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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QBED

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00322

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245318**
2.STATE VENDOR OR MEDICAID NO.
(L2) **004015100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS**
(L4) **2201 KEENAN DRIVE**
(L5) **INTERNATIONAL FALLS, MN** (L6) **56649**

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 **03/19/2015** (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 **54** (L18)

13.Total Certified Beds **54** (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: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lyla Burkman, Unit Supervisor 03/19/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/19/2015 (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
06/01/1986
(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
03/06/2015
(L33)

DETERMINATION APPROVAL

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 245318

March 19, 2015

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnesota 56649

Dear Mr. Coe:

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 the Minnesota Department of Human Services that your facility is recertified in the Medicaid program.

Effective March 4, 2015 the above facility is certified for:

54 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 54 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
March 19, 2015

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnsota 56649

RE: Project Number S5318025

Dear Mr. Coe:

On February 11, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 29, 2015. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 19, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 4, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 29, 2015, effective March 4, 2015 and therefore remedies outlined in our letter to you dated February 11, 2015, 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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Email: mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5318r15

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245318	A. Building B. Wing	3/19/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/04/2015**	ID Prefix **F0248** Reg. # **483.15(f)(1)** LSC	Correction Completed **03/04/2015**	ID Prefix **F0249** Reg. # **483.15(f)(2)** LSC	Correction Completed **03/04/2015**
ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/04/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/04/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/04/2015**
ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **03/04/2015**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/04/2015**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	LB/mm	03/19/2015	28035	03/19/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/29/2015			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QBED

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(L1) **245318**
2.STATE VENDOR OR MEDICAID NO.
(L2) **004015100**

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(L3) **GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS**
(L4) **2201 KEENAN DRIVE**
(L5) **INTERNATIONAL FALLS, MN** (L6) **56649**

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 **01/29/2015** (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 **54** (L18)

13.Total Certified Beds **54** (L17)

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A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	54			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Teresa Ament, HFE NEII 02/24/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 03/04/2015 (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)

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(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
Posted 03/06/2015 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 11, 2015

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnesota 56649

RE: Project Number S5318025

Dear Mr. Coe:

On January 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be a pattern of deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level E), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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:

<u>Opportunity to Correct</u> - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

<u>Electronic Plan of Correction</u> - when a plan of correction will be due and the information to be contained in that document;

<u>Remedies</u> - 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;

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

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
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 March 10, 2015, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

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.

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

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

- 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 April 29, 2015 (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 July 29, 2015 (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 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.

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

5318s15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS 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 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor the right to be treated in a dignified manner regarding toileting concerns for 1 of 1 resident (R3) who was reviewed for dignity. Findings include: On 1/26/15, at 6:54 p.m. R3 stated she was uncomfortable because she had just urinated in her pants. R3 stated when she informed staff of her need to urinate or have a bowel movement, staff tell her to just go in the incontinent brief and	F 241	To ensure dignity while toileting staff will honor R3 and all resident□s requests to use the toilet if their care plan allows. If their care plan doesn□t allow staff will explain this to the resident and let them know that their request will be communicated to the RN for further review. All household staff will be educated by DNS/designee to honor resident requests to use the toilet if care plan allows or to explain to the resident if it doesn□t currently allow and that it will be communicated to the RN for further	3/4/15

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

Electronically Signed | 02/20/2015

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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 241	Continued From page 1 they would clean her up. R3 stated she was unable to stand therefore staff transferred her with a mechanical lift and when she was seated in the wheelchair, staff had to transfer her into bed in order to clean her up. R3 stated sometimes her clothes got wet which she did not like. R3 added, "but what can I do? I can't stand. One day I will get on the toilet." R3 stated sometimes she could feel the urge to urinate or have a bowel movement but when she told staff they would say, "go ahead and go and we'll clean you up." R3's Diagnosis Report dated 1/28/15, indicated R3's diagnoses included pneumonia due to the inhalation of food or vomit, depression, anxiety, type 2 diabetes, pain and osteoarthrosis. R3's quarterly Minimum Data Set (MDS) dated 1/7/15, indicated R3 had moderate cognitive impairment and required extensive assistance of one staff for personal hygiene and two staff for bed mobility, transfers, dressing and toilet use. The MDS also indicated R3 was frequently incontinent of urine and always incontinent of bowel. The MDS indicated R3 was on a urinary toileting program to manage urinary continence which could include scheduled toileting, prompted voiding or bladder training. The MDS further indicated R3 was on an unidentified bowel toileting program to manage R3's bowel incontinence. R3's bladder incontinence care pan revised on 1/5/15, indicated R3's incontinence was related to short term memory impairment, decreased mobility, minimal urge to void and refusals of toileting. R3's Activities of Daily Living (ADL) care plan revised 1/5/15, indicated R3 required total	F 241	review. DNS/designee will audit to ensure residents are toileted upon request as allowed by their individual care plan to ensure dignity is maintained. Audits will be completed on random residents weekly for 4 weeks. Results will be forwarded to QA committee for further recommendation.	

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staff assistance to transfer with a mechanical lift. The care plan indicated R3's toileting schedule consisted of having the incontinent product checked and changed every three to four hours. In addition, the care plan indicated the risk and benefits of refusals of the toileting program and toilet substitutes had been discussed.

On 1/28/15, at 8:00 a.m. nursing assistant (NA)-A stated R3 did not use the toilet but used the bed pan. NA-A stated they laid R3 down every two hours and she was offered the bed pan. NA-A also stated R3 did very well with the bed pan, voided a large amount and was also usually quite wet.

On 1/28/15, at 1:45 p.m. R3 again stated staff told her to go in her pants. R3 also stated she seldom used the bedpan because she hated it. R3 stated "wetting your pants is no good. It's no good to sit in wet pants." R3 stated she can sometimes tell when she has to urinate and have a bowel movement but when she tells staff, they tell her to go ahead and go in her pants and they would clean her up. R3 stated "I don't feel good about it. I look at that toilet and I want to sit on it so bad and I've never sat on it."

On 1/28/15, at 2:20 p.m. NA-A confirmed R3 could at times tell staff when she had to urinate or have a bowel movement. However, NA-A stated she had never put R3 on the toilet due to how she transferred. NA-A stated we put R3 on the bed pan and she did well. NA-A stated she has never asked R3 if she wanted to use the toilet. NA-A verified staff would have to lay R3 down, pull down her pants and then move her to the toilet with the mechanical lift. NA-A stated R3 would probably not make it to the toilet before having an

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accident. NA-A stated there was a lift sling they could use to put R3 on the toilet.

On 1/28/15, at 2:30 p.m. NA-C stated she had never put R3 on the toilet because she was unable to walk and utilized a full sling mechanical lift to transfer. NA-C stated "we just change her." NA-C also stated she had never assisted R3 onto the bedpan.

On 1/29/15, at 11:23 a.m. registered nurse (RN)-B, stated R3 had consistently refused the toilet and the toileting program therefore R3 was to have her incontinent product checked and changed. RN-B stated R3 rarely used the bed pan. When asked if staff should tell R3 or any other resident to void / defecate in their incontinent product and they would be cleaned up afterward, RN-B stated staff should be putting R3 on the bedpan. RN-B verified the mechanical lift sling could be used to transfer a resident onto the toilet. RN-B also stated the facility had a hygiene sling but no longer used it.

On 1/29/15, at 2:00 p.m. the director of nursing (DON) stated she expected staff to follow the care plan as long as the resident's request was in line with the care plan directive. The DON was asked if it was appropriate to tell a resident who stated they needed to use the bathroom to go in their pants and then they would be cleaned up, the DON stated "No."

The facility's Resident Dignity policy issued 2/13, indicated the purpose was to maintain the dignity of all residents. The policy was to promote care for residents in a manner and an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her

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F 241	Continued From page 4 individuality.	F 241		
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 4 of 4 residents (R43, R50, R26, R19) reviewed for activities. Findings include: R43 was not provided activities according to assessed need. R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about half or more of the reference period days, felt bad about herself or that she was a failure or had let her family down nearly every day, had thoughts that she would be better off dead or of hurting herself	F 248	R43, R50, R26 and R19 are being provided activities to meet their individual interests. All residents will be reviewed to ensure they are being provided activities to meet their individual interests. All household staff will receive education by DAHL/designee on providing activities to meet each resident□s individual interests. DAHL/designee will audit to ensure activities are being provided that meet residents individual needs by auditing random residents weekly for 4 weeks. Results will be forwarded to QA committee for further recommendation.	3/4/15

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F 248	Continued From page 5 in some way nearly every day. The MDS also identified R43 felt the following activities of interest were very important to her: - to have books, newspapers and magazines to read - listen to music - be around animals such as pets - do things with groups of people - go outside to get fresh air when the weather was good - participate in religious services or practice R43's care plan lacked identification of individualized and / or group activities that would be of interest to R43. R43 was observed the following times: On 1/26/15, at 5:00 p.m. sitting in front of the television in the day room with the Weather Channel on, not actively engaged. On 1/27/15, at 9:30 a.m. sitting in her room, no television or radio on. On 1/27/15, at 11:36 a.m. sitting in the day room in front of the television on the Weather Channel, not actively engaged. On 1/28/15, at 1:23 p.m. sitting in day room watching the Weather Channel, not actively engaged. R43's activity documentation indicated R43 had attended / participated in 10 activities in 11/14, 13 activities in 12/14, and 10 activities in 1/15. R50 was not provided activities according to assessed need.	F 248		

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R50's Admission Record dated 12/12/14, identified diagnoses of chronic obstructive airway disease, hypertension and anxiety.

R50's admission MDS dated 12/25/14, indicated R50 was cognitively intact and required minimal assistance of one staff with transfers, ambulation and locomotion on the unit.

R50's MDS also indicated R50 had felt the following were very important or somewhat important to her:

- do favorite activities
- listen to music
- keep up with the news
- go outside to get fresh air when the weather was good

On 1/26/15, at 6:34 p.m. R50 was interviewed and stated activities were not offered as often as she would like, including on evenings and weekends. R50 stated the facility had not provided much in the way of activities and if they had more activities, she would go. R50 further stated the activities usually consisted of bingo and keno.

R50's care plan lacked individualized and group activities that would be of interest to R50.

On 1/28/15, at 2:16 p.m. the household life director (HL)-A was interviewed and stated the facility gathered residents individual likes and dislikes for activities and then tried to accommodate the resident's preferences. If a resident was unable to state what their

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individualized preferences were, the facility may bring them to an activity that may stimulate them like bingo, music or smaller group activities. HL-A further stated that not all activities were organized and many were spontaneous. HL-A was unable to identify spontaneous activities that had occurred from 1/26/15, through 1/28/15. HL-A also stated the nursing assistants were to utilize the the individual resident care plans to identify what activities the residents were interested in, and either assist them to the activity or initiate an activity. When asked if the nursing assistants had the actual time to initiate activities with the residents, HL-A stated probably not. HL-A verified the lack of an activity care plan and a lack of activities for R43 and R50.

On 1/29/15, at 8:13 a.m. nursing assistant (NA)-I was interviewed and stated his involvement in activities was limited to transporting residents to and from an organized activity. NA-I stated he did not have time to do spontaneous activities with residents as their were only two nursing assistants for 18 residents. NA-I further stated he was unaware if resident individual preferences were on the care plan because he doesn't have time to look at the care plans.

The facility policy and procedure on Activity Program revised 1/15, directed the facility to provide for an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental and psychosocial well-being of each resident.

R26 did not receive an individualized 1:1 activity program.

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R26's quarterly Minimum Data Set (MDS) dated 11/3/14, indicated R26 had severe cognitive impairment and was diagnosed with Alzheimer's disease and osteoarthrosis. The MDS also indicated R26 was non-ambulatory and was totally dependent upon one person for locomotion on and off the unit.

R26's Activities Care Area Assessment (CAA) dated 2/21/14, indicated R26 had reduced activity participation due to physical disability, unstable acute/chronic health problems, cognitive deficits and chronic health conditions such as incontinence or pain. The CAA indicated activities would be addressed on the care plan.

R26's undated care plan indicated R26 was dependent on staff and family for activities, cognitive stimulation and social interaction. The care plan directed staff to provide 1:1 bedside/in-room visits to promote socialization and stimulation and identified topics of interest to include woodworking, R26's grandchildren and spouse, lawn work or keeping busy in the garage. The care plan also directed staff to turn on TV, music, or book on tape in room when R26 was in his room or laying down.

On 1/26/15, at 5:22 p.m. R26 was observed seated in the wheelchair at the dining room table. At 5:30 p.m. NA-F was observed feeding R26 his meal.

On 1/27/15, at 10:15 a.m. R26's family member (FM)-B stated staff did not encourage or bring R26 to activities. FM-B stated they "never did anything with him."

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F 248	Continued From page 9 On 1/27/15, at 3:11 p.m. R26 was observed laying in bed. A keno activity was currently taking place in the fellowship hall. R26's room was without music, television or book on tape in use. On 01/28/15, at 7:19 a.m. R26 was observed in bed with the TV on. R26 remained the same until 8:09 a.m. at which time R26 was positioned on his left side and the TV remained on. R26 remained the same until 8:21 a.m. At 8:47 a.m. R26 was observed dressed and seated in the wheelchair in the dining room being fed breakfast. At 8:59 a.m. R26 had completed his meal and was observed to remain seated at the dining room table until 9:23 a.m. At 9:56 a.m. R26 was observed in bed with the TV on. On 1/28/15, at 2:05 p.m. FM-B again stated the facility did not do anything with R26 for activities. FM-B stated she would, at times, bring R26 to group activities such as bingo but stated she had not witnessed staff visiting 1:1 or assisting R26 with activities of any kind. On 1/28/15, at 2:29 p.m. NA-D and NA-E stated they were not aware of any activities done for R26. NA-E stated they would put his TV on but that was all they did. On 1/28/15, at 2:42 p.m. NA-F stated R26's wife would take him to bingo at times. NA-F also stated R26 required repositioning frequently and could not tolerate sitting up for long periods so he did not often attend any group activities. On 1/29/2015, at 10:06 a.m. R26 was observed in bed with the TV quietly on. No radio or tape player was observed in the room. The activity	F 248		

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F 248	Continued From page 10 calendar indicated a church service was scheduled for 10:00 a.m. On 1/29/2015, at 10:08 a.m. NA-H stated R26 did have a player that read stories to him that they would occasionally use. NA-H stated they might do this once a week or so. NA-H stated the only activity they usually did for R26 was to leave the TV on. On 1/29/2015, at 10:12 a.m. HL-B stated R26 was supposed to have 1:1 visits with the nursing assistants or homemakers. HL-B stated R26 was also taken to group activities in the fellowship hall at times so he could listen in. R26's Documentation Survey Report for activities for the months of November 2014, December 2014 and January 2015 was reviewed with HL-B and revealed the following: -November 2014 - documentation of 4 activity events (documentation lacked name of activity event) -December 2014 - documentation of 0 activity events. -January 2015 - documentation of 0 activity events. HL-B indicated there were additional activity attendance sheets completed by the homemakers for activities for the months of December 2014, and January 2015. These revealed R26 attended present opening on 12/25/14, a group activity on 12/26/14, and bingo on 12/31/14, 1/6/15 and 1/7/15. HL-B verified there were no other activities and no 1:1 activities documented for R26 and confirmed R26 should have had 1:1 visits. HL-B stated she would have expected staff to provide 1:1 activities for R26 as	F 248		

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F 248	Continued From page 11 directed by the care plan. On 1/29/15, at 2:44 p.m. the director of admissions and household life (AHL) indicated that she worked in coordination with HL-B to ensure activities were provided. AHL verified there was no documentation R26 had received 1:1 visits as directed on the care plan and confirmed R26 should have received 1:1 visits as directed. R19 was not provided activities according to assessed need. R19's annual MDS dated 1/13/15, indicated R19 was diagnosed with dementia and depression. The MDS also indicated R19 had severe cognitive impairment and required staff reminders and encouragement to attend activities. The MDS indicated R19's daily and activity preferences were identified as R19 enjoyed family involvement in care discussions, doing things with groups of people and participating in favorite activities. R19's Activities CAA dated 1/13/15, indicated R19's activity goals were being met and this care area had be resolved as R19 had been included in all appropriate activities. R19's Activity Interest Data Collection Tool dated 1/20/15, indicated his current leisure interests included discussion/reminisce, magazines, newspapers, hunting/fishing, camping, listening to easy listening music, he played the harmonica, 1:1 socializing, military service, animals/pets and children.	F 248		

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F 248	Continued From page 12 R19's current care plan lacked a focus area and interventions which identified R19's activity interests and needs. On 1/27/15, at 3:30 p.m. R19 was observed laying in his bed. R19 did not attend the Keno activity being held in the fellowship hall. On 1/29/15, at 2:30 p.m. the activity calendar indicated there was a social hour with a card game scheduled. At this time, R19 was observed lying awake in bed and did not participate in this activity. R19's Documentation Survey Report for activities indicated the following: -October 2014 - R19 participated in one activity event (documentation lacked name of the activity event) -November 2014 - R19 participated in one activity event (documentation lacked name of the activity event) -December 2014 - R19 participated in two activity events (one being the holiday potluck on 1/19/14) -January 2015- R19 participated in 9 activity events (included- bingo, small group, ball toss, and brides party) On 1/28/15, at 9:58 a.m. NA-E stated R19 did not participate in activities. On 1/28/15, at 10:04 a.m. HL-B stated the homemakers were responsible for the activities in the fellowship hall. When an activity was scheduled the homemakers were supposed to go around and make sure the residents who wanted	F 248		

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to attend the activity got to the activity. She stated the nursing assistants were not responsible for coordinating the activities; however they did assist in transporting the residents to the activities.

On 1/28/15, at 11:10 a.m. NA-E stated on the activity calendar they will have something listed, however nobody knows what it means. For example, on 1/4/15, the activity calendar had "couch potato" listed as a scheduled activity, there was no time designated and nobody knows what this activity means.

On 1/28/15, at 1:50 p.m. HL-B confirmed she had no documentation of what activities R19 had participated in before 11/30/14. HL-B stated "it looks pretty pathetic."

On 1/29/15, at 1:25 p.m. the HL-B and the director of admissions and household life (AHL) were interviewed. The AHL confirmed activities were normally identified on each residents care plan. The HL-B confirmed she had just resolved R19's activity goals on his care plan because she thought he had met his goals; however the HL-B admitted she had not checked R19's documentation with regards to what activities R19 had actually attended prior to her resolving R19's activity area of focus on his care plan. HL-B confirmed R19 had severe cognitive impairment and that some of the activities which would be more appropriate for R19 would be 1:1 visits, listening to music, spending time with the tinker box in his room and encouraging him to play his harmonica. HL-B confirmed according to R19's leisure interest evaluation that had been reviewed on 1/20/15, the interests R19 had identified did not match up with the activities R19 had been

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GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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F 248	Continued From page 14 offered or participated in. The Activity Program policy dated 1/15, indicated the facility would provide an ongoing activity program designed to meet the interests and the physical, mental and psychosocial well-being of each resident. In addition, the activities would focus on the cognitive, physical, spiritual, community, social and creative needs of each individual resident. The Non-Traditional Settings and Activities policy dated 6/12, indicated the residents interests would be reflected in the planned, spontaneous and self-directed activities offered. Also, the activity director would monitor and evaluate the response of the activity program to determine if the assessed needs of the resident have been met.	F 248		
F 249 SS=E	483.15(f)(2) QUALIFICATIONS OF ACTIVITY PROFESSIONAL The activities program must be directed by a qualified professional who is a qualified therapeutic recreation specialist or an activities professional who is licensed or registered, if applicable, by the State in which practicing; and is eligible for certification as a therapeutic recreation specialist or as an activities professional by a recognized accrediting body on or after October 1, 1990; or has 2 years of experience in a social or recreational program within the last 5 years, 1 of which was full-time in a patient activities program in a health care setting; or is a qualified occupational therapist or occupational therapy assistant; or has completed a training course approved by the State.	F 249		3/4/15

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F 249	Continued From page 15 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the activity program was directed by a qualified activity professional who was responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program, as required. This had the potential to effect all residents residing on 2 of 3 units. Findings include: The facility's Qualifications of Activity Director policy and procedure dated 6/12, indicated the activity program would be directed by a qualified professional who had two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program within a health care setting. On 1/27/15, at 9:00 a.m. the director of admissions and household life (AHL)-C stated she had worked full time at the facility for three years, but has not worked full time in the activity department for any of those three years. DAHL-C verified she did not have the qualifications reqiured per facility policy to be an activities director. On 1/27/15, at 9:43 a.m. the AHL-C stated she spent approximately 25-30% of her time on activities and was also responsible for admissions, referrals, discharge planning, social services, volunteers and health information management. On 1/27/15, at 9:13 a.m. the administrator verified	F 249	The Administrator/designee will ensure the facility activity director has proper qualifications. When there is a change in the person directing activities the Administrator/designee will review the new persons qualifications to ensure they are qualified to do so. Results will be forwarded to QA committee for further recommendations.	

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F 249	Continued From page 16 AHL-C had not worked full time in the activity department as has had multiple roles. The administrator also verified AHL-C was allotted 30% of her time to spend on activities.	F 249		
F 279 SS=E	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to include individualized activity needs for 3 of 4 residents (R43, R50, R19) reviewed for activities. In addition, the facility failed to develop a comprehensive care plan to include the use of psychotropic	F 279	R43, R50 and R19 will have care plan interventions developed to meet their activity needs. R43, R6, R29 and R47 will have care plan interventions developed to include the use of psychotropic medications. All residents will be reviewed to ensure they have had care plan	3/4/15

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F 279	Continued From page 17 medications for 4 of 5 residents (R43, R6, R47, R29) reviewed for unnecessary medications. Findings include: R43's care plan was not developed to include individualized activity preferences and needs. R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about half or more of the reference period days, felt bad about herself or that she was a failure or had let her family down nearly every day, had thoughts that she would be better off dead or of hurting herself in some way nearly every day. The MDS also identified R43 felt the following activities of interest were very important to her: - to have books, newspapers and magazines to read - listen to music - be around animals such as pets - do things with groups of people - go outside to get fresh air when the weather was good - participate in religious services or practice	F 279	interventions developed to meet their activity needs and to include the use of psychotropic medications. Household Leaders will be educated by DAHL/designee on developing care plan interventions to meet resident□s needs. RN□s will be educated by DNS/designee on developing care plan interventions to monitor the side effects of medications. DAHL/designee will audit random resident care plans weekly for 4 weeks to ensure care plans are developed to meet their activity needs. DNS/designee will audit random resident care plans weekly for 4 weeks to ensure care plans are developed to monitor side effects of medications. Results will be forwarded to QA committee for further recommendation.	

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F 279	Continued From page 18 R50's care plan was not developed to include individualized activity preferences and needs. R50's Admission Record dated 12/12/14, identified diagnoses of chronic obstructive airway disease, hypertension and anxiety. R50's admission MDS dated 12/25/14, indicated R50 was cognitively intact and required minimal assistance of one staff with transfers, ambulation and locomotion on the unit. R50's MDS also indicated R50 had felt the following were very important or somewhat important to her: - do favorite activities - listen to music - keep up with the news - go outside to get fresh air when the weather was good On 1/28/15, at 2:16 p.m. the household life director (HL)-A stated the facility gathered each residents individual likes and dislikes for activities and then tried to accommodate those preferences. HL-A also stated the nursing assistants were to utilize the individual resident care plans to identify what activities the residents were interested in, and either assist them to the activity or initiate an activity. HL-A verified R43 and R50's care plans lacked identification of an activity care plan and lack of preferred activities. On 1/29/15, at 8:13 a.m. nursing assistant (NA)-I stated he was unaware if resident individual preferences were identified on the care plans because he did not have time to look at the care plan.	F 279		

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R19's care plan was not developed to include interventions to address his activity needs.

R19's annual MDS dated 1/13/15, indicated R19 was diagnosed with dementia and depression. The MDS also indicated R19 had severe cognitive impairment and required staff reminders and encouragement to attend activities. The MDS indicated R19's daily and activity preferences were identified as enjoying family involvement in care discussions, doing things with groups of people and participating in favorite activities.

R19's Activities CAA dated 1/13/15, indicated R19's activity goals were being met and this care area had be resolved as R19 had been included in all appropriate activities.

R19's Activity Interest Data Collection Tool dated 1/20/15, indicated his current leisure interests included discussion/reminisce, magazines, newspapers, hunting/fishing, camping, listening to easy listening music, he played the harmonica, 1:1 socializing, military service, animals/pets, and children.

On 1/29/15, at 1:25 p.m. the HL-B and the director of admissions and household life (AHL) were interviewed. The AHL confirmed activities were normally identified on each residents care plan. The HL-B confirmed she had just resolved R19's activity goals on his care plan because she thought he had met his goals; however the HL-B admitted she had not checked R19's documentation with regards to what activities R19 had actually attended prior to her resolving R19's

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activity area of focus on his care plan. HL-B confirmed R19 had severe cognitive impairment and that some of the activities which would be more appropriate for R19 would be 1:1 visits, listening to music, spending time with the tinker box in his room, and encouraging him to play his harmonica. HL-B confirmed according to R19's leisure interest evaluation that had been reviewed on 1/20/15, the interests R19 had identified did not match up with the activities R19 had been offered or participated in.

The Care Plan policy dated 9/12, indicated each resident would have an individualized comprehensive care plan directed toward achieving and maintaining each resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs.

The Comprehensive Care Plan and Care Conferences procedure dated 6/14, specified the care plan would be comprehensive and the approaches identified would meet the resident's needs, abilities, and preferences.

R43's care plan did not address the use of risperdal (an antipsychotic medication), behaviors or behavioral interventions.

R43's Medication Review Report indicated R43 was diagnosed with unspecified psychosis. R43's physician's orders dated 1/20/15, identified an order for risperdal 0.125 milligrams (mg) po (by mouth) twice a day for psychosis, and may increase back to 0.125 mg in the a.m. and 0.25 mg in the p.m. if hallucinations return.

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F 279	Continued From page 21 R43's annual MDS dated 12/5/14, indicated R43 had severely impaired cognition, had behaviors or hallucinations, but none that were recently present. The MDS further identified R43 felt tired or had little energy about half or more of the days, felt bad about herself or that she was a failure or had let her family down nearly every day, and had thoughts that she would be better off dead, or of hurting herself in some way nearly every day. The MDS documented R43 had behaviors of hallucinations/delusions, however it indicated no behaviors were shown. R43's care plan did not address hallucinations/behaviors, staff interventions with hallucinations/behaviors, use of risperdal, staff interactions if R43 is having hallucinations or delusions, or side effects of the risperdal. R6's care plan did not address the use of Seroquel (an antipsychotic medication), behaviors nor behavioral interventions. R6's Medication Review Report indicated diagnoses that included senile dementia, insomnia, anxiety and paranoia. R6 ' s physician's orders dated 12/15/14, directed Seroquel 25 mg po three times a day, 75 mg po at bedtime, and 25 mg as needed up to two times in 24 hours between midnight and 4:00 a.m. for paranoia. R6's quarterly MDS dated 10/24/14, indicated R6 was cognitively intact, and had mood problems that included trouble falling asleep or staying asleep, or sleeping too much, and feeling tired or having little energy nearly every day. The MDS further identified R6 had no hallucinations or	F 279		

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F 279	Continued From page 22 delusions. R6's care plan did not address behaviors of paranoia, staff interventions with paranoia, use of Seroquel nor the potential side effects of the Seroquel. 01/29/15, at 9:46 a.m. registered nurse (RN)-A was interviewed and verified the lack of the use of risperdal on the care plan for R43, and the lack of Seroquel on the care plan for R6. On 1/29/15, at 1:09 p.m. the director of nursing (DON) was interviewed and stated she would expect nursing staff to follow the facility policy on what to include on the care plan. R47's care plan lacked interventions regarding the monitoring of anticoagulation medication (warfarin). R47's quarterly MDS dated 12/2/14, indicated R47 was cognitively intact and received anticoagulation medication (medication that works to prevent the clotting of the blood) daily. R47's undated Admission Record indicated R47 had diagnoses that included atrial fibrillation (quivering or irregular heartbeat that can lead to blood clots, stroke, heart failure and other heart-related complications), rheumatoid arthritis, macular degeneration and hemiplegia (paralysis on one vertical half of the body) R47's Medication Review Report dated 1/19/15, included orders for warfarin sodium give 2 mg by mouth one time a day every Sunday, Monday,	F 279		

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F 279	Continued From page 23 Tuesday, Thursday, Friday and Saturday and give 3 mg by mouth every Wednesday related to atrial fibrillation. The Federal Drug Administration (FDA) black box warning indicated warfarin sodium can cause major or fatal bleeding. R47's undated current care plan did not address monitoring for potential side effects of warfarin. On 1/29/2015, at 1:48 p.m. registered nurse (RN)-B verified that monitoring of warfarin was not addressed on the current care plan. On 1/29/2015, at 2:23 p.m. the director of nursing (DON) stated her expectation was policy and procedures were to be followed at the facility. DON confirmed the facility policy directed staff to include medications with black box warnings on the care plan. The Comprehensive Care Plan and Care Conference policy dated 6/14, indicated the interdisciplinary team would ensure the care plan was comprehensive by incorporating items that included physicians' orders and diagnoses that were currently being treated, and adverse consequences and "black box" warnings for medications. R29's care plan did not address appropriate monitoring interventions for potential adverse effects related to the use of Zyprexa (an antipsychotic) and Remeron (an antidepressant). R29's physician's orders dated 11/18/14, included	F 279		

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F 279	Continued From page 24 Zyprexa 5 mg in the evening, starting on 8/15/14, for dementia with Lewy Bodies and Remeron 15 mg in the evening starting on 8/15/14, for dementia with Lewy Bodies. R29 s quarterly MDS dated 12/18/14, identified R48 had impaired cognition, had no psychosis or behaviors, R29 rejected cares one to three days during the assessment period and had received antipsychotic and antidepressant medication daily. R29's The Diagnosis Report dated 1/29/15, indicated R29's diagnoses included dementia with Lewy Bodies and behavioral disturbances and delirium. R29 was periodically observed on 1/27/15, from 11:00 a.m. to 1:45 p.m., R29 would not open her eyes or talk when spoken to until the staff assisted with eating then R29 opened her eyes, ate but did not talk. On 1/28/15, at 9:50 a.m. R29 was observed awake and eating breakfast with staff assistance. However, one the same day, during the lunch meal R29 would not open her eyes or eat any lunch. On 1/29/15, at 11:17 a.m. RN-B confirmed R29's care plan did not address monitoring for the potential risks or side effects of the Zyprexa or the Remeron. The RN stated the staff had a drug book and should know the side effects of medications. "It should be a standard of care, they're licensed." The facility policy and procedure on Care Plan	F 279		

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F 279	Continued From page 25 dated 9/12, directed each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs.	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement repositioning interventions as directed by the care plan for 1 of 3 residents (R63) reviewed for pressure ulcers. The facility also failed to provide activity interventions as directed by the care plan for 1 of 4 residents (R26) reviewed for activities. Findings include: R63 was not repositioned every two hours as directed by her care plan. R63's Diagnosis Report dated 12/16/14, identified R63's diagnoses as pathologic fracture of the neck of the femur (bone of the thigh, upper lower leg), dementia, right hip stage 3 pressure ulcer (wound with full thickness loss of tissue, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, may be tunneled),	F 282	R63 is being repositioned per their care plan and R26□s care plan interventions for activities are being followed. All residents receiving repositioning and activities were identified to ensure their care plans are being followed. All household staff will be educated by DNS/designee on following resident care plans. DNS/designee will audit repositioning weekly for 4 weeks to ensure care plans are being followed. DAHL/designee will audit activity interventions weekly for 4 weeks to ensure care plans are being followed. Results will be forwarded to QA committee for further recommendation.	3/4/15

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arthritis, and emphysema (a chronic respiratory disease causing a decrease in lung function).

R63's care plan dated 12/16/14, identified that R63 had a pressure ulcer related to her immobility and directed staff to assist her with turning/repositioning at least every two hours.

On 1/28/15, at 7:00 a.m. R63 was observed lying in bed, positioned on her back. At 8:15 a.m. nursing assistant (NA)-E and NA-D entered R63's room and proceeded to change her incontinent brief. R63 was briefly (less than ten seconds) rolled to her right side to determine if the brief required changing. NA-D confirmed R63's brief was wet. While R63 remained on her back, NA-D opened the brief and NA-E tucked the right sides of the brief under the resident. NA-E rolled R63 slightly off of her back and NA-D removed the wet brief and positioned the new brief (R63 was not off of her back for no more than 30 seconds). NA-E and NA-D attached the new brief, placed a pillow between R63's knees and positioned R63 again on her back. R63 was observed to remain positioned on her back without repositioning or effective offloading assistance until 10:00 a.m. (3 hour).

On 1/28/15, at 10:17 a.m. registered nurse (RN)-C stated repositioning for R63 included either assisting her out of her bed into her wheelchair, or turned from side to side, including her back. RN-C confirmed she would not consider R63 to be repositioned during a brief change if R63 had not been offloaded for greater than one minute while her brief was being changed. RN-C confirmed she expected the staff to follow R63's care plan with regards to repositioning every two hours. In addition RN-C

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F 282	Continued From page 27 confirmed three hours was too long to go without R63 being repositioned or offloaded. On 1/28/15, at 11:22 a.m. NA-E and NA-D confirmed R63 had been placed back in the same position and not offloaded for more than one minute when they changed her brief at 8:15 a.m. On 1/29/15, at 9:10 a.m. the director of nursing (DON) verified staff should reposition and turn R63 every two hours as directed by her care plan. The Skin Assessment and Pressure Ulcer Prevention policy dated 6/14, indicated residents who were unable to reposition themselves independently should be repositioned as directed by their care plan. R26 did not receive an individualized 1:1 activity program as directed by the care plan R26's undated care plan indicated R26 was dependent on staff and family for activities, cognitive stimulation, and social interaction. The care plan directed staff to provide 1:1 bedside/in-room visits to promote socialization and stimulation and identified topics of interest to include woodworking, R26's grandchildren and spouse, lawn work or keeping busy in the garage. The care plan also directed staff to turn on TV, music, or book on tape in room when R26 was in his room or laying down. On 1/26/15, at 5:22 p.m. R26 was observed seated at a table in the dining room waiting for supper. At 5:30 p.m. R26 was being fed his meal by NA-F.	F 282		

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F 282	Continued From page 28 On 1/27/15, at 10:15 a.m. R26's family member (FM)-B stated staff did not encourage or bring R26 to activities. FM-B stated they "never did anything with him". On 1/27/15, at 3:11 p.m. R26 was observed laying in bed. A keno activity was currently taking place in the fellowship hall. R26's room was without music, television or book on tape in use. On 01/28/15, at 7:19 a.m. R26 was observed in bed with the TV on. R26 remained the same until 8:09 a.m. at which time R26 was positioned on his left side and the TV remained on. At 8:47 a.m. R26 was observed dressed and seated in the wheelchair in the dining room being fed breakfast. At 8:59 a.m. R26 had completed his meal and was observed to remain seated at the dining room table until 9:23 a.m. At 9:56 a.m. R26 was observed in bed with the TV on. On 1/28/15, at 2:05 p.m. FM-B again stated the facility did not do anything with R26 for activities. FM-B stated she would, at times, bring R26 to group activities such as bingo but stated she had not witnessed staff visiting 1:1 or assisting R26 with activities of any kind. On 1/28/15, at 2:29 p.m. NA-D and NA-E stated they were not aware of any activities done for R26. NA-E stated they would put his TV on but that was all they did. On 1/28/15, at 2:42 p.m. NA-F stated at times, R26's wife would take him to bingo. NA-F also stated R26 required repositioning frequently and could not tolerate sitting up for long periods so he did not often attend any group activities.	F 282		

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F 282	Continued From page 29 On 1/29/2015, at 10:06 a.m. R26 was observed laying in bed with television quietly on. No radio or tape player was observed in the room. The activity calendar indicated a church service was scheduled for 10:00 a.m. On 1/29/2015, at 10:08 a.m. NA-H stated R26 did have a player that read stories to him they would occasionally use. NA-H stated they might do this once a week or so. NA-H stated the only activity they usually did for R26 was to leave the TV on. On 1/29/2015, at 10:12 a.m. household leader (HL)-B stated R26 was supposed to have 1:1 visits with the nursing assistants or homemakers. HL-B stated R26 was also taken to group activities in the fellowship hall at times so he could listen in. R26's Documentation Survey Report for activities for the months of November 2014, December 2014 and January 2015 was reviewed with HL-B and revealed the following: -November 2014 - documentation of 4 activity events (documentation lacked name of activity event) -December 2014 - documentation of 0 activity events. -January 2015 - documentation of 0 activity events. HL-B indicated there were additional activity attendance sheets completed by the homemakers for activities for the months of December 2014 and January 2015. These revealed R26 attended present opening on 12/25/14, a group activity on 12/26/14, and bingo	F 282		

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F 282	Continued From page 30 on 12/31/14,1/6/15 and 1/7/15. HL-B verified there were no other activities and no 1:1 activities documented for R26 and confirmed R26 should have had 1:1 visits. HL-B stated she would have expected staff to provide 1:1 activities for R26 as directed by the care plan. On 1/29/15, at 2:44 p.m. the director of admissions and household life (AHL) indicated she worked in coordination with HL-B to ensure activities were provided. AHL verified there was no documentation R26 had received 1:1 visits as directed on the care plan and confirmed R26 should have received 1:1 visits as directed. The Comprehensive Care Plan and Care Conferences procedure dated 6/14, indicated a resident-specific care plan should be developed to meet the physical, needs of the resident. The Care Plan policy dated 9/12, indicated each resident would have an individualized comprehensive care plan developed to achieve and maintain the resident's optimal medical, physical, and nursing needs.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		3/4/15

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F 314	Continued From page 31 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed provide timely turning and repositiong for 1 of 3 residents (R63) identified with an active pressure ulcer and required every two hour turning and repositioning. Findings include: R63's Diagnosis Report dated 12/16/14, indicated R63 was diagnosed with a pathologic fracture of the neck of the femur (bone of the thigh, upper lower leg), dementia, anxiety, panic disorder, right hip stage 3 (wound with full thickness loss of tissue, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, may be tunneled) pressure ulcer, arthritis, and emphysema (a chronic respiratory disease causing a decrease in lung function). R63's care plan dated 12/16/14, indicated R63 had a pressure ulcer related to immobility and directed staff to assist R63 with turning and repositioning at least every two hours. R63's Positioning Assessment and Evaluation dated 12/16/14, indicated R63 was unable to make significant changes in position without assistance related to her weakness and bilateral hip and knee contractures. In addition, a repositioning program should be implemented. R63's admission Minimum Data Set (MDS) dated 12/23/14, indicated R63 had moderate cognitive impairment and required extensive assist with bed mobility, transferring, toileting and personal hygiene. In addition, R63 had been identified as	F 314	R63 is being repositioned per plan their individualized plan of care. All residents receiving repositioning were identified to ensure their care plan is being followed. All nursing department staff was educated by DNS/designee on repositioning residents per their plan of care. DNS/designee will audit repositioning weekly for 4 weeks to ensure care plans are being followed. Results will be forwarded to QA for further recommendation.	

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F 314	Continued From page 32	F 314		

at risk for the development of a pressure ulcer and had an existing unhealed stage 3 pressure ulcer on her right hip. The MDS indicated the treatment plan included a turning and repositioning program.

R63's Care Area Assessment (CAA) dated 12/23/14, indicated R63 required assistance with repositioning in bed and wheelchair. The CAA also indicated R63 had an existing stage 3 pressure ulcer with a recommended treatment plan which included a pressure relief mattress, wheelchair cushion in place and a scheduled repositioning schedule.

R63's Braden Scale Assessment (tool for predicting risk for pressure sore development) dated 1/13/15, identified R63 was at risk for the development of a pressure ulcer and the intervention guide recommended R63 should be turned frequently and have a planned turning schedule.

R63's medical record revealed the following with regards to mention of wound measurement:

-12/17/14 - 0.3 centimeters (cm) - length, 0.5 cm - width, 0.8 cm - depth.
-12/24/14 - 1.5 cm - length, 0.5 cm - width, 0.8 cm-depth. Comment indicated that the outside of the perimeter of the wound, most probable the perimeter came in contact with the dressing, causing tissue damage to good skin and causing increased in length. As an intervention, staff was instructed to ensure the dressing only contacted the wound bed.
-1/2/15 - 0.9 cm - length, 0.5 cm - width, 1.2 cm - depth
-1/12/15 - 0.9 cm - length, 0.4 cm - width, 1.0 cm

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F 314	Continued From page 33 - depth -1/26/15 - 0.7 cm - length, 0.4 cm - width, 0.8 cm - depth On 1/28/15, at 7:00 a.m. R63 was observed lying in bed, positioned on her back, twisted at the waist with her legs bent upwards towards her chest and left side. At 8:15 a.m. nursing assistant (NA)-E and NA-D entered R63's room and proceeded to change her brief. R63 was briefly (less than ten seconds) rolled to her right side in order to determine if the brief required changing. NA-D confirmed R63's brief was wet. While R63 remained on her back, NA-D opened the brief and NA-E tucked the right sides of the brief under the resident. NA-E rolled R63 slightly off of her back, NA-D removed the wet brief, positioned the new brief and returned R63 onto her back (R63 was not off of her back for no more than 30 seconds). NA-E and NA-D fastened the new brief and placed a pillow between R63's knees and left R63 positioned on her back, twisted at the waist with her legs bent upwards towards her chest and left side. R63 was observed to remain positioned on her back without repositioning or effective offloading until 10:00 a.m. (3 hours). At 10:21 a.m. licensed practical nurse (LPN)-C was observed to conduct R63's right hip pressure ulcer's daily dressing change. R63's pressure ulcer was observed to be located on her right hip area with minimal drainage observed on the dressing when removed. The margins of the wound were pink, the wound had full thickness loss of tissue and skin, however didn't appear to be tunneled. LPN-C did not reposition the resident prior to, during or after conducting the dressing change.	F 314		

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F 314	Continued From page 34 On 1/28/15, at 11:41 a.m. NA-E and NA-D entered R63's room to change her brief again. They gathered their supplies, and while R63 was positioned on to her right side her bottom area was observed. R63's bottom was observed free from open areas however; R63's left buttock and coccyx area were observed very reddened and her back had a raised, red rash in which NA-E stated was much improved. On 1/28/15, at 10:17 a.m. registered nurse (RN)-C stated repositioning for R63 included either out of her bed into her wheelchair, or turned from side to side, including her back. RN-C confirmed she would not consider R63 to be repositioned during a changing of her brief if R63 had not been offloaded for greater than one minute while her brief was being changed. RN-C confirmed she expected staff to follow R63's care plan with regards to repositioning every two hours. In addition RN-C confirmed three hours was too long to go without R63 being repositioned or offloaded. On 1/28/15, at 11:22 a.m. NA-E and NA-D confirmed R63 had been placed back in the same position and not offloaded for more than one minute when they changed her brief at 8:15 a.m. On 1/29/15, at 9:10 a.m. the director of nursing (DON) verified staff should reposition and turn R63 every two hours as directed by her care plan. The Positioning Assessment and Evaluation policy dated 3/2008, indicated the RN would determine an individualized repositioning scheduled based on the residents individual	F 314		

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F 314	Continued From page 35 resident assessment. The Mobility Support and Positioning: Positioning procedure dated 11/13, indicated an individualized repositioning schedule was recommended based on evaluation of risk factors and on observation of the resident's skin over a period of time. The Positioning Data Collection Tool dated 3/2008, defined offloading as removing pressure from an area for at least one minute. The Skin Assessment and Pressure Ulcer Prevention dated 6/14, indicated residents who are unable to reposition themselves independently should be repositioned as directed by their care plan.	F 314		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that -- (1) A resident who has been able to eat enough alone or with assistance is not fed by naso gastric tube unless the resident ' s clinical condition demonstrates that use of a naso gastric tube was unavoidable; and (2) A resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills.	F 322		3/4/15

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F 322	Continued From page 36 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of a gastrostomy tube (G-tube, a tube which goes into the stomach for food and or medications) prior to medication administration for 1 of 1 residents (R48) observed for medication administration through a G-tube. Findings include: R48's Diagnosis Report dated 1/28/15, indicated R48's diagnoses included dysphagia (difficulty swallowing) due to cerebrovascular disease, pulmonary (lungs) insufficiency and a history of recurrent pneumonia. R48's care plan dated 10/3/14, indicated R48 required a tube feeding and was NPO (nothing by mouth). On 1/28/15, at 11:55 a.m. licensed practical nurse (LPN)-C was observed during the administration of R48's Baclofen 10 milligrams (mg) via the G-tube. The LPN washed her hands, obtained the medication, crushed the medication and then dissolved the medication in approximately 20 milliliters (ml) of water. The LPN donned gloves and attached an extension tube to a port near R48's stomach area. The LPN then attached the barrel of a large syringe to the extension tube and poured in approximately 15 cc of water, poured in the medication followed by approximately 15 cc of	F 322	R48□s G-tube placement is being verified prior to administration of medication. All residents with a g-tube will be identified to ensure placement is verified prior to administration of medication. All licensed nurses will be educated by DNS/designee on verifying g-tube placement prior to administration of medication. DNS/designee will audit three times a week for 4 weeks that g-tube placement is being verified prior to administration of medication. Results will be forwarded to QA committee for further recommendation.	

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F 322	Continued From page 37 water and then put the plunger into the barrel of the syringe pushing air in to clear the extension tube. LPN-C did not check for placement of the G-tube prior to administering the water and medication. LPN-C stated that was the way she always gave R48's medication and did not check for placement of the G-tube because R48 had a short peg that goes into the stomach. On 1/29/15, at 8:30 a.m. LPN-C stated she had reviewed the facility policy and should have checked placement prior to administering R48's medication. On 1/29/15, at 2:00 p.m. the director of nursing (DON) stated she would expect staff to follow the care plan and "if the care plan directed to do so then they should." The DON also stated she would expect staff to follow the policy. The facility's Medication Administration Via Tube policy revised 11/13, indicated the tube should be checked for placement and patency prior to administering medication. The policy directed staff to check patency and position of the tube, use a syringe and inject 5-10 ml of air then aspirate gastric contents to ensure the tube was in the stomach.	F 322		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose	F 329		3/4/15

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F 329	Continued From page 38 should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure antipsychotic medications were monitored, managed and justification of use was identified for 2 of 5 residents (R6, R43) reviewed for unnecessary medications. Findings include: R6 did not have a gradual dose reduction attempted nor justification / adequate indications for use identified for the continued use of Seroquel (an antipsychotic medication). R6's Medication Review Report indicated diagnoses that included senile dementia, insomnia, anxiety and paranoia. The physician's orders dated 12/15/14, directed Seroquel 25 milligrams (mg) po (by mouth) three times a day,	F 329	R6□s Seroquel and R43□s risperdal will be reviewed for appropriate use and necessary action will be taken to ensure they are free from unnecessary medications in accordance with our policy and procedure. All residents receiving antipsychotic medications will be reviewed for appropriate use and necessary action will be taken to ensure they are free from unnecessary mediations in accordance with our policy and procedure. All licensed nurses will be educated by DNS/designee on unnecessary medications and psychopharmacological medications policies and procedures. DNS/designee will also educate all household staff on appropriately care planning and documenting mood/behaviors.	

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F 329	Continued From page 39 75 mg po at bedtime, and 25 mg as needed up to two times in 24 hours between midnight and 4:00 a.m. for paranoia. R6's quarterly Minimum Data Set (MDS) dated 10/24/14, indicated R6 was cognitively intact and had mood problems that included trouble falling asleep or staying asleep, or sleeping too much and feeling tired or having little energy nearly every day. The MDS further identified R6 had no hallucinations or delusions. R6's care plan did not address behaviors of paranoia, staff interventions for paranoid episodes, use of Seroquel nor potential side effects of the Seroquel. On 1/29/15, at 9:46 a.m. registered nurse (RN)-A was interviewed and stated if behaviors were not addressed on the care plan, it was because there were no behaviors. RN-A stated a gradual dose reduction had been attempted on 8/13, but was not successful and a reduction had not been attempted since that time. R43 was not monitored for side effects, or justification/adequate indication for use for risperdal (an antipsychotic medication) . R43's Medication Review Report identified diagnoses that included unspecified psychosis. The physician's orders dated 1/20/15, identified an order for risperdal 0.125 mg po twice a day for diagnosis of psychosis, and may increase back to 0.125 mg in the a.m. and 0.25 mg in the p.m. if hallucinations return. R43's annual MDS dated 12/5/14, indicated R43	F 329	DNS/designee will randomly audit antipsychotic medications to ensure residents are free from unnecessary medications. Audits will be done weekly for 4 weeks. Results will be forwarded to QA committee for further recommendation.	

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	245318	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

(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 329	Continued From page 40	F 329		

had severely impaired cognition, had behaviors or hallucinations, but none that were recently present. The MDS further identified R43 felt tired or had little energy about half or more of the days, felt bad about herself or that she was a failure or had let her family down nearly every day, and had thoughts that she would be better off dead or of hurting herself in some way nearly every day. The MDS documented R43 had behaviors of hallucinations/delusions, however it indicated no behaviors were shown.

R43's care plan did not address behaviors of hallucinations/behaviors, staff interventions with hallucinations / delusions / behaviors, use of risperdal or potential side effects of the risperdal.

On 1/29/15, at 9:25 a.m. RN-A was interviewed and stated R43's care plan and monitoring lacked behaviors because R43 was not having any behaviors at this time. RN-A verified side effect monitoring had not been done.

On 1/29/15, at 1:09 p.m. the director of nursing (DON) was interviewed and stated she would expect staff to follow the policy regarding gradual dose reduction of psychotropic medications, monitoring of side effects, and monitoring for justification/adequate indication for use of psychotropic medication.

The facility policy and procedure on Psychopharmalogical Medications and Sedative/Hypnotics dated 6/14, directed mood and behavior documentation must continue in order to indicate the medication has on the behavior, side effects of the medication must be monitored, and gradual dose reductions must be attempted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONAL FALLS	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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Good Samaritan Society
International Falls, MN
January 29, 2015

241 – D
Based on observation, interview and document review the facility failed to ensure dignity was maintained during toileting for 1 of 1 resident (R3) reviewed for incontinence

248 – E
Based on observation, interview and document review the facility failed to provide activities to meet the individual interests for 4 of 4 residents (R43, R50, R26, R19) reviewed for activities.

249 – E
Based on interview and document review the facility failed to provide a qualified activity director. This had the potential to affect 2 of 3 households in the facility.

279 – E
Based on observation, interview and document review the facility failed to develop care plan interventions to meet the activity needs of 3 of 4 residents (R43, R50, R19) reviewed for activities. In addition, the facility failed to develop care plan interventions to monitor the side effects of medications for 4 of 5 residents (R43, R6, R29, R47) whose medications were reviewed.

282 – D
Based on observation, interview and document review the facility failed to ensure care plan interventions for repositioning were followed 1 of 3 residents (R63) reviewed for pressure ulcers. The facility also failed to ensure care plan interventions for activities were followed for 1 of 4 residents (R26) reviewed for activities.

314 – D
Based on observation interview and document review the facility failed to ensure a repositioning and turning program had been followed for 1 of 3 residents (R63) identified with a pressure ulcer.

322 – D
Based on observation, interview and document review the facility to ensure gastrostomy (G-tube) placement was verified prior to administration of medications for 1 of 1 resident (R48) who received medications via G-tube.

329 – D
Based on observation, interview and document review, the facility failed to ensure psychotropic medications were monitored and managed appropriately for 2 of 5 residents (R43, R6) whose medication regimens were reviewed.
State Licensing:

4658.0810 –
Based on interview and document review the facility failed to ensure 4 of 5 residents (R3, R16, 50, R63) received tuberculin skin testing (TST) according to the CDC guidelines. In addition, the facility failed to ensure 1 of 5 new employees received TST according to the CDC guidelines.

144.6503 –
Based on interview and document review the facility failed to ensure Alzheimer's training was provided for employees. In addition, the facility failed to provide consumers with written information regarding the Alzheimer's training program.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**01/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATION/	**2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 03 2013 Building A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey Good Samaritan Society International Falls 03 2013 Building was found in substantial 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 18 New Health Care Occupancy. The Good Samaritan Society International Falls is a new 1-story building, no basement, and was determined to be Type V (111) construction. The building is fully sprinkler protected in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition) with quick response sprinkler heads. The building is separated from the new assisted living building with a 2-hour fire barrier. The facility has automatic smoke detectors that are on the fire alarm system, throughout the corridor system, in all areas open to the corridor and in all sleeping rooms. It is installed in accordance with NFPA 72 "The National Fire Alarm Code" (1999 edition) and the Minnesota State Fire Code 2007 edition. The fire alarm system is monitored for automatic fire department notification. The building is divided into 3 smoke compartments by 1-hour smoke barriers and 2-hour fire barriers.	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245318	A. BUILDING **03 - 2013 BUILDING** B. WING _____	**01/28/2015**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 The facility has a capacity of 54 beds and had a census of 54 at the time of the survey. The facility was surveyed as one building. The requirement at 42 CFR, Subpart 483.70(a) are MET.	K 000		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted
February 11, 2015

Mr. Adam Coe, Administrator
Good Samaritan Society - International Falls
2201 Keenan Drive
International Falls, Minnesota 56649

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5318025

Dear Mr. Coe:

The above facility was surveyed on January 26, 2015 through January 29, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This

column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

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

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
mark.meath@state.mn.us

Telephone: (651) 201-4118
Fax: (651) 215-9697

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On January 26th, 27th, 28th and 29th, 2015 surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY.	2 000		

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2 000	Continued From page 2 THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section. This MN Requirement is not met as evidenced	2 302		2/9/15

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2 302	Continued From page 3 by: Based on interview and document review, the facility failed to ensure consumers were provided in a written or electronic form, a description of facility staff training for the care of residents with dementia/Alzheimer's, categories of staff trained, frequency of training and topics covered in the training. This had the potential to affect all 53 residents in the facility, and resident representatives/families. Findings include: On 2/2/15, at 10:18 a.m., the administrator verified there was no information regarding the training provided to residents or resident's representatives/families. Suggested Methods of Correction: The administrator or designee could develop and implement policies and procedures related to the required Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302	corrected	
2 560	MN Rule 4658.0405 Subp. 2 Comprehensive Plan of Care; Contents Subp. 2. Contents of plan of care. The comprehensive plan of care must list measurable objectives and timetables to meet the resident's long- and short-term goals for medical, nursing, and mental and psychosocial needs that are identified in the comprehensive resident	2 560		3/4/15

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2 560	Continued From page 4 assessment. The comprehensive plan of care must include the individual abuse prevention plan required by Minnesota Statutes, section 626.557, subdivision 14, paragraph (b). This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop a comprehensive care plan to include individualized activity needs for 3 of 4 residents (R43, R50, R19) reviewed for activities. In addition, the facility failed to develop a comprehensive care plan to include the use of psychotropic medications for 4 of 5 residents (R43, R6, R47, R29) reviewed for unnecessary medications. Findings include: R43's care plan was not developed to include individualized activity preferences and needs. R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about half or more of the reference period days, felt bad about herself or that she was a failure or had let her family down nearly every day, had thoughts that she would be better off dead or of hurting herself in some way nearly every day. The MDS also identified R43 felt the following	2 560	corrected	

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2 560	Continued From page 5 activities of interest were very important to her: - to have books, newspapers and magazines to read - listen to music - be around animals such as pets - do things with groups of people - go outside to get fresh air when the weather was good - participate in religious services or practice R50's care plan was not developed to include individualized activity preferences and needs. R50's Admission Record dated 12/12/14, identified diagnoses of chronic obstructive airway disease, hypertension and anxiety. R50's admission MDS dated 12/25/14, indicated R50 was cognitively intact and required minimal assistance of one staff with transfers, ambulation and locomotion on the unit. R50's MDS also indicated R50 had felt the following were very important or somewhat important to her: - do favorite activities - listen to music - keep up with the news - go outside to get fresh air when the weather was good On 1/28/15, at 2:16 p.m. the household life director (HL)-A stated the facility gathered each residents individual likes and dislikes for activities and then tried to accommodate those preferences. HL-A also stated the nursing	2 560		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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2 560	Continued From page 6 assistants were to utilize the individual resident care plans to identify what activities the residents were interested in, and either assist them to the activity or initiate an activity. HL-A verified R43 and R50's care plans lacked identification of an activity care plan and lack of preferred activities. On 1/29/15, at 8:13 a.m. nursing assistant (NA)-I stated he was unaware if resident individual preferences were identified on the care plans because he did not have time to look at the care plan. R19's care plan was not developed to include interventions to address his activity needs. R19's annual MDS dated 1/13/15, indicated R19 was diagnosed with dementia and depression. The MDS also indicated R19 had severe cognitive impairment and required staff reminders and encouragement to attend activities. The MDS indicated R19's daily and activity preferences were identified as enjoying family involvement in care discussions, doing things with groups of people and participating in favorite activities. R19's Activities CAA dated 1/13/15, indicated R19's activity goals were being met and this care area had be resolved as R19 had been included in all appropriate activities. R19's Activity Interest Data Collection Tool dated 1/20/15, indicated his current leisure interests included discussion/reminisce, magazines, newspapers, hunting/fishing, camping, listening to easy listening music, he played the harmonica, 1:1 socializing, military service, animals/pets, and children.	2 560		

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GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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2 560	Continued From page 7 On 1/29/15, at 1:25 p.m. the HL-B and the director of admissions and household life (AHL) were interviewed. The AHL confirmed activities were normally identified on each residents care plan. The HL-B confirmed she had just resolved R19's activity goals on his care plan because she thought he had met his goals; however the HL-B admitted she had not checked R19's documentation with regards to what activities R19 had actually attended prior to her resolving R19's activity area of focus on his care plan. HL-B confirmed R19 had severe cognitive impairment and that some of the activities which would be more appropriate for R19 would be 1:1 visits, listening to music, spending time with the tinker box in his room, and encouraging him to play his harmonica. HL-B confirmed according to R19's leisure interest evaluation that had been reviewed on 1/20/15, the interests R19 had identified did not match up with the activities R19 had been offered or participated in. The Care Plan policy dated 9/12, indicated each resident would have an individualized comprehensive care plan directed toward achieving and maintaining each resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. The Comprehensive Care Plan and Care Conferences procedure dated 6/14, specified the care plan would be comprehensive and the approaches identified would meet the resident's needs, abilities, and preferences. R43's care plan did not address the use of risperdal (an antipsychotic medication), behaviors	2 560		

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2 560	Continued From page 8 or behavioral interventions. R43's Medication Review Report indicated R43 was diagnosed with unspecified psychosis. R43's physician's orders dated 1/20/15, identified an order for risperdal 0.125 milligrams (mg) po (by mouth) twice a day for psychosis, and may increase back to 0.125 mg in the a.m. and 0.25 mg in the p.m. if hallucinations return. R43's annual MDS dated 12/5/14, indicated R43 had severely impaired cognition, had behaviors or hallucinations, but none that were recently present. The MDS further identified R43 felt tired or had little energy about half or more of the days, felt bad about herself or that she was a failure or had let her family down nearly every day, and had thoughts that she would be better off dead, or of hurting herself in some way nearly every day. The MDS documented R43 had behaviors of hallucinations/delusions, however it indicated no behaviors were shown. R43's care plan did not address hallucinations/behaviors, staff interventions with hallucinations/behaviors, use of risperdal, staff interactions if R43 is having hallucinations or delusions, or side effects of the risperdal. R6's care plan did not address the use of Seroquel (an antipsychotic medication), behaviors nor behavioral interventions. R6's Medication Review Report indicated diagnoses that included senile dementia, insomnia, anxiety and paranoia. R6 ' s physician's orders dated 12/15/14, directed Seroquel 25 mg po three times a day, 75 mg po at bedtime, and	2 560		

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2 560	Continued From page 9 25 mg as needed up to two times in 24 hours between midnight and 4:00 a.m. for paranoia. R6's quarterly MDS dated 10/24/14, indicated R6 was cognitively intact, and had mood problems that included trouble falling asleep or staying asleep, or sleeping too much, and feeling tired or having little energy nearly every day. The MDS further identified R6 had no hallucinations or delusions. R6's care plan did not address behaviors of paranoia, staff interventions with paranoia, use of Seroquel nor the potential side effects of the Seroquel. 01/29/15, at 9:46 a.m. registered nurse (RN)-A was interviewed and verified the lack of the use of risperdal on the care plan for R43, and the lack of Seroquel on the care plan for R6. On 1/29/15, at 1:09 p.m. the director of nursing (DON) was interviewed and stated she would expect nursing staff to follow the facility policy on what to include on the care plan. R47's care plan lacked interventions regarding the monitoring of anticoagulation medication (warfarin). R47's quarterly MDS dated 12/2/14, indicated R47 was cognitively intact and received anticoagulation medication (medication that works to prevent the clotting of the blood) daily. R47's undated Admission Record indicated R47 had diagnoses that included atrial fibrillation (quivering or irregular heartbeat that can lead to	2 560		

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2 560	Continued From page 10 blood clots, stroke, heart failure and other heart-related complications), rheumatoid arthritis, macular degeneration and hemiplegia (paralysis on one vertical half of the body) R47's Medication Review Report dated 1/19/15, included orders for warfarin sodium give 2 mg by mouth one time a day every Sunday, Monday, Tuesday, Thursday, Friday and Saturday and give 3 mg by mouth every Wednesday related to atrial fibrillation. The Federal Drug Administration (FDA) black box warning indicated warfarin sodium can cause major or fatal bleeding. R47's undated current care plan did not address monitoring for potential side effects of warfarin. On 1/29/2015, at 1:48 p.m. registered nurse (RN)-B verified that monitoring of warfarin was not addressed on the current care plan. On 1/29/2015, at 2:23 p.m. the director of nursing (DON) stated her expectation was policy and procedures were to be followed at the facility. DON confirmed the facility policy directed staff to include medications with black box warnings on the care plan. The Comprehensive Care Plan and Care Conference policy dated 6/14, indicated the interdisciplinary team would ensure the care plan was comprehensive by incorporating items that included physicians' orders and diagnoses that were currently being treated, and adverse consequences and "black box" warnings for medications.	2 560		

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2 560	Continued From page 11	2 560		

R29's care plan did not address appropriate monitoring interventions for potential adverse effects related to the use of Zyprexa (an antipsychotic) and Remeron (an antidepressant).

R29's physician's orders dated 11/18/14, included Zyprexa 5 mg in the evening, starting on 8/15/14, for dementia with Lewy Bodies and Remeron 15 mg in the evening starting on 8/15/14, for dementia with Lewy Bodies.

R29 s quarterly MDS dated 12/18/14, identified R48 had impaired cognition, had no psychosis or behaviors, R29 rejected cares one to three days during the assessment period and had received antipsychotic and antidepressant medication daily.

R29's The Diagnosis Report dated 1/29/15, indicated R29's diagnoses included dementia with Lewy Bodies and behavioral disturbances and delirium.

R29 was periodically observed on 1/27/15, from 11:00 a.m. to 1:45 p.m., R29 would not open her eyes or talk when spoken to until the staff assisted with eating then R29 opened her eyes, ate but did not talk.

On 1/28/15, at 9:50 a.m. R29 was observed awake and eating breakfast with staff assistance. However, one the same day, during the lunch meal R29 would not open her eyes or eat any lunch.

On 1/29/15, at 11:17 a.m. RN-B confirmed R29's care plan did not address monitoring for the potential risks or side effects of the Zyprexa or the Remeron. The RN stated the staff had a drug

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2 560	Continued From page 12 book and should know the side effects of medications. "It should be a standard of care, they're licensed." The facility policy and procedure on Care Plan dated 9/12, directed each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure a care plan is developed for all residents. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident.	2 565		3/4/15

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2 565	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to implement repositioning interventions as directed by the care plan for 1 of 3 residents (R63) reviewed for pressure ulcers. The facility also failed to provide activity interventions as directed by the care plan for 1 of 4 residents (R26) reviewed for activities. Findings include: R63 was not repositioned every two hours as directed by her care plan. R63's Diagnosis Report dated 12/16/14, identified R63's diagnoses as pathologic fracture of the neck of the femur (bone of the thigh, upper lower leg), dementia, right hip stage 3 pressure ulcer (wound with full thickness loss of tissue, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, may be tunneled), arthritis, and emphysema (a chronic respiratory disease causing a decrease in lung function). R63's care plan dated 12/16/14, identified that R63 had a pressure ulcer related to her immobility and directed staff to assist her with turning/repositioning at least every two hours. On 1/28/15, at 7:00 a.m. R63 was observed lying in bed, positioned on her back. At 8:15 a.m. nursing assistant (NA)-E and NA-D entered R63's room and proceeded to change her incontinent brief. R63 was briefly (less than ten seconds) rolled to her right side to determine if the brief required changing. NA-D confirmed R63's brief was wet. While R63 remained on her back, NA-D	2 565	corrected	

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2 565	Continued From page 14 opened the brief and NA-E tucked the right sides of the brief under the resident. NA-E rolled R63 slightly off of her back and NA-D removed the wet brief and positioned the new brief (R63 was not off of her back for no more than 30 seconds). NA-E and NA-D attached the new brief, placed a pillow between R63's knees and positioned R63 again on her back. R63 was observed to remain positioned on her back without repositioning or effective offloading assistance until 10:00 a.m. (3 hour). On 1/28/15, at 10:17 a.m. registered nurse (RN)-C stated repositioning for R63 included either assisting her out of her bed into her wheelchair, or turned from side to side, including her back. RN-C confirmed she would not consider R63 to be repositioned during a brief change if R63 had not been offloaded for greater than one minute while her brief was being changed. RN-C confirmed she expected the staff to follow R63's care plan with regards to repositioning every two hours. In addition RN-C confirmed three hours was too long to go without R63 being repositioned or offloaded. On 1/28/15, at 11:22 a.m. NA-E and NA-D confirmed R63 had been placed back in the same position and not offloaded for more than one minute when they changed her brief at 8:15 a.m. On 1/29/15, at 9:10 a.m. the director of nursing (DON) verified staff should reposition and turn R63 every two hours as directed by her care plan. The Skin Assessment and Pressure Ulcer Prevention policy dated 6/14, indicated residents who were unable to reposition themselves independently should be repositioned as directed by their care plan.	2 565		

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2 565	Continued From page 15	2 565		

R26 did not receive an individualized 1:1 activity program as directed by the care plan

R26's undated care plan indicated R26 was dependent on staff and family for activities, cognitive stimulation, and social interaction. The care plan directed staff to provide 1:1 bedside/in-room visits to promote socialization and stimulation and identified topics of interest to include woodworking, R26's grandchildren and spouse, lawn work or keeping busy in the garage. The care plan also directed staff to turn on TV, music, or book on tape in room when R26 was in his room or laying down.

On 1/26/15, at 5:22 p.m. R26 was observed seated at a table in the dining room waiting for supper. At 5:30 p.m. R26 was being fed his meal by NA-F.

On 1/27/15, at 10:15 a.m. R26's family member (FM)-B stated staff did not encourage or bring R26 to activities. FM-B stated they "never did anything with him".

On 1/27/15, at 3:11 p.m. R26 was observed laying in bed. A keno activity was currently taking place in the fellowship hall. R26's room was without music, television or book on tape in use.

On 01/28/15, at 7:19 a.m. R26 was observed in bed with the TV on. R26 remained the same until 8:09 a.m. at which time R26 was positioned on his left side and the TV remained on. At 8:47 a.m. R26 was observed dressed and seated in the wheelchair in the dining room being fed breakfast. At 8:59 a.m. R26 had completed his

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2 565	Continued From page 16	2 565		

meal and was observed to remain seated at the dining room table until 9:23 a.m. At 9:56 a.m. R26 was observed in bed with the TV on.

On 1/28/15, at 2:05 p.m. FM-B again stated the facility did not do anything with R26 for activities. FM-B stated she would, at times, bring R26 to group activities such as bingo but stated she had not witnessed staff visiting 1:1 or assisting R26 with activities of any kind.

On 1/28/15, at 2:29 p.m. NA-D and NA-E stated they were not aware of any activities done for R26. NA-E stated they would put his TV on but that was all they did.

On 1/28/15, at 2:42 p.m. NA-F stated at times, R26's wife would take him to bingo. NA-F also stated R26 required repositioning frequently and could not tolerate sitting up for long periods so he did not often attend any group activities.

On 1/29/2015, at 10:06 a.m. R26 was observed laying in bed with television quietly on. No radio or tape player was observed in the room. The activity calendar indicated a church service was scheduled for 10:00 a.m.

On 1/29/2015, at 10:08 a.m. NA-H stated R26 did have a player that read stories to him they would occasionally use. NA-H stated they might do this once a week or so. NA-H stated the only activity they usually did for R26 was to leave the TV on.

On 1/29/2015, at 10:12 a.m. household leader (HL)-B stated R26 was supposed to have 1:1 visits with the nursing assistants or homemakers. HL-B stated R26 was also taken to group activities in the fellowship hall at times so he could listen in.

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2 565	Continued From page 17 R26's Documentation Survey Report for activities for the months of November 2014, December 2014 and January 2015 was reviewed with HL-B and revealed the following: -November 2014 - documentation of 4 activity events (documentation lacked name of activity event) -December 2014 - documentation of 0 activity events. -January 2015 - documentation of 0 activity events. HL-B indicated there were additional activity attendance sheets completed by the homemakers for activities for the months of December 2014 and January 2015. These revealed R26 attended present opening on 12/25/14, a group activity on 12/26/14, and bingo on 12/31/14,1/6/15 and 1/7/15. HL-B verified there were no other activities and no 1:1 activities documented for R26 and confirmed R26 should have had 1:1 visits. HL-B stated she would have expected staff to provide 1:1 activities for R26 as directed by the care plan. On 1/29/15, at 2:44 p.m. the director of admissions and household life (AHL) indicated she worked in coordination with HL-B to ensure activities were provided. AHL verified there was no documentation R26 had received 1:1 visits as directed on the care plan and confirmed R26 should have received 1:1 visits as directed. The Comprehensive Care Plan and Care Conferences procedure dated 6/14, indicated a resident-specific care plan should be developed to meet the physical, needs of the resident.	2 565		

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2 565	Continued From page 18 The Care Plan policy dated 9/12, indicated each resident would have an individualized comprehensive care plan developed to achieve and maintain the resident's optimal medical, physical, and nursing needs. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure the implementation of the care plan. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565		
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores	2 900		3/4/15

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2 900	Continued From page 19 receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed provide timely turning and repositiong for 1 of 3 residents (R63) identified with an active pressure ulcer and required every two hour turning and repositioning. Findings include: R63's Diagnosis Report dated 12/16/14, indicated R63 was diagnosed with a pathologic fracture of the neck of the femur (bone of the thigh, upper lower leg), dementia, anxiety, panic disorder, right hip stage 3 (wound with full thickness loss of tissue, subcutaneous fat may be visible but bone, tendon or muscle are not exposed, may be tunneled) pressure ulcer, arthritis, and emphysema (a chronic respiratory disease causing a decrease in lung function). R63's care plan dated 12/16/14, indicated R63 had a pressure ulcer related to immobility and directed staff to assist R63 with turning and repositioning at least every two hours. R63's Positioning Assessment and Evaluation dated 12/16/14, indicated R63 was unable to make significant changes in position without assistance related to her weakness and bilateral hip and knee contractures. In addition, a repositioning program should be implemented. R63's admission Minimum Data Set (MDS) dated 12/23/14, indicated R63 had moderate cognitive	2 900	corrected	

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2 900	Continued From page 20 impairment and required extensive assist with bed mobility, transferring, toileting and personal hygiene. In addition, R63 had been identified as at risk for the development of a pressure ulcer and had an existing unhealed stage 3 pressure ulcer on her right hip. The MDS indicated the treatment plan included a turning and repositioning program. R63's Care Area Assessment (CAA) dated 12/23/14, indicated R63 required assistance with repositioning in bed and wheelchair. The CAA also indicated R63 had an existing stage 3 pressure ulcer with a recommended treatment plan which included a pressure relief mattress, wheelchair cushion in place and a scheduled repositioning schedule. R63's Braden Scale Assessment (tool for predicting risk for pressure sore development) dated 1/13/15, identified R63 was at risk for the development of a pressure ulcer and the intervention guide recommended R63 should be turned frequently and have a planned turning schedule. R63's medical record revealed the following with regards to mention of wound measurement: -12/17/14 - 0.3 centimeters (cm) - length, 0.5 cm - width, 0.8 cm - depth. -12/24/14 - 1.5 cm - length, 0.5 cm - width, 0.8 cm-depth. Comment indicated that the outside of the perimeter of the wound, most probable the perimeter came in contact with the dressing, causing tissue damage to good skin and causing increased in length. As an intervention, staff was instructed to ensure the dressing only contacted the wound bed. -1/2/15 - 0.9 cm - length, 0.5 cm - width, 1.2 cm -	2 900		

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2 900	Continued From page 21 depth -1/12/15 - 0.9 cm - length, 0.4 cm - width, 1.0 cm - depth -1/26/15 - 0.7 cm - length, 0.4 cm - width, 0.8 cm - depth On 1/28/15, at 7:00 a.m. R63 was observed lying in bed, positioned on her back, twisted at the waist with her legs bent upwards towards her chest and left side. At 8:15 a.m. nursing assistant (NA)-E and NA-D entered R63's room and proceeded to change her brief. R63 was briefly (less than ten seconds) rolled to her right side in order to determine if the brief required changing. NA-D confirmed R63's brief was wet. While R63 remained on her back, NA-D opened the brief and NA-E tucked the right sides of the brief under the resident. NA-E rolled R63 slightly off of her back, NA-D removed the wet brief, positioned the new brief and returned R63 onto her back (R63 was not off of her back for no more than 30 seconds). NA-E and NA-D fastened the new brief and placed a pillow between R63's knees and left R63 positioned on her back, twisted at the waist with her legs bent upwards towards her chest and left side. R63 was observed to remain positioned on her back without repositioning or effective offloading until 10:00 a.m. (3 hours). At 10:21 a.m. licensed practical nurse (LPN)-C was observed to conduct R63's right hip pressure ulcer's daily dressing change. R63's pressure ulcer was observed to be located on her right hip area with minimal drainage observed on the dressing when removed. The margins of the wound were pink, the wound had full thickness loss of tissue and skin, however didn't appear to be tunneled. LPN-C did not reposition the resident prior to, during or after conducting the	2 900		

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2 900	Continued From page 22 dressing change. On 1/28/15, at 11:41 a.m. NA-E and NA-D entered R63's room to change her brief again. They gathered their supplies, and while R63 was positioned on to her right side her bottom area was observed. R63's bottom was observed free from open areas however; R63's left buttock and coccyx area were observed very reddened and her back had a raised, red rash in which NA-E stated was much improved. On 1/28/15, at 10:17 a.m. registered nurse (RN)-C stated repositioning for R63 included either out of her bed into her wheelchair, or turned from side to side, including her back. RN-C confirmed she would not consider R63 to be repositioned during a changing of her brief if R63 had not been offloaded for greater than one minute while her brief was being changed. RN-C confirmed she expected staff to follow R63's care plan with regards to repositioning every two hours. In addition RN-C confirmed three hours was too long to go without R63 being repositioned or offloaded. On 1/28/15, at 11:22 a.m. NA-E and NA-D confirmed R63 had been placed back in the same position and not offloaded for more than one minute when they changed her brief at 8:15 a.m. On 1/29/15, at 9:10 a.m. the director of nursing (DON) verified staff should reposition and turn R63 every two hours as directed by her care plan. The Positioning Assessment and Evaluation policy dated 3/2008, indicated the RN would determine an individualized repositioning scheduled based on the residents individual	2 900		

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2 900	Continued From page 23 resident assessment. The Mobility Support and Positioning: Positioning procedure dated 11/13, indicated an individualized repositioning schedule was recommended based on evaluation of risk factors and on observation of the resident's skin over a period of time. The Positioning Data Collection Tool dated 3/2008, defined offloading as removing pressure from an area for at least one minute. The Skin Assessment and Pressure Ulcer Prevention dated 6/14, indicated residents who are unable to reposition themselves independently should be repositioned as directed by their care plan. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure residents do not develop a pressure ulcer unless it is clinically unavoidable, and residents who do have pressure ulcers are receiving the proper care and services needed to promote healing, prevent infection and promote new pressure ulcers from developing. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 900		

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2 930	Continued From page 24	2 930		
2 930	MN Rule 4658.0525 Subp. 7 B. Rehab - Nasogastric, Gastrostomy tubes Subp. 7. Nasogastric tubes, gastrostomy tubes, and feeding syringes. Based on the comprehensive resident assessment, a nursing home must ensure that: B. a resident who is fed by a nasogastric or gastrostomy tube or feeding syringe receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal feeding function. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to check placement of a gastrostomy tube (G-tube, a tube which goes into the stomach for food and or medications) prior to medication administration for 1 of 1 residents (R48) observed for medication administration through a G-tube. Findings include: R48's Diagnosis Report dated 1/28/15, indicated R48's diagnoses included dysphagia (difficulty swallowing) due to cerebrovascular disease, pulmonary (lungs) insufficiency and a history of recurrent pneumonia. R48's care plan dated 10/3/14, indicated R48 required a tube feeding and was NPO (nothing by	2 930	corrected	3/4/15

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2 930	Continued From page 25 mouth). On 1/28/15, at 11:55 a.m. licensed practical nurse (LPN)-C was observed during the administration of R48's Baclofen 10 milligrams (mg) via the G-tube. The LPN washed her hands, obtained the medication, crushed the medication and then dissolved the medication in approximately 20 milliliters (ml) of water. The LPN donned gloves and attached an extension tube to a port near R48's stomach area. The LPN then attached the barrel of a large syringe to the extension tube and poured in approximately 15 cc of water, poured in the medication followed by approximately 15 cc of water and then put the plunger into the barrel of the syringe pushing air in to clear the extension tube. LPN-C did not check for placement of the G-tube prior to administering the water and medication. LPN-C stated that was the way she always gave R48's medication and did not check for placement of the G-tube because R48 had a short peg that goes into the stomach. On 1/29/15, at 8:30 a.m. LPN-C stated she had reviewed the facility policy and should have checked placement prior to administering R48's medication. On 1/29/15, at 2:00 p.m. the director of nursing (DON) stated she would expect staff to follow the care plan and "if the care plan directed to do so then they should." The DON also stated she would expect staff to follow the policy. The facility's Medication Administration Via Tube policy revised 11/13, indicated the tube should be checked for placement and patency prior to administering medication. The policy directed staff to check patency and position of the tube, use a syringe and inject 5-10 ml of air then	2 930		

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2 930	Continued From page 26 aspirate gastric contents to ensure the tube was in the stomach. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident with feeding tubes are monitored for proper placement of that feeding tube. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 930		
21426	MN St. Statute 144A.04 Subd. 3 Tuberculosis Prevention And Control (a) A nursing home provider must establish and maintain a comprehensive tuberculosis infection control program according to the most current tuberculosis infection control guidelines issued by the United States Centers for Disease Control and Prevention (CDC), Division of Tuberculosis Elimination, as published in CDC's Morbidity and Mortality Weekly Report (MMWR). This program must include a tuberculosis infection control plan that covers all paid and unpaid employees, contractors, students, residents, and volunteers. The Department of Health shall provide technical assistance regarding implementation of the guidelines. (b) Written compliance with this subdivision must	21426		3/4/15

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21426	Continued From page 27 be maintained by the nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure 4 of 5 residents (R3, R16, R50, R63) received tuberculin skin testing (TST) according to the Centers for Disease Control & Prevention (CDC) guidelines. In addition, the facility failed to ensure 1 of 5 new employees (NA-C) received TST according to the CDC guidelines. Findings include: RESIDENT TST: R3 was admitted to the facility on 10/1/14. R3's medical record indicated she received the first step of her TST on 10/1/14, and this test was read as negative 0 millimeters (mm) induration on 10/3/14. R3 received the second step of her TST on 10/8/14, results were read on 10/10/14, as "negative" (lacked documentation of induration). R16 was admitted to the facility on 12/15/14. R16's medical record indicated she received the first step of her TST on 12/16/14, at 5:54 a.m. and results were read as negative - 0 mm induration on 12/17/14, at 5:59 p.m. (36 hours later). R16 received the second step of her TST on 12/22/14, and the results were read on the same day 12/22/14, and documented as negative - 0 mm induration.	21426	corrected	

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21426	Continued From page 28	21426		

R50 was admitted to the facility on 12/12/14. R50's medical record indicted she received the first step of her TST on 12/13/14, and the results were read as negative - 0 mm induration on 12/15/14. R50 received the second step of her TST on 12/22/14, results were read on 12/25/14, as "negative" (lacked documentation of induration).

R63 was admitted to the facility on 12/16/14. R63's medical record indicated she received the first step of her TST on 12/16/14. The record lacked documentation of when the first step was read and the results. R63 received the second step of her TST on 1/23/15, results were read on 12/26/15, as "negative" (lacked documentation of induration).

On 1/27/15, at 3:25 p.m. registered nurse (RN)-A confirmed R50's medical record lacked documentation of induration of the results of the second TST, and it should have indicated induration.

On 1/27/15, at 3:29 p.m. RN-C confirmed:
- R3' s medical record lacked documentation of induration for her second step TST
- R16's first step was read too early. RN-C verified there should be 48-72 hours before the TST results are read.
-R63's medical record lacked documentation of when her first step was read and the results. In addition, the induration of the results of the second step where not documented.

EMPLOYEE TST:

Nursing assistant (NA)-C's hire date was 11/18/14. NA-C's TST administration form

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21426	Continued From page 29 indicated NA-C received the first step of her TST on 11/14/14. This test was read on 11/16/14, with a negative - 0 mm result. NA-C received the second step of her TST on 12/11/14 (27 days later), results were read on 12/13/14, with a negative - 0 mm result. On 1/29/15, at 9:21 a.m. the director of nursing (DON) stated it was her expectation that staff followed the facility's policy and the standards of practice with regards to tuberculosis screening, and the TST procedure. On 1/29/15, at 9:30 a.m. the DON confirmed NA-A had received her second step of her TST beyond the three week (21 days) guidelines per their facility policy. The Screening of Residents for Tuberculosis procedure dated 11/14, indicated all new residents would receive a baseline TST. This involved administration of the initial test upon admission, which would be read 48 to 72 hours later. If the first TST was negative, the second step would be completed one to three weeks after the placement of the first step. The second test would be read 48 to 72 hours after it was administered. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to the required tuberculosis TST process . The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21)	21426		

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21426	Continued From page 30 days	21426		
21435	MN Rule 4658.0900 Subp. 1 Activity and Recreation Program; General Subpart 1. General requirements. A nursing home must provide an organized activity and recreation program. The program must be based on each individual resident's interests, strengths, and needs, and must be designed to meet the physical, mental, and psychological well-being of each resident, as determined by the comprehensive resident assessment and comprehensive plan of care required in parts 4658.0400 and 4658.0405. Residents must be provided opportunities to participate in the planning and development of the activity and recreation program. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide activities to meet the individual interests for 4 of 4 residents (R43, R50, R26, R19) reviewed for activities. Findings include: R43 was not provided activities according to assessed need. R43's Admission Record dated 7/13/12, indicated diagnoses of blindness in both eyes, unspecified psychosis and major depressive disorder. R43's annual Minimum Data Set (MDS) dated 12/5/14, indicated R43 had severely impaired cognition, required extensive assistance of one	21435	corrected	3/4/15

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21435	Continued From page 31	21435		

staff with transfers and locomotion on the unit and had behaviors or hallucinations but none that were recently present. The MDS further indicated R43 felt tired or had little energy about half or more of the reference period days, felt bad about herself or that she was a failure or had let her family down nearly every day, had thoughts that she would be better off dead or of hurting herself in some way nearly every day.

The MDS also identified R43 felt the following activities of interest were very important to her:

- to have books, newspapers and magazines to read
- listen to music
- be around animals such as pets
- do things with groups of people
- go outside to get fresh air when the weather was good
- participate in religious services or practice

R43's care plan lacked identification of individualized and / or group activities that would be of interest to R43.

R43 was observed the following times:

On 1/26/15, at 5:00 p.m. sitting in front of the television in the day room with the Weather Channel on, not actively engaged.
On 1/27/15, at 9:30 a.m. sitting in her room, no television or radio on.
On 1/27/15, at 11:36 a.m. sitting in the day room in front of the television on the Weather Channel, not actively engaged.
On 1/28/15, at 1:23 p.m. sitting in day room watching the Weather Channel, not actively engaged.

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21435	Continued From page 32 R43's activity documentation indicated R43 had attended / participated in 10 activities in 11/14, 13 activities in 12/14, and 10 activities in 1/15. R50 was not provided activities according to assessed need. R50's Admission Record dated 12/12/14, identified diagnoses of chronic obstructive airway disease, hypertension and anxiety. R50's admission MDS dated 12/25/14, indicated R50 was cognitively intact and required minimal assistance of one staff with transfers, ambulation and locomotion on the unit. R50's MDS also indicated R50 had felt the following were very important or somewhat important to her: - do favorite activities - listen to music - keep up with the news - go outside to get fresh air when the weather was good On 1/26/15, at 6:34 p.m. R50 was interviewed and stated activities were not offered as often as she would like, including on evenings and weekends. R50 stated the facility had not provided much in the way of activities and if they had more activities, she would go. R50 further stated the activities usually consisted of bingo and keno. R50's care plan lacked individualized and group activities that would be of interest to R50.	21435		

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21435	Continued From page 33 On 1/28/15, at 2:16 p.m. the household life director (HL)-A was interviewed and stated the facility gathered residents individual likes and dislikes for activities and then tried to accommodate the resident's preferences. If a resident was unable to state what their individualized preferences were, the facility may bring them to an activity that may stimulate them like bingo, music or smaller group activities. HL-A further stated that not all activities were organized and many were spontaneous. HL-A was unable to identify spontaneous activities that had occurred from 1/26/15, through 1/28/15. HL-A also stated the nursing assistants were to utilize the the individual resident care plans to identify what activities the residents were interested in, and either assist them to the activity or initiate an activity. When asked if the nursing assistants had the actual time to initiate activities with the residents, HL-A stated probably not. HL-A verified the lack of an activity care plan and a lack of activities for R43 and R50. On 1/29/15, at 8:13 a.m. nursing assistant (NA)-I was interviewed and stated his involvement in activities was limited to transporting residents to and from an organized activity. NA-I stated he did not have time to do spontaneous activities with residents as their were only two nursing assistants for 18 residents. NA-I further stated he was unaware if resident individual preferences were on the care plan because he doesn't have time to look at the care plans. The facility policy and procedure on Activity Program revised 1/15, directed the facility to provide for an ongoing activities program designed to meet, in accordance with the comprehensive assessment, the interests and the	21435		

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	00322	A. BUILDING: _____ B. WING _____	01/29/2015

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21435	Continued From page 34 physical, mental and psychosocial well-being of each resident. R26 did not receive an individualized 1:1 activity program. R26's quarterly Minimum Data Set (MDS) dated 11/3/14, indicated R26 had severe cognitive impairment and was diagnosed with Alzheimer's disease and osteoarthrosis. The MDS also indicated R26 was non-ambulatory and was totally dependent upon one person for locomotion on and off the unit. R26's Activities Care Area Assessment (CAA) dated 2/21/14, indicated R26 had reduced activity participation due to physical disability, unstable acute/chronic health problems, cognitive deficits and chronic health conditions such as incontinence or pain. The CAA indicated activities would be addressed on the care plan. R26's undated care plan indicated R26 was dependent on staff and family for activities, cognitive stimulation and social interaction. The care plan directed staff to provide 1:1 bedside/in-room visits to promote socialization and stimulation and identified topics of interest to include woodworking, R26's grandchildren and spouse, lawn work or keeping busy in the garage. The care plan also directed staff to turn on TV, music, or book on tape in room when R26 was in his room or laying down. On 1/26/15, at 5:22 p.m. R26 was observed seated in the wheelchair at the dining room table. At 5:30 p.m. NA-F was observed feeding R26 his meal.	21435		

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21435	Continued From page 35 On 1/27/15, at 10:15 a.m. R26's family member (FM)-B stated staff did not encourage or bring R26 to activities. FM-B stated they "never did anything with him." On 1/27/15, at 3:11 p.m. R26 was observed laying in bed. A keno activity was currently taking place in the fellowship hall. R26's room was without music, television or book on tape in use. On 01/28/15, at 7:19 a.m. R26 was observed in bed with the TV on. R26 remained the same until 8:09 a.m. at which time R26 was positioned on his left side and the TV remained on. R26 remained the same until 8:21 a.m. At 8:47 a.m. R26 was observed dressed and seated in the wheelchair in the dining room being fed breakfast. At 8:59 a.m. R26 had completed his meal and was observed to remain seated at the dining room table until 9:23 a.m. At 9:56 a.m. R26 was observed in bed with the TV on. On 1/28/15, at 2:05 p.m. FM-B again stated the facility did not do anything with R26 for activities. FM-B stated she would, at times, bring R26 to group activities such as bingo but stated she had not witnessed staff visiting 1:1 or assisting R26 with activities of any kind. On 1/28/15, at 2:29 p.m. NA-D and NA-E stated they were not aware of any activities done for R26. NA-E stated they would put his TV on but that was all they did. On 1/28/15, at 2:42 p.m. NA-F stated R26's wife would take him to bingo at times. NA-F also stated R26 required repositioning frequently and could not tolerate sitting up for long periods so he did not often attend any group activities.	21435		

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21435	Continued From page 36 On 1/29/2015, at 10:06 a.m. R26 was observed in bed with the TV quietly on. No radio or tape player was observed in the room. The activity calendar indicated a church service was scheduled for 10:00 a.m. On 1/29/2015, at 10:08 a.m. NA-H stated R26 did have a player that read stories to him that they would occasionally use. NA-H stated they might do this once a week or so. NA-H stated the only activity they usually did for R26 was to leave the TV on. On 1/29/2015, at 10:12 a.m. HL-B stated R26 was supposed to have 1:1 visits with the nursing assistants or homemakers. HL-B stated R26 was also taken to group activities in the fellowship hall at times so he could listen in. R26's Documentation Survey Report for activities for the months of November 2014, December 2014 and January 2015 was reviewed with HL-B and revealed the following: -November 2014 - documentation of 4 activity events (documentation lacked name of activity event) -December 2014 - documentation of 0 activity events. -January 2015 - documentation of 0 activity events. HL-B indicated there were additional activity attendance sheets completed by the homemakers for activities for the months of December 2014, and January 2015. These revealed R26 attended present opening on 12/25/14, a group activity on 12/26/14, and bingo on 12/31/14, 1/6/15 and 1/7/15. HL-B verified there were no other activities and no 1:1 activities	21435		

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21435	Continued From page 37	21435		

documented for R26 and confirmed R26 should have had 1:1 visits. HL-B stated she would have expected staff to provide 1:1 activities for R26 as directed by the care plan.

On 1/29/15, at 2:44 p.m. the director of admissions and household life (AHL) indicated that she worked in coordination with HL-B to ensure activities were provided. AHL verified there was no documentation R26 had received 1:1 visits as directed on the care plan and confirmed R26 should have received 1:1 visits as directed.

R19 was not provided activities according to assessed need.

R19's annual MDS dated 1/13/15, indicated R19 was diagnosed with dementia and depression. The MDS also indicated R19 had severe cognitive impairment and required staff reminders and encouragement to attend activities. The MDS indicated R19's daily and activity preferences were identified as R19 enjoyed family involvement in care discussions, doing things with groups of people and participating in favorite activities.

R19's Activities CAA dated 1/13/15, indicated R19's activity goals were being met and this care area had be resolved as R19 had been included in all appropriate activities.

R19's Activity Interest Data Collection Tool dated 1/20/15, indicated his current leisure interests included discussion/reminisce, magazines, newspapers, hunting/fishing, camping, listening to easy listening music, he played the harmonica,

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21435	Continued From page 38 1:1 socializing, military service, animals/pets and children. R19's current care plan lacked a focus area and interventions which identified R19's activity interests and needs. On 1/27/15, at 3:30 p.m. R19 was observed laying in his bed. R19 did not attend the Keno activity being held in the fellowship hall. On 1/29/15, at 2:30 p.m. the activity calendar indicated there was a social hour with a card game scheduled. At this time, R19 was observed lying awake in bed and did not participate in this activity. R19's Documentation Survey Report for activities indicated the following: -October 2014 - R19 participated in one activity event (documentation lacked name of the activity event) -November 2014 - R19 participated in one activity event (documentation lacked name of the activity event) -December 2014 - R19 participated in two activity events (one being the holiday potluck on 1/19/14) -January 2015- R19 participated in 9 activity events (included- bingo, small group, ball toss, and brides party) On 1/28/15, at 9:58 a.m. NA-E stated R19 did not participate in activities. On 1/28/15, at 10:04 a.m. HL-B stated the homemakers were responsible for the activities in the fellowship hall. When an activity was scheduled the homemakers were supposed to go	21435		

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21435	Continued From page 39	21435		

around and make sure the residents who wanted to attend the activity got to the activity. She stated the nursing assistants were not responsible for coordinating the activities; however they did assist in transporting the residents to the activities.

On 1/28/15, at 11:10 a.m. NA-E stated on the activity calendar they will have something listed, however nobody knows what it means. For example, on 1/4/15, the activity calendar had "couch potato" listed as a scheduled activity, there was no time designated and nobody knows what this activity means.

On 1/28/15, at 1:50 p.m. HL-B confirmed she had no documentation of what activities R19 had participated in before 11/30/14. HL-B stated "it looks pretty pathetic."

On 1/29/15, at 1:25 p.m. the HL-B and the director of admissions and household life (AHL) were interviewed. The AHL confirmed activities were normally identified on each residents care plan. The HL-B confirmed she had just resolved R19's activity goals on his care plan because she thought he had met his goals; however the HL-B admitted she had not checked R19's documentation with regards to what activities R19 had actually attended prior to her resolving R19's activity area of focus on his care plan. HL-B confirmed R19 had severe cognitive impairment and that some of the activities which would be more appropriate for R19 would be 1:1 visits, listening to music, spending time with the tinker box in his room and encouraging him to play his harmonica. HL-B confirmed according to R19's leisure interest evaluation that had been reviewed on 1/20/15, the interests R19 had identified did not match up with the activities R19 had been

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21435	Continued From page 40 offered or participated in. The Activity Program policy dated 1/15, indicated the facility would provide an ongoing activity program designed to meet the interests and the physical, mental and psychosocial well-being of each resident. In addition, the activities would focus on the cognitive, physical, spiritual, community, social and creative needs of each individual resident. The Non-Traditional Settings and Activities policy dated 6/12, indicated the residents interests would be reflected in the planned, spontaneous and self-directed activities offered. Also, the activity director would monitor and evaluate the response of the activity program to determine if the assessed needs of the resident have been met. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's have an inidivdualized activity program that meets their needs. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21435		

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21445	Continued From page 41	21445		
21445	MN Rule 4658.0900 Subp. 3 Activity and Recreation Program; Director Subp. 3. Activity and recreation program director. The activity and recreation program director must be a person who is trained or experienced to direct the activity and recreation staff and program at that nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the activity program was directed by a qualified activity professional who was responsible for directing the development, implementation, supervision and ongoing evaluation of the activities program, as required. This had the potential to effect all residents residing on 2 of 3 units. Findings include: The facility's Qualifications of Activity Director policy and procedure dated 6/12, indicated the activity program would be directed by a qualified professional who had two years of experience in a social or recreational program within the last five years, one of which was full-time in a patient activities program within a health care setting. On 1/27/15, at 9:00 a.m. the director of admissions and household life (AHL)-C stated she had worked full time at the facility for three years, but has not worked full time in the activity department for any of those three years. DAHL-C verified she did not have the qualifications reqiured per facility policy to be an activities director. On 1/27/15, at 9:43 a.m. the AHL-C stated she	21445	corrected	3/4/15

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21445	Continued From page 42 spent approximately 25-30% of her time on activities and was also responsible for admissions, referrals, discharge planning, social services, volunteers and health information management. On 1/27/15, at 9:13 a.m. the administrator verified AHL-C had not worked full time in the activity department as has had multiple roles. The administrator also verified AHL-C was allotted 30% of her time to spend on activities. SUGGESTED METHOD OF CORRECTION: The administrator or designee could ensure the activity director has the proper qualifications. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21445		
21535	MN Rule4658.1315 Subp.1 ABCD Unnecessary Drug Usage; General Subpart 1. General. A resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used: A. in excessive dose, including duplicate drug therapy; B. for excessive duration; C. without adequate indications for its use; or D. in the presence of adverse consequences which indicate the dose should be reduced or discontinued. In addition to the drug regimen review required in part 4658.1310, the nursing home must comply with provisions in the Interpretive Guidelines for Code of Federal Regulations, title 42, section 483.25 (1) found in Appendix P of the State	21535		3/4/15

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21535	Continued From page 43 Operations Manual, Guidance to Surveyors for Long-Term Care Facilities, published by the Department of Health and Human Services, Health Care Financing Administration, April 1992. This standard is incorporated by reference. It is available through the Minitex interlibrary loan system and the State Law Library. It is not subject to frequent change. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure antipsychotic medications were monitored, managed and justification of use was identified for 2 of 5 residents (R6, R43) reviewed for unnecessary medications. Findings include: R6 did not have a gradual dose reduction attempted nor justification / adequate indications for use identified for the continued use of Seroquel (an antipsychotic medication). R6's Medication Review Report indicated diagnoses that included senile dementia, insomnia, anxiety and paranoia. The physician's orders dated 12/15/14, directed Seroquel 25 milligrams (mg) po (by mouth) three times a day, 75 mg po at bedtime, and 25 mg as needed up to two times in 24 hours between midnight and 4:00 a.m. for paranoia. R6's quarterly Minimum Data Set (MDS) dated 10/24/14, indicated R6 was cognitively intact and had mood problems that included trouble falling asleep or staying asleep, or sleeping too much and feeling tired or having little energy nearly every day. The MDS further identified R6 had no	21535	corrected	

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21535	Continued From page 44 hallucinations or delusions. R6's care plan did not address behaviors of paranoia, staff interventions for paranoid episodes, use of Seroquel nor potential side effects of the Seroquel. On 1/29/15, at 9:46 a.m. registered nurse (RN)-A was interviewed and stated if behaviors were not addressed on the care plan, it was because there were no behaviors. RN-A stated a gradual dose reduction had been attempted on 8/13, but was not successful and a reduction had not been attempted since that time. R43 was not monitored for side effects, or justification/adequate indication for use for risperdal (an antipsychotic medication) . R43's Medication Review Report identified diagnoses that included unspecified psychosis. The physician's orders dated 1/20/15, identified an order for risperdal 0.125 mg po twice a day for diagnosis of psychosis, and may increase back to 0.125 mg in the a.m. and 0.25 mg in the p.m. if hallucinations return. R43's annual MDS dated 12/5/14, indicated R43 had severely impaired cognition, had behaviors or hallucinations, but none that were recently present. The MDS further identified R43 felt tired or had little energy about half or more of the days, felt bad about herself or that she was a failure or had let her family down nearly every day, and had thoughts that she would be better off dead or of hurting herself in some way nearly every day. The MDS documented R43 had behaviors of hallucinations/delusions, however it indicated no behaviors were shown.	21535		

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21535	Continued From page 45 R43's care plan did not address behaviors of hallucinations/behaviors, staff interventions with hallucinations / delusions / behaviors, use of risperdal or potential side effects of the risperdal. On 1/29/15, at 9:25 a.m. RN-A was interviewed and stated R43's care plan and monitoring lacked behaviors because R43 was not having any behaviors at this time. RN-A verified side effect monitoring had not been done. On 1/29/15, at 1:09 p.m. the director of nursing (DON) was interviewed and stated she would expect staff to follow the policy regarding gradual dose reduction of psychotropic medications, monitoring of side effects, and monitoring for justification/adequate indication for use of psychotropic medication. The facility policy and procedure on Psychopharmalogical Medications and Sedative/Hypnotics dated 6/14, directed mood and behavior documentation must continue in order to indicate the medication has on the behavior, side effects of the medication must be monitored, and gradual dose reductions must be attempted. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's medications are free from unnecessary medications. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could develop monitoring systems to ensure ongoing compliance.	21535		

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21535	Continued From page 46 TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21535		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to honor the right to be treated in a dignified manner regarding toileting concerns for 1 of 1 resident (R3) who was reviewed for dignity. Findings include: On 1/26/15, at 6:54 p.m. R3 stated she was uncomfortable because she had just urinated in her pants. R3 stated when she informed staff of her need to urinate or have a bowel movement, staff tell her to just go in the incontinent brief and they would clean her up. R3 stated she was unable to stand therefore staff transferred her with a mechanical lift and when she was seated in the wheelchair, staff had to transfer her into bed in order to clean her up. R3 stated sometimes her clothes got wet which she did not like. R3 added, "but what can I do? I can't stand. One day I will get on the toilet." R3 stated sometimes she could feel the urge to urinate or have a bowel movement but when she told staff	21805	corrected	3/4/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00322	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INTERNATIONA	2201 KEENAN DRIVE INTERNATIONAL FALLS, MN 56649

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21805	Continued From page 47	21805		

they would say, "go ahead and go and we'll clean you up."

R3's Diagnosis Report dated 1/28/15, indicated R3's diagnoses included pneumonia due to the inhalation of food or vomit, depression, anxiety, type 2 diabetes, pain and osteoarthrosis.

R3's quarterly Minimum Data Set (MDS) dated 1/7/15, indicated R3 had moderate cognitive impairment and required extensive assistance of one staff for personal hygiene and two staff for bed mobility, transfers, dressing and toilet use. The MDS also indicated R3 was frequently incontinent of urine and always incontinent of bowel. The MDS indicated R3 was on a urinary toileting program to manage urinary continence which could include scheduled toileting, prompted voiding or bladder training. The MDS further indicated R3 was on an unidentified bowel toileting program to manage R3's bowel incontinence.

R3's bladder incontinence care pan revised on 1/5/15, indicated R3's incontinence was related to short term memory impairment, decreased mobility, minimal urge to void and refusals of toileting. R3's Activities of Daily Living (ADL) care plan revised 1/5/15, indicated R3 required total staff assistance to transfer with a mechanical lift. The care plan indicated R3's toileting schedule consisted of having the incontinent product checked and changed every three to four hours. In addition, the care plan indicated the risk and benefits of refusals of the toileting program and toilet substitutes had been discussed.

On 1/28/15, at 8:00 a.m. nursing assistant (NA)-A stated R3 did not use the toilet but used the bed pan. NA-A stated they laid R3 down every two

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21805	Continued From page 48	21805		

hours and she was offered the bed pan. NA-A also stated R3 did very well with the bed pan, voided a large amount and was also usually quite wet.

On 1/28/15, at 1:45 p.m. R3 again stated staff told her to go in her pants. R3 also stated she seldom used the bedpan because she hated it. R3 stated "wetting your pants is no good. It's no good to sit in wet pants." R3 stated she can sometimes tell when she has to urinate and have a bowel movement but when she tells staff, they tell her to go ahead and go in her pants and they would clean her up. R3 stated "I don't feel good about it. I look at that toilet and I want to sit on it so bad and I've never sat on it."

On 1/28/15, at 2:20 p.m. NA-A confirmed R3 could at times tell staff when she had to urinate or have a bowel movement. However, NA-A stated she had never put R3 on the toilet due to how she transferred. NA-A stated we put R3 on the bed pan and she did well. NA-A stated she has never asked R3 if she wanted to use the toilet. NA-A verified staff would have to lay R3 down, pull down her pants and then move her to the toilet with the mechanical lift. NA-A stated R3 would probably not make it to the toilet before having an accident. NA-A stated there was a lift sling they could use to put R3 on the toilet.

On 1/28/15, at 2:30 p.m. NA-C stated she had never put R3 on the toilet because she was unable to walk and utilized a full sling mechanical lift to transfer. NA-C stated "we just change her." NA-C also stated she had never assisted R3 onto the bedpan.

On 1/29/15, at 11:23 a.m. registered nurse (RN)-B, stated R3 had consistently refused the

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21805	Continued From page 49 toilet and the toileting program therefore R3 was to have her incontinent product checked and changed. RN-B stated R3 rarely used the bed pan. When asked if staff should tell R3 or any other resident to void / defecate in their incontinent product and they would be cleaned up afterward, RN-B stated staff should be putting R3 on the bedpan. RN-B verified the mechanical lift sling could be used to transfer a resident onto the toilet. RN-B also stated the facility had a hygiene sling but no longer used it. On 1/29/15, at 2:00 p.m. the director of nursing (DON) stated she expected staff to follow the care plan as long as the resident's request was in line with the care plan directive. The DON was asked if it was appropriate to tell a resident who stated they needed to use the bathroom to go in their pants and then they would be cleaned up, the DON stated "No." The facility's Resident Dignity policy issued 2/13, indicated the purpose was to maintain the dignity of all residents. The policy was to promote care for residents in a manner and an environment that maintained or enhanced each resident's dignity and respect in full recognition of his or her individuality. SUGGESTED METHOD OF CORRECTION: The Director of Nursing or designee could develop, review, and/or revise policies and procedures to ensure resident's dignity is maintained. The Director of Nursing or designee could educate all appropriate staff on the policies and procedures. The Director of Nursing or designee could	21805		

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21805	Continued From page 50 develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21805		