		
F 725 SS=E	Sufficient Nursing Staff CFR(s): 483.35(a)(1)(2) §483.35(a) Sufficient Staff. 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). §483.35(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	F 725		5/30/18

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F 725	Continued From page 47 limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure sufficient staffing was consistently available in order to provide timely assistance with personal cares according to the residents' assessed needs on 1 of 4 unties (Unit 3) in the facility which had the potential to affect all 22 residents who resided on Unit 3. Findings include: Based on observation, interview and document review, the facility failed to ensure timely toileting assistance was provided. R45 did not received assistance for five hours and 5 minutes, and R43 had not received assistance for hour hours. Refer to F690. Based on observation, interview and document review, the facility failed to ensure timely repositioning/offloading was provided in order to minimize the risk and/or prevent pressure ulcers from developing. R34 had not recieved assistance with repositioning/offloading for up to five hours. R45 had not recieved assistance for repositioning/offloading for five hours and five minutes. Refer to F686. Review of Station 3 Resident Council Minutes indicated the following:	F 725	R12, R49, R55, R34, R37, R88, R80, and R60 will be interviewed to determine what needs have not been met specifically focusing on call lights, meal assistance, toileting assistance, and assistance with cares. All nursing staff schedules will be reviewed and updated to ensure adequate staffing levels are maintained to ensure timely and comprehensive services are provided to residents. Nursing staff were re-educated on staffing patterns using resident acuity, and facility census to ensure adequate staffing is provided to meet current resident needs. This education was completed on 5/10/2018 and 5/11/2018 by DNS and staff development Audits will be conducted by DNS or designee via observation and interview to ensure adequate staffing is available to meet resident needs. These audits will be completed on R12, R49, R55, R34, R37, R88, R80, and R60 as well as other random residents to ensure their care needs are being met. 3x/wk for 4 weeks with results to QAPI Committee meeting monthly for review and further	

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F 725	Continued From page 48 -Meeting notes dated 11/16/17, indicated the residents had reported that non nursing staff members were answering their call lights by shutting them off and leaving without assisting the residents. -Meeting notes dated 12/21/17, indicated the residents continued to express concerns related to long call wait times. One unidentified resident reported that a nursing assistant had reported to her that other residents had also requested assistance therefore he/she did not have the time to answer the resident's call light. Four other unidentified residents reported that their call lights were being shut off without being assisted and that they [residents] felt rushed when talking to the staff. The council minutes indicated the response to call lights was to be addressed at the next meeting. - Meeting notes dated 1/18/18, indicated the council unanimously stated the call lights were not being answered timely and were being shut off without the residents receiving the assistance they had requested. - Meeting notes dated 2/15/18, the resident continued to express concerns related to call lights being shut off without their needs being met. The staff members at the meeting reminded the residents to turn the call lights back on or to ask the staff to leave the light on if they were unable to assist with the resident request. - Meeting notes dated 3/12/18, indicated the residents felt the lights were being answered a little better. During a facility resident council meeting on 4/19/18, at 2:00 p.m. five of the residents in attendance resided on Unit 3 and expressed concerns related to call light response time, however, felt it had improved some.	F 725	recommendations.	

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RESIDENT CONCERNS:

On 4/16/18, at 11:40 a.m. R55, an alert and orientated resident, stated she had to wear an incontinence pad because sometimes the staff did not get to here in time and would have "to go in the pad."

On 4/17/18, at 12:37 p.m. R12, an alert and oriented resident, stated she had to wait up to a half an hour for the staff to answer her call light/use the bathroom. R12 stated her family member visited the facility daily from 6:00 a.m. to 4:00 p.m. to assist with cares and to also take her to the bathroom.

On 4/16/18, at 2:33 p.m. R49, an alert and oriented resident, stated at least weekly, she had to wait 45 minutes to an hour for help. This happened on both shifts. R49 described an incident in which she could not recall the date, whereby she sat on the toilet without the light being answered promptly which caused her legs to go numb. R49 stated "They [the staff] just don't answer the lights promptly" and she had also been incontinent of stool while waiting for the staff to answer her light. R49 stated Unit 3 had two nursing assistants working the unit and occasionally would have three staff during the day shift.

Review of Grievances filed by Unit 3 residents/family/staff members:

-On 1/19/18, R49 reported the nursing assistants were not using a basin of water for evening cares rather the NA's would wet a washcloth and it was cold. NA's informed R49 it took too long.

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-On 1/26/18, family member (FM)-B reported that he/she did not feel R55 had received assistance with lunch or supper.
-On 2/13/18, FM-B reported her loved one had been left on a bedpan for two hours.
-On 2/21/18, a staff person reported on behalf of R34 and R37 that at 3:45 p.m. both residents were seated at the dining room table with their noon meal on the table. Lunches appeared untouched, cold, and dry.
-On 3/9/18, a staff person reported on behalf of R55, that R55 was lying down, on the bedpan, with her dinner on the table over her lap. An unidentified NA came in, removed from bedpan but never sat R55 up or assisted her with the meal. At 6:15 p.m. activity staff assisted resident with eating after watching her trying to reach her food and not being able to.
-On 3/16/18, R12 reported she had been left on the toilet for 30 minutes.
-On 4/13/18, R88 reported to be left on the bedpan for 45 minutes.

Review of the Grievance Log included a resolution section, however, there were no interventions towards a resolution to the aforementioned concerns.

OBSERVATIONS:

On 4/19/18 at 8:00 a.m. R80's call light was observed to be on. At 8:31 a.m. an unidentified staff member entered R80's room and stated she would be right back. At 8:34 a.m. nursing assistants (NA)- E and NA-A entered the R80's room with a stand aide transfer aide. R80 was assisted to the restroom prior to being escorted to dining room for breakfast. (A total of 34 minutes later.)

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R60's quarterly MDS dated 3/15/18, indicated that R60 had severe cognitive impairment and diagnosis included osteoarthritis, anxiety disorder, and pressure ulcer right buttocks Stage 3 (full thickness ulcer). The MDS indicated R60 required total dependence of two staff person for transfers and toileting.

On 4/19/18, at 07:12 a.m. R60's call light was on and banging was heard coming from her room.
-At 7:22 a.m. NA-A walked by room not answering light. R60 continued to make banging noises on overbed table.
-At 7:24 a.m. NA-E entered room and told R60 it was going to be a few minutes before the staff could get back to her. NA-E was observed to leave R60's room, however, the call light remained on.
-At 7:31 a.m. Call light remains on
-At 7:34 a.m. the activity director stopped in R60's room, spoke with R60 and turned the call light off.
-At 7:35 a.m. the activity director reported R60 did not want anything and thus she had turned off the light.
-At 7:53 a.m. R60 turned the call light on and began hitting the overbed table with her hand.
-At 7:55 a.m. licensed practical nurse (LPN)-A entered R60's room and informed her that it was not time to get up yet, as it was not 8:00 a.m. LPN-A then left R60's room.
-At 7:58 a.m. NA-E entered room with the mechanical stand aide. NA-E turned the light off and assisted R60 out of bed and into the wheelchair. R60 was then wheeled to the dining room for breakfast.

R55's annual MDS dated 2/7/18, indicated R55's

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cognition was intact and had diagnosis included Parkinson's disease and arthritis. The MDS indicated that R55 required extensive assist of two staff for bed mobility and toileting, and was at risk for pressure ulcers.

On 4/19/18 at 8:02 a.m. R55's call light came on and remained on without staff response until 8:32 a.m. even though at 8:20 a.m., NA-A was observed to walk by R55's room and did not respond, and at 8:29 a.m.
NA-A and NA-E were noted to be standing outside of R55's room without responding to the call light until 8:32 a.m at which time R55 stated she could not recall why she had turned the call light on.

STAFF CONCERNS:

On 4/17/18, at 11:54 a.m. NA-E stated Unit 3 was short staffed. NA-E stated the unit was to have four NA's however, usually only three NA's were available for cares. NA-E stated the restorative services were not being completed, as directed. NA-E also stated in the past two months, the NA's had not had enough time to make sure all of the residents had received their baths, as scheduled. The NA's did not have have time to complete turning/repositioning/toileting schedules in accordance to the care plan. NA-E stated the weekends were especially difficult and some of the residents had not been assisted to bed until after 11:00 p.m. because there was not enough staff.
- At 1:26 p.m. .licensed practical nurse (LPN)-E confirmed the unit was very busy and the residents did not always get the assistance they needed. LPN-E stated an additional NA from another unit did come to Unit 3, to assist. The

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facility attempted to have three NA's on the unit at all times, but functioned better when there were four.
- At 2:33 p.m. NA-F stated she was a new employee to the facility and confirmed the facility had two NAs to work on the evening shift and it was difficult to complete the cares for the residents.
-At 5:04 p.m. NA-G stated the Unit 3 was to have three NA's on the evening shift, however, it was not uncommon to have two NAs to care for the 24 residents. NA-G stated he/she was routinely assigned to work on the Unit 3, however, the second NA frequently was a staff member from another unit. NA-G stated it was difficult for two staff to do the work and was even harder when the second NA was unfamiliar with the resident needs and routines. NA-G stated it was difficult to ensure the baths and cares were completed for the residents.

On 4/18/18 at 7:30 p.m. NA-C stated there was not enough staff because the call lights were constantly going so we do not have time to help with cares and have not been completing them timely. NA-C stated the staff were "running" all the time.

On 4/19/18, at 8:14 a.m. clinical manager (CM)- A stated her expectation was that the call lights were answered within 10-15 minutes and verified a greater than 20 minute response time was too long of a delay for the call lights to be answered.
-At 2:34 p.m. CM-A stated when four staff are scheduled to work, the Unit generally went very well. CM-A also stated facility leadership discussed staffing at Quality Assurance/Performance Improvement meetings.
-At 3:00 p.m. NA-F stated resident needs are not

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being met as the staff cannot assist with toileting and repositioning timely nor answer call lights timely.

On 4/20/18 at 10:00 a.m. LPN-B stated she did not have time to assist the nursing assistants as much as he/she would like to. LPN-B stated Unit 3 was in need of more staff.
-At 11:35 a.m. CM-A stated out of the 22 residents residing on the unit, two were independent with their cares, seven required the use of a full body mechanical lift, six required a mechanical standing lift or a stand aide, and eight of the residents required at least two staff members for personal cares. CM-A stated it went much better when she was working as she would assist with answering call lights, assist with personal needs, and to assist to eat. CM-A confirmed she provided direct patient care five days a week.
-At 1:19 p.m. director of nursing (DON) stated the staffing patterns were determined according to the acuity level needs of the residents. The DON confirmed Unit 3 residents required more assistance than the other unit residents. The DON stated the number of staff varied from day to day depending upon the acuity and the number required ranged from 2 to 4 staff, depending on the needs. When asked for the past six weeks acuity documentation, the DON stated she would have to gather the information as she did not maintain any type of acuity data.
-At 5:22 p.m. the DON stated she would make a spread sheet for six weeks for Unit 3 showing daily census, acuity, staffing, and identify if a shift was working short. The DON stated she would review the information and send it to the survey staff.

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F 725	Continued From page 55 Documentation received from the DON via email on 4/22/18, indicated for the dates 3/13/18 - 4/19/18, Unit 3's census ranged from 22-25 residents per day. According to the DON's acuity calculations the facility had been short from 1.5 hours up to 12 hours of daily direct care staffing hours on 29 of the 38 days reviewed. The Evening shift calculations revealed insufficient staffing hours from 0.55 hours to 4.5 hours daily, on eight out of the 38 days. The undated Facility Assessment indicated the number of staff required was based on resident individual assessments. Types of staff needed for interventions varied based on individual resident needs. Resident care plans would reflect the individual needs and are available to all staff to reference as needed. The assessment further indicated the facility would determine staffing levels by running the acuity for the facility based on the Minimum Data Set (MDS) submissions twice per week to determine base staffing hours. Individual resident diagnosis and treatments are reviewed daily with DON and nurse managers, adjustments made based on review.	F 725		
F 755 SS=D	Pharmacy Srvcs/Procedures/Pharmacist/Records CFR(s): 483.45(a)(b)(1)-(3) §483.45 Pharmacy Services The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.70(g). The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. §483.45(a) Procedures. A facility must provide	F 755		5/30/18

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F 755	Continued From page 56 pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. §483.45(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who- §483.45(b)(1) Provides consultation on all aspects of the provision of pharmacy services in the facility. §483.45(b)(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and §483.45(b)(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement policies and procedures to ensure rapid detection of potential narcotic diversion for 3 of 5 medication carts reviewed during the survey. This had potential to affect 43 of 43 residents with current orders for narcotic medication and/or controlled substances (medications regulated and classified by the Drug Enforcement Agency) on Units 1, 2 and 3. Findings include: The facility Controlled Substances policy revised 5/16, indicated every time the keys which secured the medications changed from nurse to nurse, the oncoming and off going nurses worked together	F 755	Narcotic counts are be completed with each change in nurse and documented accordingly on the narcotic count record. All residents who receive narcotic medication have the potential to be affected Narcotic counts and documentation will be monitored. Nursing staff were re-educated on GSS policy and procedure as it relates to the process of narcotic counting and documentation during education sessions presented by DNS and staff development	

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F 755	Continued From page 57 to count all controlled substances which included the discontinued controlled medications. If the record and actual count are in agreement, both nurses initialed the Controlled Drugs-Count Record. An undated facility supplied resident list identified 43 residents resided on Units 1, 2 and 3 and had current orders for controlled substances and/or narcotic medications. On 4/17/18, at 1:38 p.m. Station 3's medication cart was reviewed with licensed practical nurse (LPN)- A. The cart was locked with a physical key. The second row contained a permanently affixed locked box which contained narcotics and other controlled medications. A narcotic count was completed and found to be correct. LPN-A stated the staff reconciled the medication every shift and documented the count was accurate on the Controlled Drugs-Count Record. A single sheet Controlled Drugs-Count Record dated April 2018, was taped into the black narcotic book. The count sheet had a column for the oncoming nurse and off coming nurse to initial and a spot to indicate the narcotic count was accurate, for three shifts. The count sheet revealed 19 shifts were missing staff initials and/or confirmation the controlled medication count was accurate. When interviewed immediately following the observation, LPN-A confirmed there were shifts missing the staff initials and stated it was important to sign off all areas to ensure an accurate count. On 4/17/18, at 1:38 p.m. Unit 1's medication cart	F 755	on 5/10/18 and 5/11/18. Audits of narcotic count documentation will be completed By DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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was reviewed with LPN-E. The cart was locked with a physical key, and the second row contained a permanently affixed locked box which contained narcotics and other controlled medications. A narcotic count was completed and found to be correct. LPN-E stated the staff reconciled the medications every shift and documented the count was accurate on the Controlled Drugs-Count Record.

A single sheet Controlled Drugs-Count Record dated April 2018, was taped into the black narcotic book. The count sheet had a column for the oncoming nurse and off coming nurse and a spot to indicate the narcotic count was accurate, for all three shifts. The count sheet revealed 20 shifts were missing initials and/or a confirmation the controlled medications count was accurate.

When interviewed immediately following, LPN-E stated everyone counted the controlled medications regardless if they were signed off or not, however stated it was important to make sure to record the count was accurate.

On 4/17/18, at 4:46 p.m. Unit 2's medication cart was reviewed with LPN-B. The cart was locked with a physical key, and the second row contained a permanently affixed locked box which contained narcotics and other controlled medications. A narcotic count was completed and found to be correct. LPN-B stated the staff reconciled the medications every shift and documented the count was accurate on the Controlled Drugs-Count Record.

A single sheet Controlled Drugs-Count Record dated April 2018, was taped into the black narcotic book. The count sheet had a column for

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F 755	Continued From page 59 the oncoming nurse and off going nurse and a spot to indicate the narcotic count was accurate, for all three shifts. The count sheet revealed 18 shifts were missing initials and/or a confirmation the controlled medication count was accurate. When interviewed immediately following, LPN-B stated there had never been issues with missing narcotics from the med carts and if the count was off, the medications were reconciled again. If the count was off, it was usually due to someone forgetting to document. If the count was off and the staff doing the count could not rectify the accuracy of the count the supervisor was called immediately. During interview on 4/20/18, at 10:51 a.m. the director of nursing stated her expectations were for the oncoming and off going nurses to initial and then document the count was correct. It was important to detect missing narcotics if there was a problem as she would need to go back to the last time both nurses signed off and indicated the narcotic count was accurate in order to detect any possible errors.	F 755		
F 790 SS=D	Routine/Emergency Dental Srvcs in SNFs CFR(s): 483.55(a)(1)-(5) §483.55 Dental services. The facility must assist residents in obtaining routine and 24-hour emergency dental care. §483.55(a) Skilled Nursing Facilities A facility- §483.55(a)(1) Must provide or obtain from an outside resource, in accordance with with §483.70(g) of this part, routine and emergency	F 790		5/30/18

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F 790	Continued From page 60 dental services to meet the needs of each resident; §483.55(a)(2) May charge a Medicare resident an additional amount for routine and emergency dental services; §483.55(a)(3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility; §483.55(a)(4) Must if necessary or if requested, assist the resident; (i) In making appointments; and (ii) By arranging for transportation to and from the dental services location; and §483.55(a)(5) Must promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a resident received dental services for a chipped tooth for 1 of 2 residents (R84) reviewed for dental. Findings include: R84's admission MDS dated 3/30/18, identified R84 was cognitively intact and did not indicate	F 790	Resident R84 received dental services for his chipped tooth on 5/3/2018. All residents whose oral assessments showed need for dental follow up will have appointments offered/scheduled as indicated by the nurse manager or designee by 5/18/2018.	

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F 790	Continued From page 61 R84 had any broken natural teeth. On 4/16/18, at 11:47 a.m. R84 stated he needed to see a dentist for a chipped tooth he had sustained from a fall prior to entering the facility. R84's front lower tooth was noted to be chipped. R84 stated it did not cause him pain, but was "aggravating" due to being uneven. R84 stated no one at the facility had inquired about his dental status or offered him a dental appointment even thought R84 himself had asked staff about his need to see a dentist. R84 stated he had asked about a dental appointment a couple of times, but could not recall who he had asked. During interview on 4/20/18, at 9:43 p.m. nursing assistant (NA)-C stated R84 had never complained about a chipped tooth and she had never see his chipped tooth as R84 did his own oral cares. At 9:56 a.m. registered nurse (RN)-A stated a nursing assessment was done on admission and should have identified any dental issues. RN-A stated the assessment included an oral inspection of a resident's mouth and asking the resident if they had any dental concerns. If any concerns were identified, an appointment would be made with a dentist. RN-A stated she was unaware R84 had a chipped tooth. R84's Nursing Admit Re-Admit Data Collection- V 3 dated 3/23/18, indicated R84 had his own teeth and there were no broken natural teeth. His last dental appointment was identified as unknown. On 4/20/18, at 10:19 a.m. physical therapist (PT)-A was in R84's room and stated there was a definite chipped lower tooth.	F 790	All nursing staff were re-educated on completion of the oral assessment and the nursing admission assessment to ensure accuracy at education sessions on 5/10/18 and 5/11/18 completed by DNS and staff development. Staff also educated on the need to offer dental services to residents based on the oral assessment. Audits of oral assessments and offering of dental services will be completed by DNS or designee 3x/wk for 4 weeks with results reported to the QAPI committee for further recommendation.	

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F 790	Continued From page 62 -At 10:11 a.m. clinical manager (CM)-C stated if the oral assessment on admission was done correctly it would have included a visual assessment as well as asking the resident if they had any concerns warranting a dental appointment. If concerns noted, CM-C or social services would arrange a dental appointment. CM-C stated she was not aware R84 was admitted with a chipped tooth and was inquiring about seeing a dentist. -At 10:19 a.m. registered nurse (RN)-B stated she completed the MDS's however did not personally do visual inspections of a resident rather she relied on the accurate completion of the nursing assessments which were completed on admission by the floor nurses. RN-B confirmed R84's MDS was coded incorrectly due to the admission assessment being incorrect in not identifying the chipped tooth. RN-B stated had the admission assessment been coded accurately, the MDS would have been coded accurately and would have triggered the need for a further assessment of R84's oral/dental status. The resident would then have been asked about wanting to pursue a dental appointment. The facility Oral/Dental Assessment dated 9/16. identified an oral assessment included an exam of the residents lips and oral cavity. Referral for dental evaluation should be considered for residents who exhibit dental or oral issues.	F 790		
F 809 SS=D	Frequency of Meals/Snacks at Bedtime CFR(s): 483.60(f)(1)-(3) §483.60(f) Frequency of Meals §483.60(f)(1) Each resident must receive and the	F 809		5/30/18

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F 809	Continued From page 63 facility must provide at least three meals daily, at regular times comparable to normal mealtimes in the community or in accordance with resident needs, preferences, requests, and plan of care. §483.60(f)(2)There must be no more than 14 hours between a substantial evening meal and breakfast the following day, except when a nourishing snack is served at bedtime, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span. §483.60(f)(3) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure breakfast was provided no later than 14 hours after the evening meal for 1 of 1 resident (R34) reviewed who required assistance with eating. Findings include: R34's annual Minimum Data Set (MDS) dated 1/30/18, indicated R34 diagnoses included Alzheimer's disease, anemia, and weakness. The MDS also indicated R34 had severe cognitive impairment and required extensive assistance with all activities of daily living and required supervision, oversight, encouragement and cues to eat. R34's care plan dated 4/19/18, indicated R34 was able to express when agreeing to food intake	F 809	R34 is receiving breakfast meals no later than 14 hours after the evening meals. R 34 is also being offered an HS snack. Residents requiring assistance with meals are at risk of the same. They are receiving breakfast meals no later than 14 hours after the evening meal and being offered an HS snack. Staff were re-educated on GSS policy and procedure as it relates to frequency of meals and snacks by DNS and staff development on 5/10/2018 and 5/11/2018 Audits of meals and HS snack offering for resident 34 and other random residents will be completed by DNS or designee 3x/wk for 4 weeks with results reported to	

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F 809	Continued From page 64 or not. R34 had potential for nutritional problem related to pain, depression, cognitive impairment, congestive heart failure and history of chewing and swallowing problems. The care plan directed staff to provide set up at meal times, provide diet as ordered, and extras at meals to promote intake. R34 was receiving hospice services. On 4/16/18, at 12:22 p.m. a family member was observed assisting R34 with a meal. R34 ate bites of a cookie and ice cream but did not eat the entree. On 4/18/18, at 12:24 p.m. R34 was observed seated in her wheelchair, at the dining table. R34 had been served a meal which consisted of a cheeseburger (no bun), raw vegetables, a cookie, canned fruit, juice, water and ice cream. R34 was not observed to attempt to feed herself. An unidentified nursing assistant (NA) was also seated at the table along with three other residents, however, there was no interaction between the NA and the residents. -At 12:46 p.m. R34 remained seated at the dining room table with all food/fluids remaining untouched. The unidentified NA remained at the table but did not attempt to assist R34 with her meal. -At 12:52 p.m. R34 was observed to drink her coffee. All other items remained untouched. -At 12:58 p.m. NA-E assisted R34 to take a bite of ice cream. -At 1:03 p.m. R34 was wheeled out of the dining room, taken to her room and assisted to bed. On 4/18/18, at 6:00 p.m. R34 was observed resting in bed. At this same time, dietary aide (DA)-B began the evening meal distribution in the dining room.	F 809	the QAPI committee for further recommendation.	

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F 809	Continued From page 65 -At 6:16 p.m. DA-B had completed the resident meal distribution and had begun to remove the food items from the steam table. R34 continued to remain in bed. -At 6:57 p.m. DA-B confirmed R34 had not received her evening meal and stated she had left a meal tray for R34 on the counter next to the kitchenette refrigerator for the nursing staff to serve R34 when she was ready. -At 7:00 p.m. R34 remained in bed. No staff members had been observed to assist R34 with the meal. -At 7:00 p.m. NA-B stated she had not assisted R34 with any fluids or nourishments since the start of her shift at 2:00 p.m. -At 7:01 p.m. NA-C was questioned and stated she had not assisted R34 with any fluids or nourishments since the start of her shift at 2:00 p.m. nor offered R34 the evening meal. -At 7:20 p.m. licensed practical nurse (LPN)-C stated a meal was left for R34 in the kitchenette and the staff were to serve it to R34 when she was ready to eat. LPN-C stated the staff should have offered R34 the meal during the regularly scheduled meal time. When questioned if it would be safe to serve a meal tray that had been sitting on the counter for 1.5 hours, LPN-C stated she would have to check with the dietary staff members. -At 7:30 p.m. NA-C confirmed she had not yet provided R34 with her evening meal. -At 7:31 p.m. upon leaving the unit, there were no observations of evening snacks being offered to any of the residents on Unit 3. -At 8:17 p.m. NA-C stated R34 had refused supper but had drank 320 cubic centimeters (cc) of fluid. NA-C stated R34 had not eaten an evening snack.	F 809		

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F 809	Continued From page 66	F 809		

On 4/19/18, during continuous observation from 7:03 a.m. until 9:18 a.m., R34 was observed lying in bed. During this observation, no staff entered R34's room nor provided or assisted R34 with a breakfast meal.
-At 9:18 a.m. NA-E was observed to provide cares for R34 and repositioned her to a sitting, upright position in bed. Breakfast was not served to R34.
-At 9:57 a.m. NA-D stated R34 only wanted toast and coffee for breakfast, however, NA-D confirmed R34 had not been provided the toast and coffee.
-At 10:00 a.m. NA-E confirmed R34 was not served a breakfast meal. NA-E stated she thought another staff person was going to serve R34 the coffee and toast. NA-E proceeded to make toast for R34.

-At 2:29 p.m. R34 was observed in bed, awake. No fluids were observed to be within reach of R34.

On 4/20/18, at 9:34 a.m. Cook-A stated she the kitchen staff did not not send out special carts for evening snacks although items are available for snacks in the kitchenette on Unit 3.
-At 10:28 a.m. NA-D stated she does not usually work evenings, however, when she does, the facility had snacks available in the kitchenettes for residents who requested an evening snack.
-At 10:29 a.m. NA-I stated the facility had evening snacks available, but did not pass them to the residents unless a resident requested one.
-At 11:28 a.m. clinical manager (CM)-A confirmed bedtime snacks should have been offered to each resident on the unit. CM-A accessed R34's electronic record for recording bedtime snacks from 3/21/18, to 4/18/18, which revealed R34 had

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F 809	Continued From page 67 refused 14 times, was sleeping three times, not applicable was indicated three times, and R34 had accepted a bedtime snack three times. -At 12:19 p.m. NA-E verified through electronic NA documentation that R34 had refused supper at 6:00 p.m. on 4/19/18, and the bedtime snack documentation on 4/19/18, indicated R34 was sleeping. NA-E confirmed the documentation revealed R34 had nothing to eat since lunch on 4/18, until 10:00 a.m. on 4/19, for a total of 22 hours between nourishment. -At 12:46 p.m. CM-A stated R34 was a resident they struggled with regarding nutritional needs. CM-A verified R34 was not assisted with a meal for greater than 14 hours. -At 4:17 p.m. NA-J stated the snacks available on the Unit 3 kitchenette consisted of juice, applesauce, pudding, ice cream, cottage cheese, bread, bananas, animal crackers, cereal and soups (vegetables/chicken noodle/tomato/cream of mushroom). A policy related to meal times and bedtime snacks was requested and none was provided.	F 809		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program.	F 880		5/30/18

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F 880	Continued From page 68 The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and	F 880		

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F 880	Continued From page 69 (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop and maintain an ongoing, comprehensive infection control surveillance program related to the tracking and trending of infections. This had the potential to effect all 90 residents who resided in the facility. In addition, the facility failed to ensure proper cleaning of a community used glucometer (machine to obtain blood sugar readings) for 1 of 1 resident (R58) with the potential to affect all 5 residents who utilized the same glucometer on Station 2. Findings include: On 4/20/18, at 1:30 p.m. registered nurse (RN)-G was interviewed and confirmed she was responsible for the infection control prevention and surveillance program. RN-G indicated that she was not aware of the infection control logs prior to her start in the position four weeks earlier. RN-G stated she had completed the logs by	F 880	Resident R58's glucometer was cleaned and disinfected per manufacturer recommendations. Infection logs added to daily communication to ensure potential infections are being monitored real time. All facility glucometers are being cleaned and disinfected appropriately for all diabetic residents All residents are at risk for not having a comprehensive infection control surveillance program related to the tracking and trending of infections. Nursing staff are monitoring residents and documenting each shift those residents with potential of infectious process. This information is followed up on by Infection Preventionist as indicated and per GSS policy and procedure. All licensed nursing staff were re-educated on the need to properly disinfect the glucometer machines	

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F 880	Continued From page 70 running a report of antibiotics used in the previous month, as a look-back, and no real time surveillance of infections was being done. RN-G also stated she only looked at those residents with antibiotics ordered and did not track those who demonstrated active symptoms of illness. The facility had policies in place for isolation precautions but did not have a system to track when an individual was taken out of isolation. On 4/20/18, at 1:45 p.m. the director of nursing (DON) confirmed the infection control program only looked at those residents prescribed antibiotics and conducted a look behind as opposed to daily (real time). The DON was able to locate past infection control logs, however, they only identified residents who had been on antibiotics. The DON confirmed not all illness/infections were treated with antibiotic and symptom tracking of viruses should have been included in the infection control surveillance program. The facility's Infection Prevention and Control Program Policy revised on 11/16, indicated each facility would maintain an infection prevention and control program to provide a safe, sanitary and comfortable environment for residents, patients, children, families, visitors and employees and to help prevent the development and transmission of communicable diseases and infections. The facility's Infection Monitoring and Exposure Control Surveillance Policy revised on 3/16, indicated surveillance was an activity that a health care institution employed to find, analyze, control, and prevent nosocomial infections. Surveillance included: definitions of infection; data collection procedures; forms and reports; analysis by using	F 880	immediately after resident use according to manufactures instructions on 5/10/18 and 5/11/18 by staff development and DNS. Licensed nursing staff will be educated on the GSS policy and procedures for monitoring, tracking and trending of all potential infections by DNS and Infection Preventionist/designee on 5/21/2018. Observation audits of glucometer cleaning and disinfecting for R 58 and other random residents will occur by DNS or designee 3x/wk for 4 wks with results to QAPI committee for further recommendations. Observation and chart review audits will be completed to ensure that we monitoring potential infections real time. This audit will be completed by DNS or designee 3x/wk for 4 wk.	

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F 880	Continued From page 71	F 880		

cultures, changes in prevalent organisms and increase in rates and results, which are given to appropriate persons.
R58's quarterly Minimum Data Set dated 3/14/18, indicated R58 was diagnosed with diabetes mellitius and received insulin injections.

On 4/17/18, at 4:40 p.m. licensed practical nurse (LPN)-B was observed to gather the glucometer, a blood glucose strip, lancet and gloves and entered R58's room. LPN put on the gloves, used the lancet to poke R58's finger, placed the blood glucose strip into the glucometer, and obtained a sample of R58's blood. LPN-B gave R58 a tissue to place on his finger, placed the lancet into the sharps container in the bathroom, removed her gloves and sanitized her hands. LPN-B grabbed the glucometer, returned to the medication cart and set the glucometer on a paper towel on top of the medication cart. LPN-B proceeded to sanitize her hands and obtained a wipe from a purple top Sani-Cloth container. She wiped down the glucometer and placed it on a clean paper towel on top of the nursing cart to air dry. LPN-B stated all the residents on Station 2 used the same glucometer and her process for disinfecting the machine between each resident was to wipe it down with a Sani-Cloth disinfecting wipe and let it air dry. LPN-B read the instruction on the Sani-Cloth which indicated in order to adequetly disinfect the glucometer, the machine needed to be wiped down and kept wet for two minutes before allowing it to air dry. LPN-B confirmed she had not been disinfecting the glucometer machines per directions and stated she was unaware it needed to stay wet for two minutes.

During interview on 4/20/18, at 10:54 a.m. the director of nursing (DON) stated the purple top

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F 880	Continued From page 72 Sani-Cloths were the wipes utilized to disinfect the glucometers. The nurses were expected to wipe the machine with the cloth and then wrap a wet wipe around the glucometer for two minutes followed by allowing it to air dry. The DON stated this process was to be conducted after each resident use. The facility policy Blood Glucose Monitoring, Disinfecting and Cleaning revised 10/17, identified blood glucose meters should be cleaned and disinfected after each use using a germicidal disposable wipe. The undated manufacturers instructions for Super Sani- Cloth Germicidal Disposable Wipe was effective against bloodborne pathogens including Hepatitis B, Hepatitis C, Tuberculosis and HIV. To disinfect nonfood contact services only: Unfold a clean wipe and thoroughly wet surface. Allow treated surface to remain wet for a full two minutes. Let air dry.	F 880		
F 921 SS=F	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the kitchen floor was maintained in a clean and sanitary manner. This has the potential to affect all 90 of 90 residents who received meals from the kitchen.	F 921	Kitchen floors have been thoroughly cleaned to include along walls, under work counters, under cook stove, under combi oven, in storage room and floor edges outside of walk-in cooler. All residents have the potential to be	5/30/18

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F 921	Continued From page 73 Findings include: On 4/19/18, at 10:57 a.m. the initial tour of the kitchen was completed with the Food and Nutrition Supervisor (FNS). The following concerns were identified and verified by the FNS: -The floors throughout the kitchen were observed to have approximately one inch of debris along the floor boards and ground in black debris, approximately three inches from the wall edge. -The floors under work counters, cook stove, and steamer had black debris approximately two inches around the legs of the equipment. -The dry storage floor had a black substance approximately two feet wide on the floor between shelves. -The floor edges outside of the walk in cooler located outside of the kitchen had approximately one inch of debris along the floor boards. -At 11:05 a.m. the FNS stated the dietary staff were assigned to clean the work areas which included the floors. The FNS confirmed the floors were not clean and sanitary. -At 12:41 p.m. the Food and Nutrition Manager (FNM) confirmed the staffs' cleaning schedule but stated there was no deep cleaning schedule for the kitchen floors. The FNM confirmed the unclean/unsanitary condition of the floors and stated it was the result of buildup overtime. The General Sanitation Policy last revised 9/17, stated the food preparation, kitchen, and serving areas were cleaned and sanitized on a regular	F 921	affected by this practice. Daily cleaning task schedules were revised to include documentation of floor cleaning. Re-education on floor cleaning will be completed by Food and Nutrition leadership staff with all Food and Nutrition team members by May 30, 2018. Observation audits of completion of floor cleaning will be completed by Food and Nutrition leadership staff or designee three times per week times four weeks; twice weekly times four weeks and weekly thereafter for one month with results reported to the QAPI Committee for further recommendation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245500	A. BUILDING _____ B. WING _____	04/20/2018

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F 921	Continued From page 74 basis to limit contamination and prevent food borne illness.	F 921		

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	245500	A. BUILDING **01 - MAIN BUILDING** B. WING _____	**04/17/2018**

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GOOD SAMARITAN SOCIETY - BETHANY	**804 WRIGHT STREET BRAINERD, MN 56401**

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/16/2018

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

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to both: Marian.Whitney@state.mn.us and, Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The facility was inspected as one building. Good Samaritan Society Bethany is a 1-story building without a basement. The building was constructed at six different times. The original building was constructed in 1969, is 1- story and was determined to be of Type II(000) construction. In 1974, two, 1-story additions were constructed, one to the south west and one to the east side of the original building, that were determined to be of Type II(111) construction and are separated with 2- hour fire barriers form the existing building. In 1980 an 1- story addition was constructed to the south and east of the 1974 south addition, was determined to be Type II (111) construction and is separated with a 2- hour fire barrier. In 1983 a small 1- story connecting link	K 000		

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K 000	Continued From page 2 was added to the south of the 1980 addition to connect the facility to an apartment building and was determined to be Type V (000) construction. This link is not separated from the facility but a 2-hour fire barrier is between the link and the apartment building. In 1994 the Physical Therapy 1- story addition was added to the north of the original building and was determined to be Type II (111) construction. In 1998 an 1- story addition was constructed to the north of the 1960 building and 1974 addition, was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The main level is divided into 11 smoke zones by 30 minute and 90 minute fire barriers. The entire building is protected by a complete automatic fire sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition with quick response heads in the 1998 addition and standard response heads in all other areas. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridor system, in common areas and in all sleeping rooms that is installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition and is monitored for automatic fire department notification. Other hazardous areas have automatic fire detection that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The facility has a capacity of 124 beds and had a census of 88 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is	K 000		

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K 000	Continued From page 3 NOT MET as evidenced by:	K 000		
K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, it was revealed that 1 of multiple - two hour fire separation was found not in compliance with NFPA 101 "The Life Safety Code" 2012 edition (LSC) sections 8.3.3.1 and 19.1.1.4.1. These deficient conditions could allow the products of combustion to travel from one building to another, which could negatively affect 32 of 114 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 04/17/2018, observations revealed that the 90	K 133	Hy-Tec construction of Brainerd, MN secured the loose fire rated glass pane in 90 minute fire rated door in the Station 3 fire rated assembly that separated the care center from an assisted living. This was completed on 5/10/2018 The environmental services director or designee will be responsible for correction and monitoring to prevent reoccurrence of this deficiency, with results reported to the QAPI committee for further recommendation.	5/30/18

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K 133	Continued From page 4 minute fire rated door in the Station 3 fire rated assembly that separated the care center from an assisted living had a loose fire rated glass pane that moved more than 1/4 inch vertically in it's frame when checked during the facility walk through. This deficient condition was verified by a Housekeeping Staff Supervisor.	K 133		
K 351 SS=F	Sprinkler System - Installation CFR(s): NFPA 101 Spinkler System - Installation 2012 EXISTING Nursing homes, and hospitals where required by construction type, are protected throughout by an approved automatic sprinkler system in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. In Type I and II construction, alternative protection measures are permitted to be substituted for sprinkler protection in specific areas where state or local regulations prohibit sprinklers. In hospitals, sprinklers are not required in clothes closets of patient sleeping rooms where the area of the closet does not exceed 6 square feet and sprinkler coverage covers the closet footprint as required by NFPA 13, Standard for Installation of Sprinkler Systems. 19.3.5.1, 19.3.5.2, 19.3.5.3, 19.3.5.4, 19.3.5.5, 19.4.2, 19.3.5.10, 9.7, 9.7.1.1(1) This REQUIREMENT is not met as evidenced by: Based on observations, the automatic sprinkler system is not installed and maintained in accordance with NFPA 13 the Standard for the Installation of Sprinkler Systems 2010 edition.	K 351	1. a.The maintenance staff of Good Samaritan Society – Bethany or licensed contractor will seal, with appropriate	5/30/18

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K 351	Continued From page 5 The failure to maintain the sprinkler system in compliance with NFPA 13 (10) could allow system being place out of service causing a decrease in the fire protection system capability in the event of an emergency that could affect 32 of 114 residents, as well as an undetermined number of staff, and visitors. Findings include: On facility tour between 11:00 a.m. to 3:00 p.m. on 04/17/2018, observations revealed the following deficient conditions: 1. In the station 3 section in the laundry room behind the dryers there is a 20 x 24 inch opening above the boiler next to a sprinkler head; 2. The sprinkler head located above the boiler in the laundry room is corroded; and 3. The door to the storage room SR 2-3 by resident room 234 in Station 2 did not have any sign or labeling identifying that there is fire sprinkler equipment located in that room. This deficient condition was confirmed by a Maintenance Supervisor.	K 351	materials, the 20 x 24 inch opening above the boiler next to a sprinkler head in the station 3 section in the laundry room behind the dryers. b.Brothers Fire and Security of Elk River, MN replaced the corroded sprinkler head located above the boiler in the laundry room. c.The maintenance staff of Good Samaritan Society – Bethany affixed a sign to the door to the storage room SR 2-3 by resident room 234 in Station 2. 2. a. The 20 x 24 inch opening will be sealed on or before 5/30/2018 b. Corroded sprinkler head was replaced on 4/30/2018 c. The sign was affixed on 4/30/2018 3.The environmental services director or designee will be responsible for correction and monitoring to prevent reoccurrence of this deficiency, with results reported to the QAPI committee for further recommendation.	