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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QLQ6

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00697

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245593**

2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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 **1/18/2018** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **51** (L18)

13.Total Certified Beds **51** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(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 :
Lois Boerboom, HFE NE II 02/1/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 2/01/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245593
February 1, 2018

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Dear Ms. Hagstrand:

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

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

Effective January 8, 2018 the above facility is certified for:

51 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 51 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 1, 2018

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: Project Number S5593028

Dear Ms. Hagstrand:

On December 29, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on December 4, 2017. 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 January 18, 2018, the Minnesota Department of Health and the Minnesota Department of Public Safety completed Post Certification Revisits (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on December 4, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 8, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on December 4, 2017, effective January 8, 2018 and therefore remedies outlined in our letter to you dated December 29, 2017, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us
cc: Licensing and Certification File

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 1, 2018

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: Reinspection Results - Project Number S5593027

Dear Ms. Hagstrand:

On January 18, 2018 survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 4, 2017, with orders received by you on December 29, 2017. At this time these correction orders were found corrected and are listed on the accompanying Revisit Report Form submitted to you electronically.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: QLQ6

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(L1) **245593**
2.STATE VENDOR OR MEDICAID NO.
(L2) **713343000**

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(L3) **GOOD SAMARITAN SOCIETY - ST JAMES**
(L4) **1000 SOUTH SECOND STREET**
(L5) **ST JAMES, MN** (L6) **56081**

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 **12/04/2017** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

01 Hospital	**05 HHA**	**09 ESRD**	**13 PTIP**	**22 CLIA**
02 SNF/NF/Dual	**06 PRTF**	**10 NF**	**14 CORF**	
03 SNF/NF/Distinct	**07 X-Ray**	**11 ICF/IID**	**15 ASC**	
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FISCAL YEAR ENDING DATE: (L35)
12/31

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	51			
(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 :
Kathy Hahn, HFE NF II 01/11/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 01/25/2018 (L20)

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

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

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3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
01/01/1992
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
December 29, 2017

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: State Nursing Home Licensing Orders - Project Number S5593028

Dear Ms. Hagstrand:

The above facility was surveyed November 28 through December 4, 2017, for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should contact Kathryn Serie, Unit Supervisor at (507) 476-4233 or at kathryn.serie@state.mn.us.

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

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted on 11/28/17, 11/29/17, 11/30/17, 12/1/17 through 12/4/17, during a recertification survey. Good samaritan Society St. James was in compliance with the regulations.	E 000		
F 000	INITIAL COMMENTS On 11/28/17,11/29/17, 11/30/17, 12/1/17 and 12/4/17, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable	F 656		1/5/18

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

Electronically Signed | 01/08/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 656	Continued From page 1 objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to develop and implement interventions on the person centered care plan for	F 656	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 656	Continued From page 2 2 of 5 residents (R11, R36) reviewed for unnecessary medication and for 1 of 1 resident (R92) reviewed for hearing impairment. Findings include: R11's diagnoses information obtained in the medical record included: Major depressive disorder, dementia with lewy body disease, Parkinson's and generalized anxiety disorder. R11 was admitted on 10/18/16. During observation on 11/28/17, at 7:00 p.m. R11 appeared calm and pleasant, seated by her room door waiting for staff to assist her into bed. When interviewed at this time, R11 indicated feeling tired and wanted to get into bed. During morning cares on 11/29/17, at 9:00 a.m. R11 appeared pleasant but slightly restless/fidgety, asking staff repetitive questions even when redirected. When interviewed at this time, R11 indicated she thought staff assisting with cares had been talking about her and that she felt bad. Interview on 11/30/17, at 9:00 a.m. with nursing assistant (NA)-A, indicated R11 will become paranoid and restless at times, but is usually pleasant and cooperative. Review of the significant change Minimum Data Set (MDS) assessment dated 8/30/17, R11 was identified as having a Brief Interview of Mental Status (BIMS) score of "4" (meaning cognition is severely impaired). The MDS indicated R11 exhibited moods of having trouble falling asleep or sleeping too much 12-14 days during the assessment period. The MDS further indicated	F 656	the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provision of federal and state law. For the purpose of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operation Manual. R 11□s plan of care was updated on 12-6 -17 to include the use of Ativan. Target behaviors were identified and put in the plan of care, as well as monitoring for specific side effects/adverse reactions. All residents receiving antianxiety meds were identified and their plans of care were reviewed. Plans of care have been updated as necessary for those identified. The Case Managers and Social Services Director will continue to review care plans in the monthly med review meeting as well as with any newly prescribed antianxiety medication. The Director of Nursing or Designee will complete bi-monthly care plan audits for three months to ensure compliance. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review. R 92□s hearing aid was reordered and payment offered on 12-1-17. The plan of care was updated to include HOH in both ears and use of devices in both ears. Other residents using hearing devices were identified, and plans of care	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 656	Continued From page 3 R11 exhibited behaviors of delusions. Review of R11's current physicians orders included: Ativan 0.5 milligrams (mg) four times daily (QID) and 0.5 mg tablet (1) as needed (PRN) during the night (for generalized anxiety disorder). Review of the medication administration record (MAR) indicated R11 had not received PRN Ativan since 10/27/17 (34 days prior). The resident was admitted with these orders on 10/18/16. Review of R11's current plan of care did not include the use of Ativan nor did it include any monitoring of target behaviors or side effects/adverse reactions related to the Ativan use. Interview on 11/30/17, at 3:00 p.m. with the director of nursing (DON), confirmed the plan of care for R11 did not include the use of Ativan nor did it include specific target behaviors or side effect monitoring for the use of the Ativan. During observation and interview on 11/29/17, at 3:09 p.m. R92 and family member (FM)-B indicated R92 had been missing his right hearing aide since July 2017. FM-B further indicated she visits daily and explained that R92 had his hearing aid one evening and the following morning it was missing. FM-B stated she reported the missing hearing aide but staff were unable to locate the hearing device. FM-B stated she was in the process of purchasing another hearing aid, but was unsure whether she would have to pay for the replacement. FM-B revealed the facility staff had not offered to assist with replacement of the right hearing aide. It was noted at this time that R92 had a hearing aid in the left ear but none	F 656	reviewed and updated as appropriate. The Social Services Director reviewed missing items to identify any other concerns. The Social Services Director will review the missing items log daily and immediately follow up with residents and family regarding missing item concerns. To ensure compliance, missing items logs and related suggestion/concern form audits will be completed weekly for three months by the Director of Nursing or designee. Audit results will be monitored by the Director of Nursing and forwarded to the Quality Committee for review. R36□s Diagnosis and indication for the use of Paxil was reviewed. The plan of care was reviewed and updated to identify specific target behaviors and interventions related to sexual comments. Diagnosis and indication for the use of Paxil was reviewed. All residents on antidepressants were identified and plans of care were reviewed and updated as appropriate. The Case Managers and Social Services Director will continue to review care plans in the monthly med review meeting as well as with any new antidepressant medication. The Director of Nursing or Designee will complete bi-monthly care plans audits for three months to ensure compliance. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/04/2017

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in the right. When interviewed at this time, R92 stated he was having a difficult time hearing normal conversation due to the missing hearing aide in the right ear. FM-B responded it was more difficult to communicate with R92 since the right hearing aide was missing.

Review of the Nursing Admission Data Collection form dated 6/20/17, identifies R92 as having left and right hearing aids to aid in the ability to hear.

Review of the admission MDS dated 6/27/17, identifies R92 as utilizing hearing aids for hearing. The resident has a BIMS score of "9" (meaning moderately impaired cognition) and the resident is usually understood and understands.

Review of R92's current plan of care identifies the resident as having a communication problem related to hard of hearing (HOH) and needs a hearing aide. Interventions listed; monitor effectiveness of communication strategies and assistive devices, ensure left hearing aid is in place and keep in medication cart at bedtime. Although R92 was identified upon admission as having hearing impairment in the right ear and utilizing a hearing aid, this was not included in the plan of care.

Interview on 11/30/17, at 7:52 a.m. licensed practical nurse (LPN)-A confirmed R92 was HOH in the right and left ears and had hearing aids for both ears.

Interview on 11/30/17, at 8:07 a.m. the DON confirmed R92 was HOH in the left and right ears and utilized hearing aids in both ears to assist with hearing and communication. The DON verified R92's HOH and use of an assistive

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device should have been in the plan of care.

R36, admitted on 10/26/17, with diagnoses including depressive episodes and unspecified dementia with behavioral disturbance. When admitted the physician ordered Paxil 10 milligrams daily. The physician progress note dated 11/16/17, indicated: [R36] is on Paxil which is a good antidepressant but in the elderly that of forgetfulness and may make symptoms worse, recommend tapering off the Paxil. Subsequently, the physician ordered the Paxil 10 mg daily dose be decreased for a week with discontinuation of the medication. The medication administration record (MAR) identified that Paroxetine HCl (Paxil) 10 mg tablet was administered daily related to other "specified depressive episodes".

A fax dated 11/21/17, from facility staff was communicated to the physician, which documented the following: having some inappropriate comments and unable to sleep since Paxil was discontinued? Can we restart at 10 mg daily? Also memory is no better and worse since meds were changed. The physician response included: restart Paxil 10 mg per oral at HS (bedtime) x 1 month; Dx dementia; dated 11/22/17.

The plan of care indicated R36 had impaired cognitive function with a BIMS score of 8/15, as identified on the MDS dated 11/1/17. The depression score identified on the PHQ-9 dated 11/1/17, was 1/27. The identified intervention dated 11/14/17, related to the depression diagnosis included: attempt non-pharmacological interventions, allow to vent feelings. The care plan lacked any interventions related to the behaviors noted related to inappropriate sexual

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comments to staff during cares.

During review of mood/behavior documentation since admission on 10/26/17, nursing documentation identified that R36 made inappropriate sexual comments to female staff on 11/19, 11/20 (twice), 11/22 (twice), 11/24 and 11/29/17.

When interviewed on 11/30/17, at 8:00 a.m. clinical manager (CM)-B explained that Paxil was restarted due to an increase in sexual comments made by R36 to female staff.

When interviewed on 12/1/17, at 10:06 a.m. NA-B indicated that R36 usually made inappropriate comments in the evening but it can be anytime during the day. NA-B also stated that R36 makes comments that one does not want to hear and some staff are scared of R36 and worry about providing care due to the sexual comments.

During interview with a male NA-D on 12/01/17, at 10:13 a.m. it was stated that R36 talks inappropriate with the female staff and when he attempts to take care of him, R36 becomes upset if the "girls" don't provide care.

When interviewed on 12/01/17, at 10:46 a.m. the licensed social worker (LSW) and the administrator were unable to verify whether the rationale for the administration of the Paxil was for depressive episodes and/or sexually inappropriate comments. The LSW acknowledged she was aware of the sexually inappropriate behaviors exhibited by R36 and indicated she had talked with staff to verbally instruct them how to respond (provide cares with

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F 656	Continued From page 7 2 staff) but confirmed she not identified specific interventions on the plan of care. The LSW verified she had just made a revision to the care plan today 12/1/17, which included the following: Resident displays/has displayed inappropriate sexual advances toward staff R/T [related to] cognitive impairment E/B [evidenced by] sexual comments-initiated 12/1/17 -Interventions were: Contact health care provider to report new behavior and seek input (dated initiated 12/1/17) SEXUALLY INAPPROPRIATE- attempt non-pharmacological interventions. When questioned further related to how staff know what interventions to implement, a response was not communicated.	F 656		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure services were coordinated with the hospice agency for 2 of 2 residents (R18, R41) reviewed who received hospice services. Findings include: The significant change Minimum Data Set (MDS) assessment dated 9/28/17, indicated R18 was	F 684	Verbal education was given to the Hospice Nurse on 12-1-18 regarding the necessity of communicating with facility nursing staff following visits. Case Managers received reeducation regarding monitoring of the Hospice calendar to ensure visits have occurred as scheduled, and to contact the Hospice agency if a visit has not occurred.	1/2/18

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F 684	Continued From page 8 totally dependent on staff for bed mobility and locomotion on/off the unit, and required extensive staff assistance with transfer, dressing, eating, personal hygiene, and toilet use. R18's Compassionate Care Hospice care plan dated 10/25/17, indicated the registered nurse (RN) would visit 1-2 times a week and PRN (as needed), and the hospice aide was to visit 5 times a week. Review of the hospice calendar dated November 2017, indicated the RN had visited with R18 on 11/10/17 and 11/15/17. The calendar did not reflect the RN schedule for the remainder of the month. When interviewed on 11/30/17, at 7:42 a.m. hospice aide (HA)-A stated she came to the facility 5 days a week to provide cares for R18. HA-A stated she typically arrived in the morning help get R18 up for the day and provide morning cares. HA-A added she still called the facility each day to inform them of her arrival time. HA-A submitted R18's hospice folder located behind the nurses desk that included the resident's care plan, hospice visit log, and monthly calendar indicating the schedule for the hospice aide and hospice RN. HA-A stated the RN comes 1-2 times/week depending upon the resident's condition. HA-A confirmed the November monthly calendar did not include the RN schedule for the last 2 weeks of the month. HA-A shared the RN that had been working with R18 was no longer employed by Compassionate Care Hospice and the agency was attempting to fill the position. HA-A further added the agency did have part-time RN's that would be providing the visits to R18 until another staff was hired.	F 684	Licensed nursing staff received written instruction regarding assessing and documenting the physical status of those on Hospice and immediately reporting changes in condition to Hospice. Follow up education will be completed at the January Nurse meeting, and include facility contracted Hospice agencies. The Director of Nursing or designee will complete Hospice visit audits weekly for three months to ensure compliance. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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When interviewed on 11/30/17, at 1:39 p.m. nursing assistant (NA)-B stated the hospice aide checks in with staff upon arrival and also would call the facility around 4:30 a.m. to verify time of arrival. NA-B further stated the hospice RN checks in with the charge nurse before and the resident visit.

When interviewed on 12/1/17, at 10:23 a.m. trained medication aide (TMA)-A stated the hospice nurse would check in with staff upon arrival and prior to leaving to communicate with staff any changes and whether they be returning again that week for another visit. TMA-A thought the case manager was notified of the RN's schedule but was unsure.

When interviewed on 12/1/17, at 10:27 a.m. RN case manager (CM)-B shared being newly hired and still in training. CM-B stated she was not notified when the hospice RN would be arriving to visit R18 but was unsure whether another staff had been informed. CM-B stated she wasn't sure but thought that Compassionate Care Hospice had a form to communicate with staff the scheduled RN visit.

When interviewed on 12/1/17, at 10:35 a.m. CM-A stated the hospice nurse checks with the charge nurse after a visit to inform them of the return visit date. CM-A added there was also a monthly calendar located in R18's hospice folder indicating the hospice RN's schedule and sometimes the hospice nurse would also add the next scheduled visit into the progress note. CM-A stated she thought the hospice nurse was at the facility last week to visit R18, adding the hospice RN was a "new nurse". CM-A added she thought

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the hospice RN would make weekly visits but now with the change in nurse staffing, she was unsure the frequency of the schedule. CM-A confirmed R18's previous hospice nurse always informed them of return date but the new hospice nurse didn't check with staff prior to leaving the facility. CM-A checked R18's hospice calendar schedule and confirmed it did not reflect the last time the hospice RN had visited nor the scheduled return date. CM-A also reviewed the hospice charting in R18's medical record which reflected the most recent skilled nursing visit was dated 11/22/17; however, documentation did not indicate the scheduled return date. CM-A confirmed it had been more than a week since the most recent visit by the hospice RN and no date of return. CM-A indicated she would contact the hospice nurse to confirm the anticipated schedule.

On 12/01/17, at 11:00 a.m. CM-A informed surveyor that a return call from R18's hospice nurse was received and the visit was scheduled for Tuesday (11/28/17) but R18 was busy at a musical program located in the dining room at the time she arrived. The hospice RN explained she didn't want to disrupt R18 from the program so informed CM-A via the return call she would return Friday (12/1/17). The hospice RN explained to CM-A that since no staff was around to inform of the next scheduled visit, she just left the facility.

When interviewed on 12/1/17, at 12:39 p.m. the director of nursing (DON) stated she would expect the hospice nurse to at least inform the facility staff a week in advance of scheduled visits and inform staff if that changed. The DON further stated facility staff should recognize when hospice staff have not been at the facility as

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scheduled to follow up. DON confirmed she expected hospice staff to communicate with staff and/or document that last Tuesday (11/28/17) she arrived, had not assessed and would return on Friday 12/1/17 to visit R18.

When interviewed on 12/1/17, at 1:11 p.m. hospice RN (RN)-B confirmed she had evaluated R18 for the first time on 11/22/17, arrived at the facility on Tuesday (11/28/17), located R18 though had not conducted an assessment since R18 was involved in a music activity. RN-B confirmed she had not communicated with facility staff that R18 had not been assessed as it was a "busy day"; adding no staff were around to notify of them of the plan to return on Friday with updated calendars. RN-B further confirmed she failed to document she had attempted a visit on 11/28/17, and did not leave a communication note regarding her planned return visit.

The facility policy and procedure titled, Hospice Services Provided in a Skilled Nursing Facility, last revised 3/2017 included: A coordinated comprehensive plan of care shall be jointly developed by the rehab/skilled care location and hospice representative is required.

Electronic medical record (EMR) review identified R41 was admitted on 8/10/17, with a diagnosis of cancer of the brain. Subsequent admission to hospice was dated 8/22/17, and remained until the time of death (9/22/17).

A note dated 9/23/17, in the EMR by the hospice nurse identified that at 11:42 a.m., the hospice nurse (HN)-B received a call from R41's sister asking whether hospice had come to see the resident yet. She stated another nurse was going

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to make a visit later today and asked if he was doing ok. R41's sister replied to her "No, he can't breathe." HN-B went to the facility to see R41. Upon entering his room, his respirations were 44 per minute (normal = 16 to 20), they were rapid, short, and labored. HN-B placed a call to [the physician] to obtain an order to schedule Morphine [controls pain and shortness of breath during the dying process]. A physician order was received for scheduled Morphine and as needed (PRN).. HN-B administered the first dose at that time. R41's respirations decreased to 35 per minute and the nursing staff was instructed to give morphine if R41's respirations exceeded 24 breaths/minute and/or if they were labored. The facility nurse verbalized understanding. R41 was able to open his eyes but was not able to communicate his needs; not restless or anxious.

Documentation was lacking to indicate that facility nursing staff had contacted and/or communicated with the hospice nurse to report abnormal vital signs and impending death. During the period R41 received the hospice benefit, limited communication was documented between facility staff and the hospice nurse related to R41's care; documentation revealed only 5 nursing notes entered between 8/22/17 and 9/24/17, related to health status and/or care plan. .

Interview on 12/1/17, at 9:14 a.m. with hospice nurse (HN)-B indicated R41's family member (FM) had contacted her on 9/24/17, regarding R41's shortness of breath (SOB). The family member told HN-B that contact with the director of nursing (DON) about symptom control that morning had been communicated. HN-B explained the Morphine dose was due to be administered, but staff had not yet administered

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at the time of arrival and no notification of the SOB symptoms had been communicated. HN-B stated she understood from the family they were in charge of contacting her about R41's condition. HN-B explained a verbal report from the facility nurse only occurred while she was onsite, no documentation related to status was entered in the EMR on days she was not onsite for her to review. HN-B confirmed the EMR lacked documentation related to resident health status prior to death and it was difficult to determine whether nursing assessments had been performed. HN-B further indicated communication was not good between the staff and hospice. HN-B stated that PRN doses of medication were not always administered when needed as staff assume the symptoms were part of the dying process and not to provide symptom relief during the process.

Review of the R41's nursing progress notes identified that no PRN Morphine, (initiated 8/22/17 to be given orally or under the tongue every 2 hours as needed for pain or SOB) had been administered prior to the hospice nurse arriving at the facility on 9/23/17. Documentation was lacking that a nursing assessment of R41's condition had been performed even though routine medications had been administered prior to the hospice nurse arrival.

Review of R41's facility care plan, identified facility staff were to monitor, document, and report to health care providers any changes. Review of R41's 8/22/17, hospice care plan indicated nursing staff were to monitor for client's respiratory status. Staff were instructed on administration, schedule, route and side effects of medication for respiratory status, including the

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use of Morphine. Medication ordered on 8/22/17, as part of the plan of care was Morphine, 0.25 milliliters (ml)/5 milligrams (mg) PRN oral or sublingual (under the tongue) every 2 hours PRN for pain or SOB.

Review of the R41's nursing progress notes identified that no PRN Morphine, (initiated 8/22/17 to be given orally or under the tongue every 2 hours as needed for pain or SOB) had been administered prior to the hospice nurse arriving at the facility on 9/23/17. Documentation was lacking that a nursing assessment of R41's condition had been performed even though routine medications had been administered prior to the hospice nurse arrival.

Interview and record review on 12/1/17, at 12:53 p.m. with the administrator (A) related to R 41 and the events leading up to his death indicated she agreed documentation was lacking related to cares provided. The administrator verified it was staff responsibility to contact hospice not FM and agreed there was a lack of communication between nursing staff and hospice staff. The administrator commented that additional education with nursing staff was required to ensure documentation reflected cares provided and timely communication with the hospice staff.

When interviewed on 12/1/17, at 1:30 p.m. the DON indicated she met the R41's FM in the parking lot that day and was aware of their concerns and was aware they were going to contact the hospice nurse. The DON agreed staff should have contacted hospice to report a change in condition, not the family. The DON concurred documentation was lacking in the record to support that staff contacted and/or

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F 684	Continued From page 15 communicated with hospice staff while R41 received the hospice benefit. Review of the facility's 11/2016 Care Plan policy indicated resident's will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented.	F 684		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide assistance to ensure hearing aids were available to maintain hearing/communication needs for 1 of 1 resident	F 685	R 92□s hearing aid was reordered and payment offered on 12-1-17. The plan of care was updated to include HOH and use of devices in both ears. The Social	1/2/18

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F 685	Continued From page 16 (R92) reviewed for hearing. Finding include: During observation and interview on 11/29/17, at 3:09 p.m. R92 and family member (FM)-B indicated R92 had been missing his right hearing aid since July 2017. FM-B further indicated she visits daily and explained that R92 had his hearing aid one evening and the following morning it was missing. FM-B stated she reported the missing hearing aid but staff were unable to locate the hearing device. FM-B stated she was in the process of purchasing another hearing aid, but was unsure whether she would have to pay for the replacement. FM-B revealed the facility staff had not offered to assist with replacement of the right hearing aid. It was noted at this time that R92 had a hearing aid in the left ear but none in the right. When interviewed at this time, R92 stated he was having a difficult time hearing normal conversation due to the missing hearing aid in the right ear. FM-B responded it was more difficult to communicate with R92 since the right hearing aid was missing. Review of the admission Minimum Data Set (MDS) assessment dated 6/27/17, identifies R92 as utilizing hearing aids for hearing. The resident has a Brief Interview of Mental Status (BIMS) score of "9" (meaning moderately impaired cognition) and the resident is usually understood and understands. Review of the Nursing Admission Data Collection form dated 6/20/17, identifies R92 as having left and right hearing aids to aide in the ability to hear. Review of R92's current plan of care identifies the	F 685	Services Director reviewed missing items to identify any other concerns. The Social Services Director will review the missing items log daily and immediately follow up with residents and family regarding missing item concerns. To ensure compliance, missing items logs and related suggestion/concern form audits will be completed weekly for three months by the Director of Nursing or designee. Audit results will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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F 685	Continued From page 17	F 685		

resident as having a communication problem related to hard of hearing (HOH) and needs a hearing aid. Interventions listed: monitor effectiveness of communication strategies and assistive devices, ensure left hearing aid is in place and keep in medication cart at bedtime. Although R92 was identified upon admission as having hearing impairment in the right ear and utilizing a hearing aid, this was not included in the plan of care.

Review of the nursing notes from admission on 6/20/17 to 12/4/17, indicated the staff stored R92's right and left hearing aids in the medication cart each evening. The nurses note dated 7/7/17, indicated only the left hearing aid was stored in the medication cart on that date. There was no further documentation related to the right hearing aid.

R92's treatment record since admission on 6/27/17 to 12/4/17 was reviewed. The signed treatment record for July and August indicated R92's right and left hearing aids had been stored in the medication cart each night. Review of the signed treatment record for September, October and November, indicated only the left hearing aid had been stored in the medication cart. There was no documentation addressing why the right hearing aid was no longer being stored on the medication cart for the past 3 months.

When interviewed on 11/29/17, at 3:14 p.m. clinical manager (CM)-A indicated shortly after admission, R92's right hearing aid was missing. CM-A confirmed R92 has not utilized the right hearing aid since that time, and consequently, has had a difficult time hearing without a assistive device.

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F 685	Continued From page 18 When interviewed on 11/30/17, at 7:52 a.m. licensed practical nurse (LPN)-A, indicated she was aware of R92's missing right hearing aid and confirmed it had been missing for several months. LPN-A confirmed R92 was HOH and had difficulty hearing normal conversation without his right hearing aid. Interview on 11/30/17, at 8:07 a.m. the director of nursing (DON) confirmed R92 had not utilized his right hearing aid since it had been identified missing shortly (7/7/17) after admission. The DON verified R92 is HOH without the use of his hearing aids of which affected his communication needs. The DON also indicated the staff should have investigated the missing hearing aid and provided assistance with a replacement upon learning the hearing device was missing.	F 685		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to properly assess/reassess the continued need for a Wanderguard device after hospitalization to ensure adequate supervision for 1 of 1 resident (R20) reviewed who was identified with	F 689	R 20 was reassessed for elopement risk. An order for a wanderguard device was obtained on 12-19-17. The plan of care for elopement risk was reviewed and updated. Residents with wanderguards were identified and reassessed for	1/8/18

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F 689	Continued From page 19 wandering behavior prior to hospitalization. Findings include: R20 had been readmitted to the facility on 11/9/17, after a brief discharge to a psychiatric facility for behaviors associated with her dementia. Diagnoses included Alzheimer's, dementia with behavioral disturbances and restlessness and agitation. When interviewed on 11/28/17, at 2:12 p.m. licensed practical nurse (LPN)-A indicated R20 had recently returned from a psychiatric hospital after approximately 2 weeks. LPN-A stated that R20's behaviors had improved and was cooperative with cares. LPN-A explained that prior to hospitalization, R20 had experienced hallucinations, new meds had been started and some medications discontinued. LPN-A indicated that prior to hospitalization, R20 remained in her room to eat and since medication adjustments, had been participating with eating meals in the dining room and visiting with other residents. Observations were noted as follows: (1) On 11/28/17, at 4:01 p.m. R20 was wearing a Wanderguard on her right wrist, was pleasant in conversation and moved independently about the room with the use of her walker. (2) On 11/29/17, at 2:30 p.m., R20 seated in a wheelchair enjoying coffee and a snack in the dining room with other residents; no behaviors and a Wanderguard was noted on the right wrist. (3) On 11/30/17, at 8:15 a.m. R20 was seated in a recliner located in her room, walker in front of her and Wanderguard on her right wrist. No behaviors noted. (4) Later at 11/30/17, at 12:36 p.m. R20 was	F 689	elopement risk. Verbal education was given to the Case Managers regarding reviewing and clarifying Physicians orders. Verbal education was also given to the Case Managers regarding assessing residents for elopement risk upon admission. This assessment will include prior risk, the admission UDA, and monitoring each shift for wandering, elopement risks and elopement attempts. Elopement risk assessment audits will be done the Director of Nursing or Designee with each admission and readmission for three months. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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F 689	Continued From page 20	F 689		

seated in a dining chair in the dining room with her walker beside her; Wanderguard was attached to the walker and not on her wrist.

When interviewed on 11/30/17, at 12:40 p.m. trained medication aide (TMA)-B explained that any resident with a Wanderguard, required a physician order with documentation on the treatment administration record (TAR). Upon review of R20's TAR, TMA-B was unable to locate documentation to indicate the battery had been checked to ensure it was working properly. TMA-B indicated the night staff may have checked it's functioning and then proceeded to check the device which had been placed on the R20's walker. It was noted the battery was functional. However, TMA-B was unclear the reason the device had been removed from R20's wrist and placed on the walker.

Review of the Minimum Data Set (MDS) assessment dated 10/5/17, prior to R20's psychiatric stay, indicated she wandered 1 to 3 days during the lookback period of 7 days at that time. The MDS dated after her return on 11/16/17, indicated she had made no attempts to wander.

When interviewed on 11/30/17, at 1:30 p.m. the director of nursing (DON) confirmed no assessment related to elopement or wandering was available for review. She explained the social worker was responsible for adding any information to the MDS assessment related to elopement or wandering.

Review of the medical record for R20 indicated an elopement from the facility occurred on 10/17/17. There were no witnesses to the

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incident, but staff summarized the "Resident was confused- thought there was a fire due to alarm sounding. The resident had more recent confusion. Staff took [R20] out for a walk outside to calm her. Dr. reviewing her medications. Currently has WanderGuard, reviewed meds." The report made no mention of the care plan being amended and/or revised.

When interviewed on 12/1/17, at 10:18 a.m. RN case manager (CM)-B indicated she was aware R20 had a Wanderguard placed since she has been employed with the facility (June 2017) and the registered nurse/health information manager (RN/HIM)-C inputs into the computer all the physician orders after a readmission which is reviewed with another case manager (CM-A). CM-B stated when a resident is immobile, meaning confined to a wheelchair, a Wanderguard device is placed on the device and not the resident. CM-B clarified that since R20 was mobile with the use of the walker, the device should be placed on the wrist and not the walker. Upon reviewing the care plan, CM-B agreed it lacked any mention of wandering behaviors nor did it address the use of a Wanderguard device. CM-B stated she was unaware of an assessment related to wandering and/or elopement risk as it was the social worker's responsibility to assess wandering. She further stated only medication orders were double checked for accuracy upon return from hospitalization and not anything else (device).

Document review for R20 revealed there was no physician order for the use of a wander guard and no assessment related to elopement risk nor wandering. The MDS assessment notes were unclear whether R20 wandered throughout the

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F 689	Continued From page 22 facility, into other resident's rooms and/or whether attempts to leave the facility with exit-seeking behavior. Interview on 12/1/17, at 11:48 a.m. and again at 12:39 p.m. with the administrator confirmed it was the expectation that R20 should have been periodically assessed for placement of a Wanderguard to re-evaluate the necessity of the device, elopement risk and supervision needs. The administrator also agreed a physician order for the device was necessary and when previous orders were followed post hospitalization, accuracy should be verified prior to input into the EMR. The administrator confirmed that staff also needed to monitor the device to ensure it was working correctly. The facility had no WanderGuard or Elopement policy. Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented.	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered	F 695		1/3/18

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F 695	Continued From page 23 care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to properly rinse a nebulizer medication receptacle after use for 1 of 2 residents (R12) reviewed who used a nebulizer during medication administration. Findings include: Review of R12's signed physician orders dated 11/16/17, included an order for Albuterol sulfate nebulization solution (2.5 milligrams/3 milliliters) 0.083%, 1 dose inhale orally via nebulizer three times a day for wheezing related to chronic obstructive pulmonary disease. The physician orders further indicated R12 may self-administer nebulizer after staff set-up. Review of the electronic medication administration record (eMAR) dated November 2017, indicated R12 received the scheduled Albuterol sulfate at 10:00 a.m., 4:00 p.m., and 8:00 p.m. On 11/28/17, at 7:29 p.m. registered nurse (RN)-A was observed setting up and administering medications to R12 which included Albuterol sulfate nebulizer solution. Upon entering R12's room the nebulizer mask and medication receptacle remained attached and connected to the tubing attached to the nebulizer machine. The medication receptacle had visible moisture on all sides and a small amount of liquid visible in the bottom. RN-A poured the prescribed medication into the nebulizer medication receptacle and assisted with placing the mask on	F 695	The nurse involved was reeducated regarding cleaning the nebulizer medication receptacle. Other residents receiving nebulizer treatments were monitored to ensure proper practice. The policy and procedure for this practice was communicated to all licensed nursing staff and Medication Aides. Follow-up training will be completed at the January Nurse meeting. Nebulizer cleaning audits will continue to be completed by the Director of Nursing or designee weekly for one month then biweekly for two months. Audit results will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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F 695	Continued From page 24 R12's face. RN-A then switched the machine on, advised R12 to keep the mask on for 15 minutes, then exited the room. When interviewed immediately following the observation, RN-A confirmed there had still been moisture/liquid in R12's nebulizer receptacle prior to administering the current dose of medication. RN-A stated it was probably left over from the 4:00 p.m. nebulizer treatment and confirmed being the nurse who administered that treatment. RN-A stated she would clean and disinfect the nebulizer mask and medication receptacle at the end of the shift after the 8:00 p.m. nebulizer treatment had been administered. RN-A confirmed she did not rinse out the medication receptacle between the 4:00 p.m. and 8:00 p.m. treatments since it was the same medication. RN-A questioned the surveyor whether it should be rinsed. RN-A also shared R12 would sometimes take the nebulizer mask off before all the medication had been administered. When interviewed on 12/1/17, at approximately 12:35 p.m. the director of nursing (DON) confirmed R12's nebulizer medication receptacle and mask should be rinsed with hot water and placed on a clean paper towel to dry after each use, then cleaned and disinfected at the end of each day. Review of the procedure titled Nebulizer, revised 9/15 included: Following medication administration, rinse equipment with hot water and place on paper towel to dry. Then, wash hands.	F 695		
F 745 SS=D	Provision of Medically Related Social Service CFR(s): 483.40(d)	F 745		1/2/18

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F 745	Continued From page 25 §483.40(d) The facility must provide medically-related social services to attain or maintain the highest practicable 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 assistance and/or arrangements to obtain a replacement hearing device after it was reported missing for 1 of 2 residents (R92) reviewed who had missing property. Findings include: During observation and interview on 11/29/17, at 3:09 p.m. R92 and family member (FM)-B indicated R92 had been missing his right hearing aid since July 2017. FM-B further indicated she visits daily and explained that R92 had his hearing aid one evening and the following morning it was missing. FM-B stated she reported the missing hearing aid but staff were unable to locate the hearing device. FM-B stated she was in the process of purchasing another hearing aid, but was unsure whether she would have to pay for the replacement. FM-B revealed the facility staff had not offered to assist with replacement of the right hearing aid. It was noted at this time that R92 had a hearing aid in the left ear but none in the right. When interviewed at this time, R92 stated he was having a difficult time hearing normal conversation due to the missing hearing aid in the right ear. FM-B responded it was more difficult to communicate with R92 since the right hearing aid was missing. Review of the admission Minimum Data Set (MDS) assessment dated 6/27/17, identifies R92 as utilizing hearing aids for hearing. The resident has a Brief Interview of	F 745	R 92□s hearing aid was reordered and payment offered on 12-1-17. The plan of care was reviewed and updated to include the use of the devices. The Social Services Director reviewed missing items to identify any other concerns. The Social Services Director will review the missing items log daily and immediately follow up with residents and family regarding missing item concerns. To ensure compliance, missing items logs and related suggestion/concern form audits will be completed weekly for three months by the Director of Nursing or designee. Audit results will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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F 745	Continued From page 26	F 745		

Mental Status (BIMS) score of "9" (meaning moderately impaired cognition) and the resident is usually understood and understands.

Review of the Nursing Admission Data Collection form dated 6/20/17, identifies R92 as having left and right hearing aids to aide in the ability to hear.

Review of R92's current plan of care identifies the resident as having a communication problem related to hard of hearing (HOH) and needs a hearing aid. Interventions listed: monitor effectiveness of communication strategies and assistive devices, ensure left hearing aid is in place and keep in medication cart at bedtime. Although R92 was identified upon admission as having hearing impairment in the right ear and utilizing a hearing aid, this was not included in the plan of care.

Review of the facility lost and found document dated 9/16/17, indicated R92 was missing his right hearing aid which had been reported to the facility licensed social worker (LSW).

Review of the nursing notes from admission on 6/20/17 to 12/4/17, indicated the staff stored R92's right and left hearing aids in the medication cart each evening. The nurses note dated 7/7/17, indicated only the left hearing aid was stored in the medication cart on that date. There was no further documentation related to the right hearing aid.

R92's treatment record since admission on 6/27/17 to 12/4/17 was reviewed. The signed treatment record for July and August indicated R92's right and left hearing aids had been stored in the medication cart each night. Review of the

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F 745	Continued From page 27	F 745		

signed treatment record for September, October and November, indicated only the left hearing aid had been stored in the medication cart. There was no documentation addressing why the right hearing aid was no longer being stored on the medication cart for the past 3 months.

When interviewed on 11/29/17, at 3:14 p.m. clinical manager (CM)-A indicated shortly after admission, R92's right hearing aid was missing. CM-A confirmed R92 has not utilized the right hearing aid since that time, and consequently, has had a difficult time hearing without an assistive device.

During interview with the LSW on 11/29/17, at 3:20 p.m. indicated she was not aware of R92's missing right hearing aid and was unable to find a missing personal item report. The LSW confirmed R92's right hearing was documented as missing in the lost and found record on 9/19/17, but failed to investigate the whereabouts of the missing right hearing aid.

When interviewed on 11/30/17, at 7:52 a.m. licensed practical nurse (LPN)-A, indicated she was aware of R92's missing right hearing aid and confirmed it had been missing for several months. LPN-A further indicated she thought the LSW had followed through and had discussed the missing item with the resident/family. LPN-A confirmed R92 was HOH and had difficulty hearing normal conversation without his right hearing aid.

Interview on 11/30/17, at 8:07 a.m. the director of nursing (DON) and the administrator confirmed staff initially was aware of R92's missing right hearing aid on 7/7/17, when it was first

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F 745	Continued From page 28 documented and the LSW should have followed through with resolving the missing item as the facility policy directs. Review of the facility policy and procedure for Missing Items dated 4/16, included reporting missing items to the supervisor immediately, start a search for the item, if the item is not found and is of nominal value, complete a suggestion/concern form and social services (SS) will report to the resident/family or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months.	F 745		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section.	F 757		1/5/18

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F 757	Continued From page 29 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify adequate indications for the use of Gabapentin (anti-seizure medication) to ensure adequate monitoring for it's effectiveness for 1 of 5 resident (R20) reviewed for unnecessary medications. Findings include: R20 had been readmitted to the facility on 11/9/17, after a brief discharge to a psychiatric facility for behaviors associated with her dementia. Diagnoses included Alzheimer's and dementia with behavioral disturbances and restlessness and agitation. When interviewed on 11/28/17, at 2:12 p.m. licensed practical nurse (LPN)-A indicated R20 had recently returned from a psychiatric hospital after approximately 2 weeks. LPN-A stated that R20's behaviors had improved and was cooperative with cares. LPN-A explained that prior to hospitalization, R20 had experienced hallucinations, new meds had been started and some medications discontinued. LPN-A indicated that prior to hospitalization, R20 remained in her room to eat and since medication adjustments, had been participating with eating meals in the dining room and visiting with other residents. Observations were noted as follows: (1) On 11/28/17, at 4:01 p.m. R20 was wearing a Wanderguard on her right wrist, was pleasant in conversation and moved independently about the room with the use of her walker. (2) On 11/29/17, at 2:30 p.m., R20 seated in a wheelchair enjoying coffee and a snack in the	F 757	R 20□s Gabapentin order and clarification was reviewed and signed by the primary Physician on 12-13-17. The plan of care was reviewed and updated to include the use of the medication for agitation and restlessness. Target behaviors were identified and included in the plan of care. R 20 was reassessed for elopement risk. An order for a wanderguard device was obtained on 12-19-17. The plan of care elopement risk was reviewed and updated. Residents with wanderguards were identified and reassessed for elopement risk. The Case Managers were reeducated regarding reviewing and clarifying Physicians orders, as well as reviewing for proper diagnosis. Reeducation was also given to the Case Managers regarding assessing residents for elopement risk upon admission. This assessment will include prior risk, the admission UDA, and monitoring each shift for wandering, elopement risks and elopement attempts. Order verification audits as well as elopement risk assessment audits will be done by the Director of Nursing or Designee with each admission and readmission for three months. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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dining room with other residents; no behaviors and a Wanderguard was noted on the right wrist.
(3) On 11/30/17, at 8:15 a.m. R20 was seated in a recliner located in her room, walker in front of her and Wanderguard on her right wrist. No behaviors noted.
(4) Later at 11/30/17, at 12:36 p.m. R20 was seated in a dining chair in the dining room with her walker beside her; Wanderguard was attached to the walker and not on her wrist.

Review of the electronic medical record (EMR) for R20 indicated Gabapentin was initiated during the psychiatric hospital stay prior to return to the facility. The physician's orders inputted into the EMR by nursing staff were:
(1) Gabapentin 300 milligrams (MG) give 1 capsule by mouth in the evening related to restlessness and agitation.
(2) Gabapentin 100 MG, give 2 capsule by mouth two times a day related to pain, unspecified.

The original telephone physician order signed by the nurse dated 11/8/17, received from the psychiatric hospital and provided upon R20's return, indicated the reason for the administration of Gabapentin was to treat nerve pain. Documentation was lacking in the EMR that R20 had a diagnosis related to nerve pain. In addition, the telephone order had not yet been countersigned by the ordering physician.

Review of R20's mood and behavior notes indicated there was only one documented nurses' note dated 11/15/17, when R20 exited the bed and independently went to the bathroom. Documentation indicated she was assisted back to bed and stayed in bed for the remainder of the night. No other documentation was noted relative

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to mood/behavior notes in the EMR per the DON on 12/1/17, when requested.

Review of the Minimum Data Set (MDS) assessment dated 10/5/17, prior to R20's psychiatric stay, indicated she wandered 1 to 3 days during the lookback period of 7 days at that time. The MDS dated after her return on 11/16/17 indicated she had made no attempts to wander.

Interview on 11/30/17 at 1:30 p.m. with the director of nursing (DON) the facility had no assessment for elopement or wandering. The Social Worker was responsible for adding any information to the MDS assessment related to elopement or wandering.

When interviewed on 12/1/17, at 10:54 p.m. with clinical managers (CM)-B and CM-A regarding the Gabapentin order, it was learned they were unaware the Gabapentin had been identified as being administered for nerve pain. A note from the psychiatric hospital dated 10/26/17, identified the Gabapentin was administered for anxiety and agitation. CM-A agreed the conflicting information regarding the need for the Gabapentin should be clarified with the physician especially due to the fact the returning telephone order had not been countersigned. In addition, facility staff could not monitor the effectiveness of the medication when unsure the rationale for the administration of this medication. CM-A was unaware the original order received from the psychiatric facility had not been countersigned by a physician. CM-A agreed R20 never had a diagnosis related to nerve pain.

Interview on 12/1/17, at 12:39 p.m. with the administrator confirmed the expectation for staff to clarify physician orders and corresponding

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F 757	Continued From page 32 diagnosis be accurate, especially upon initiation of a new medication. Review of the facility's November 2016 Physician/Practitioner Orders policy indicated its purpose was to provide individualized care to each resident and provide staff a procedure by obtaining appropriate, accurate, and timely physician's orders. Telephone orders will be signed and dated by the physician within the time period required by state law. Nursing orders must be documented as care plan approaches, not as a physician order. When a resident returns from the hospital, physician's orders must be updated to reflect the resident's current needs. Clarification orders are needed when reviewing any type of physician order that is incomplete or raises questions. Never assign a diagnosis to an order, even if a diagnosis appears obvious. Only a physician may diagnose. Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic;	F 758		1/5/18

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F 758	Continued From page 33 (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for	F 758		

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F 758	Continued From page 34 the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to evaluate, monitor and justify the continued use of a psychoactive medications and/or failed to include parameters for as needed (PRN) antianxiety medication for 2 of 5 residents (R11, R36) reviewed for unnecessary medications. Findings include: R11's diagnoses information obtained in the medical record included: Major depressive disorder, dementia with lewy body disease, Parkinson's and generalized anxiety disorder. R11 was admitted on 10/18/16. During observation on 11/28/17, at 7:00 p.m. R11 appeared calm and pleasant, seated by her room door waiting for staff to assist her into bed. When interviewed at this time, R11 indicated feeling tired and wanted to get into bed. During morning cares on 11/29/17, at 9:00 a.m. R11 appeared pleasant but slightly restless/fidgety, asking staff repetitive questions even when redirected. When interviewed at this time, R11 indicated she thought staff assisting with cares had been talking about her and that she felt bad. Interview on 11/30/17, at 9:00 a.m. with nursing assistant (NA)-A, indicated R11 will become paranoid and restless at times, but is usually pleasant and cooperative. Review of the significant change Minimum Data	F 758	R 11□s plan of care was updated on 12-6-17 to include the use of Ativan. Target behaviors were identified and put in the plan of care, as well as monitoring for specific side effects/adverse reactions. Education was given to the resident□s family regarding the necessity of a dose reduction, and a gradual dose reduction was initiated on 12-6-17. All residents on antianxiety, antidepressant and psychotropic medications were reviewed to identify the need for any further dose reductions. The Case Managers were educated to initiate the use of a medication monitoring calendar to ensure dose reductions are completed at the proper times. The Director of Nursing or designee will audit this practice monthly following med review committee for three months, and with newly ordered medications that require gradual dose reductions. Results of the audits will be monitored monthly and forwarded to the Quality Committee for review. R36□s Diagnosis and indication for the use of Paxil was reviewed. The plan of care was reviewed and updated to identify specific target behaviors and interventions related to sexual comments. Diagnosis and indication for the use of Paxil was reviewed. Residents on antidepressants were identified and plans of care reviewed and updated as appropriate. The Case Managers and Social Services Director will to continue to review care plans in the monthly med review meeting as well as	

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F 758	Continued From page 35 Set (MDS) assessment dated 8/30/17, R11 was identified as having a Brief Interview of Mental Status (BIMS) score of "4" (meaning cognition is severely impaired). The MDS indicated R11 exhibited moods of having trouble falling asleep or sleeping too much 12-14 days during the assessment period. The MDS further indicated R11 exhibited behaviors of delusions. Review of R11's current physicians orders included: Ativan 0.5 milligrams (mg) four times daily (QID) and 0.5 mg tablet (1) as needed (PRN) during the night (for generalized anxiety disorder). Review of the medication administration record (MAR) indicated R11 had not received PRN Ativan since 10/27/17 (34 days prior). The resident was admitted with these orders on 10/18/16. Review of R11's current plan of care did not include the use of Ativan nor did it include any monitoring of target behaviors or side effects/adverse reactions related to the Ativan use. Review of the consulting pharmacist drug regimen review for R11 included the following recommendations: (1) dated 12/15/16, discontinue R11's Ativan orders and avoid prolonged daily use due to adverse reactions in the elderly. The physician responded with no changes and to reassess in 6 months; (2) dated 2/15/17, discontinue the scheduled Ativan use due to R11 falling. The physician responded with no changes due to family request; (3) dated 8/13/17, discontinue the scheduled Ativan order and address the Ativan use in R11's plan of care. The report also included a	F 758	with any new medication. The Director of Nursing or Designee will complete bi-monthly care plan audits for three months to ensure compliance. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	

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justification and duration of use was needed for the continued use of the PRN Ativan following the initial 14 days. The physician responded to continue the current Ativan order due to family request; and
(4) dated 10/20/17, document a justification for continued use of the PRN Ativan as well as the duration for use following the initial 14 days. The physician responded to continue the current Ativan order due to husband request.

Review of the physicians dictated notes dated 11/22/16, 12/12/16, 1/9/17, 3/13/17, 4/10/17, 6/20/17, 8/14/17 and 10/9/17, addressed R11's history of falls, Parkinson's, lewy body disease, depression/anxiety. The physician did not address R11's current Ativan use or the justification for the continued use.

Review of the progress notes for R11, did not included any documented mood or behaviors in the past 6 months other than exhibiting 2 episodes of being identified as "needy" and not wanting certain staff in her room.

Interview on 11/30/17, at 3:00 p.m. with the director of nursing (DON), indicated R11 does become restless and anxious often and is difficult to redirect, but confirmed the medical record lacked documentation confirming these behaviors nor the frequency they occurred. The DON also confirmed there were no behaviors identified for the use of the Ativan to establish efficacy, and a gradual dose reduction had not been attempted in the past year.

Interview on 12/01/17, at 9:11 a.m.. with licensed practical nurse (LPN)-A, indicated R11 did not exhibit any behaviors of anxiety or restlessness

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that she has observed or that the NA's have reported in the past several weeks. LPN-A could not recall the last time R11 was observed to exhibit these behaviors.

R36, admitted on 10/26/17, had diagnoses including depressive episodes and unspecified dementia with behavioral disturbance and had physician ordered Paxil 10 milligrams daily. The physician progress note dated 11/16/17, indicated: [R36] is on Paxil which is a good antidepressant but in the elderly that if forgetful and may make symptoms worse, recommend tapering off the Paxil. Subsequently, the physician ordered the Paxil 10 mg daily dose be decreased for a week with discontinuation of the medication. The medication administration record (MAR) identified that Paroxetine HCl (Paxil) 10 mg tablet was administered daily related to other "specified depressive episodes".

A fax dated 11/21/17, from facility staff was communicated to the physician, which documented the following: having some inappropriate comments and unable to sleep since Paxil was discontinued? Can we restart at 10 mg daily? Also memory is no better and worse since meds were changed. The physician response included: restart Paxil 10 mg per oral at HS (bedtime) x 1 month; diagnosis dementia; dated 11/22/17.

The plan of care indicated R36 had impaired cognitive function with a BIMS score of 8/15, as identified on the MDS dated 11/1/17. The depression score identified on the PHQ-9 dated 11/1/17, was 1/27, indicating depressive symptoms minimal. The identified intervention dated 11/14/17, related to the depression

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diagnosis included: attempt non-pharmacological interventions, allow to vent feelings.

During review of mood/behavior documentation since admission on 10/26/17, nursing documentation identified that R36 made inappropriate sexual comments to female staff on 11/19, 11/20 (twice), 11/22 (twice), 11/24 and 11/29/17.

When interviewed on 11/30/17, at 8:00 a.m. clinical manager (CM)-B explained that Paxil was restarted due to an increase in sexual comments made by R36 to female staff.

When interviewed on 12/1/17, at 10:06 a.m. NA-B indicated that R36 usually made inappropriate comments in the evening but it can be anytime during the day. NA-B also stated that R36 makes comments that one does not want to hear and some staff are scared of R36 and worry about providing care due to the sexual comments.

During interview with a male NA-D on 12/01/17, at 10:13 a.m. it was stated that R36 talks inappropriate with the female staff and when he attempts to take care of him, R36 becomes upset if the "girls" don't provide care.

When interviewed on 12/01/17, at 10:46 a.m. the licensed social worker (LSW) and the administrator were unable to verify whether the rationale for the administration of the Paxil was for depressive episodes and/or sexually inappropriate comments. When questioned how they tracked and monitored the effectiveness of the medication based on the rationale for the administration of the medication , they were

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F 758	Continued From page 39 unable to respond. When further requested documentation to identify the rationale for the Paxil, none was provided. The LSW acknowledged she was aware of the sexually inappropriate behaviors exhibited by R36 and indicated she had not identified the behaviors to monitor related to the use of the anti-depressant nor specific interventions on the plan of care.	F 758		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure follow-up laboratory monitoring was obtained related to an elevated thyroid stimulating hormone (TSH) laboratory value (a test to find out if your thyroid gland is working the way it should) for 1 of 5 residents (R21) reviewed for unnecessary medications. Findings include: R21's annual Minimum Data Set (MDS) assessment dated 10/5/17, included a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS further	F 770	R 21□s TSH was drawn on 12-12-17 with a result of 4.4. The Primary Physician ordered a repeat draw in six months. An Audit was completed to identify any other residents that may require orders for lab draws. The Case Managers will continue to monitor this with routine Physician□s rounds. The DNS or designee will audit this practice following Physicians round monthly for three months. Results of the audits will be monitored by the Director of Nursing and forwarded to the Quality Committee for review.	1/3/18

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F 770	Continued From page 40	F 770		

indicated R21 was independent with walking in room/corridor and ambulation on/off the unit and utilized a walker; diagnoses included chronic obstructive pulmonary disease (COPD).

Review of R21's laboratory results dated 1/24/17, included an elevated TSH value of 5.29 (normal reference range: 0.27-4.20). The facility fax sent to the physician dated 1/24/17, indicated laboratory results had been received and questioned if there were any new orders. The physician response dated 1/24/17 indicated: "No chg [sik] will just watch TSH". Further review of R21's medical record did not include evidence of a follow-up TSH being completed.

Review of R21's weights over the past year (12/2/16 - 11/24/17) indicated a gradual weight gain of 22 pounds (lbs) (140- 162 lbs). Common symptoms of hypothyroidism include weight gain or increased difficulty losing weight.

The physician progress note dated 2/15/17, indicated a weight gain of about 8 lbs in 2 months. The plan included to increase R21's Lasix; the elevated TSH from 1/24/17 was not addressed.

The physician progress note dated 4/19/17, indicated R21 was concerned about her weight gain because she is liking to eat. The note further indicated R21's weight had increased 6 lbs since last seen and up 8 lbs previous to that. The physician progress note did not address the elevated TSH from 1/24/17, and/or rationale for no follow up of elevated laboratory value.

Further review of the physician progress notes dated 6/7/17, 8/9/17, and 10/10/17, did not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	12/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(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 770	Continued From page 41 address R21's elevated TSH from 1/24/17. When interviewed on 12/1/17, at 12:45 p.m. the director of nursing (DON) stated she would have expected R21's elevated TSH from 1/24/17 to be followed up on by now. DON reviewed R21's medical record and confirmed the TSH had not been repeated and would contact the physician for an order.	F 770		
F 865 SS=D	QAPI Prgm/Plan, Disclosure/Good Faith Attmpt CFR(s): 483.75(a)(2)(h)(i) §483.75(a) Quality assurance and performance improvement (QAPI) program. §483.75(a)(2) Present its QAPI plan to the State Survey Agency no later than 1 year after the promulgation of this regulation; §483.75(h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section. §483.75(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee monitored compliance related to coordination of hospice services to ensure correction was achieved and sustained since the previous survey; this resulted	F 865	The Quality Coordinator was instructed to include annual survey results in the monthly Quality minutes. Survey tags and remedies will be reviewed and audited by the quality Committee on a quarterly basis. The Director of Nursing or	12/21/17

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F 865	Continued From page 42 in lack of coordination of hospice services for 2 of 4 residents (R18, R41) reviewed for hospice care services. Findings include: Interview and document review with the facility QAA coordinator on 12/1/17, at 11:42 a.m. indicated the QAA committee met on a quarterly basis. Review of the meeting dates since the last annual survey on 10/20/16, included: 11/16/17, 8/17/17, 5/18/17, 2/16/17 and 11/17/16. The committee attendees included the QAA coordinator, activity director, housekeeping director, social service director, maintenance director, director of nursing (DON), administrator, pharmacist and medical director. Current concerns identified during the survey were discussed with the QAA coordinator, including lack of coordination/communication of hospice services as well as implementation of the hospice plan of care. When questioned how the QAA committee monitored the coordination and communication between facility staff and hospice services since this was identified during the previous recertification survey, the QAA coordinator indicated she was unaware of any ongoing audits and/or corrective action plans which had been implemented over the past year. The QAA coordinator was unable to provide any information to verify that coordination of hospice services had been discussed at any of the QAA meetings and/or a corrective action plan had been implemented to achieve continued compliance. The QAA coordinator verified she had been unaware of any hospice service concerns and indicated this needs to be addressed by the QAA committee for review and subsequent corrective action.	F 865	Designee will audit the Quality minutes quarterly for compliance, and bring back to the Quality Committee for review.	

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F 865	Continued From page 43 Interview with the DON on 12/1/17, at 12:10 p.m. confirmed the deficient practice related to hospice services had not been discussed at the QAA meetings with the committee members and explained she had implemented a plan of correction for the deficient practice related to lack of hospice coordination identified at the time of the previous survey but failed to involve the QAA committee to implement a plan to sustain compliance. See F-0684 and F-0656	F 865		

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	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2017**

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K 000	INITIAL COMMENTS	K 000		

FIRE SAFETY

THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE.

UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.

A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division, on November 30, 2017. At the time of this survey, Good Samaritan Society St. James was found not to be in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care Occupancies.

PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO:

Health Care Fire Inspections
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145, or

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		01/08/2018

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

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	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/30/2017**

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. This one-story with partial basement facility was determined to be of Type V(000) construction. The original building was constructed in 1963, with additions in 1965, 1993, 1996 and 2002. The facility was fully sprinklered, and had a complete corridor smoke detection system with monitoring for automatic fire department notification. The facility has a capacity of 53 beds and had a census of 44 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 372 SS=E	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction	K 372		12/14/17

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K 372	Continued From page 2 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1.(1). This deficient practice could affect 41 of 41 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. Findings include:	K 372	Surveyor 245593 on November 30th, 2017 found an improper smoke barrier penetration. The penetration in the smoke barrier wall on the 100 wing was repaired and sealed by the Director of Maintenance using concrete and plaster. The Director of Maintenance will follow up with any contractors who perform work in the facility to verify there are no penetrations prior to them leaving the job site. Monthly inspections of the smoke barriers will be conducted and monitored by the Director of Maintenance or his designee and findings will be reviewed by the QAPI Committee. This corrective action was completed on December 14, 2017.	

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K 372	Continued From page 3 On facility tour between 10:00 AM and 2:00 PM on 11/30/2017, a vent pipe was observed penetrating the wall in the Section 1 North smoke barrier. NOTE: All smoke barriers in the Facility need to be checked to ensure there are no penetrations in the smoke barriers. These deficient practices were verified by the Facility Maintenance Director.	K 372		
K 912 SS=E	Electrical Systems - Receptacles CFR(s): NFPA 101 Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This REQUIREMENT is not met as evidenced by: Electrical Systems - Receptacles Power receptacles have at least one, separate, highly dependable grounding pole capable of maintaining low-contact resistance with its mating plug. In pediatric locations, receptacles in patient rooms, bathrooms, play rooms, and activity rooms, other than nurseries, are listed tamper-resistant or employ a listed cover. If used in patient care room, ground-fault circuit interrupters (GFCI) are listed. 6.3.2.2.6.2 (F), 6.3.2.4.2 (NFPA 99) This deficient practice could affect 41 of 41 residents.	K 912	Surveyor 245593 on November 30th, 2017 found that documentation could not be provided to show that the yearly electrical receptacles inspection of resident rooms was conducted. Sellner Electric was here immediately that day to conduct electrical checks and repairs. An electrical receptacle inspection was completed and the documentation was retained and added to our records. The Director of Maintenance or his designee will continue to perform annual electrical receptacle inspections of resident rooms	12/29/17

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GOOD SAMARITAN SOCIETY - ST JAMES	**1000 SOUTH SECOND STREET** **ST JAMES, MN 56081**

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K 912	Continued From page 4 Findings include: On facility tour between 10:00 AM and 2:00 PM on 11/30/2017, documentation could not be located to show that an electrical outlet inspection had occurred throughout the facility. These deficient practices were verified by the Facility Maintenance Director.	K 912	and place documentation of the inspection and findings in the documentation book kept in the maintenance office. This action will be performed and monitored by the Director of Maintenance and reviewed by the QAPI Committee. This corrective action was completed on December 29, 2017.	

Electronically delivered
December 29, 2017

Ms. Ursula Hagstrand, Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: Project Number S5593028

Dear Ms. Hagstrand:

On December 4, 2017, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be 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 electronically delivered CMS-2567, whereby corrections are required.

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

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

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

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

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor
Mankato Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
1400 East Lyon Street, Suite 201
Marshall, Minnesota 56258-2504
Email: kathryn.serie@state.mn.us
Phone: (507) 476-4233
Fax: (507) 344-2723

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 January 13, 2018, 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 March 4, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was

issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by June 4, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145
Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: kamala.fiske-downing@state.mn.us

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: _____ B. WING _____	12/04/2017

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GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

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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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	00697	A. BUILDING: _____ B. WING _____	12/04/2017

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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 11/28/17-12/4/17, surveyors of this Department's staff, visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		

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2 000	Continued From page 2 THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 255	MN Rule 4658.0070 Quality Assessment and Assurance Committee A nursing home must maintain a quality assessment and assurance committee consisting of the administrator, the director of nursing services, the medical director or other physician designated by the medical director, and at least three other members of the nursing home's staff, representing disciplines directly involved in resident care. The quality assessment and assurance committee must identify issues with respect to which quality assurance activities are necessary and develop and implement appropriate plans of action to correct identified quality deficiencies. The committee must address, at a minimum, incident and accident reporting, infection control, and medications and pharmacy services. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the quality assessment and assurance (QAA) committee monitored compliance related to coordination of hospice services to ensure correction was achieved and sustained since the previous survey; this resulted in lack of coordination of hospice services for 2 of 4 residents (R18, R41) reviewed for hospice care services. Findings include:	2 255	Corrected on 1-2-18	1/2/18

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2 255	Continued From page 3 Interview and document review with the facility QAA coordinator on 12/1/17, at 11:42 a.m. indicated the QAA committee met on a quarterly basis. Review of the meeting dates since the last annual survey on 10/20/16, included: 11/16/17, 8/17/17, 5/18/17, 2/16/17 and 11/17/16. The committee attendees included the QAA coordinator, activity director, housekeeping director, social service director, maintenance director, director of nursing (DON), administrator, pharmacist and medical director. Current concerns identified during the survey were discussed with the QAA coordinator, including lack of coordination/communication of hospice services as well as implementation of the hospice plan of care. When questioned how the QAA committee monitored the coordination and communication between facility staff and hospice services since this was identified during the previous recertification survey, the QAA coordinator indicated she was unaware of any ongoing audits and/or corrective action plans which had been implemented over the past year. The QAA coordinator was unable to provide any information to verify that coordination of hospice services had been discussed at any of the QAA meetings and/or a corrective action plan had been implemented to achieve continued compliance. The QAA coordinator verified she had been unaware of any hospice service concerns and indicated this needs to be addressed by the QAA committee for review and subsequent corrective action. Documentation review identified that lack of coordination of hospice services was evident for R18 and F41. Interview with the director of nursing (DON) on 12/1/17, at 12:10 p.m. confirmed the deficient	2 255		

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2 255	Continued From page 4 practice related to hospice services had not been discussed at the QAA meetings with the committee members and explained she had implemented a plan of correction for the deficient practice related to lack of hospice coordination identified at the time of the previous survey but failed to involve the QAA committee to implement a plan to sustain compliance. SUGGESTED METHOD OF CORRECTION: Policy and procedures should be implemented related to discussions and review of the state survey results at the QAPI meetings to include a plan of correction for the deficient practice as well as on-going compliance. The administrator or designee could audit facility compliance periodically and report to the QAPI committee for further recommendations for facility practice and ongoing monitoring. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 255		
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 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:	2 560		1/5/18

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2 560	Continued From page 5 Based on observation, interview and document review the facility failed to develop and implement interventions on the person centered care plan for 2 of 5 residents (R11, R36) reviewed for unnecessary medication and for 1 of 1 resident (R92) reviewed for hearing impairment. Findings include: R11's Diagnosis information obtained in the medical record included: major depressive disorder, dementia with Lewy body disease, Parkinsons and generalized anxiety disorder. The resident was admitted on 10/18/16. Observation and interview on 11/28/17, at 7:00 p.m. R11 was observed to be calm and pleasant. Sitting by her room door waiting for staff to assist her into bed. She indicated she was very tired and just wanted to get into bed. Observation and interview on 11/29/17, at 9:00 a.m. R11 was observed to be pleasant but slightly restless/fidgety with am cares. R11 would ask the staff repetitive questions even when redirected. R11 indicated she thought the staff assisting her with cares had been talking about her and that she felt bad. Interview on 11/30/17, at 9:00 a.m. with nursing assistant (NA)-A, indicated R11 will become paranoid and restless at times, but is usually pleasant and cooperative. Review of the significant change Minimum Data Set (MDS) dated 8/30/17, R11 was identified as having a Brief Interview of Mental Status (BIMS) score of "4" (meaning cognition is severely impaired). The MDS indicated R11 exhibited moods of having trouble falling asleep or sleeping too much 12-14 days during the assessment	2 560	Corrected R11 on 12-6-17 Corrected R92 on 12-1-17	

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2 560	Continued From page 6 period. The MDS further indicated R11 exhibited behaviors of delusions. Review of R11's current physicians orders included: Ativan 0.5 milligrams (mg) four times daily (QID) and 0.5 mg tablet (1) as needed (PRN) during the night (for generalized anxiety disorder). Review of the medication administration record (MAR) indicated R11 had not received PRN Ativan since 10/27/17 (34 days prior). The resident was admitted to the facility with these orders on 10/18/16. Review of R11's current plan of care did not include the use of Ativan nor did it include any monitoring of target behaviors or side effects/adverse reactions related to the Ativan use. Interview on 11/30/17, at 3:00 p.m. with the director of nursing (DON), confirmed the plan of care for R11 did not include the use of Ativan nor did it include specific target behaviors or side effect monitoring for the use of the Ativan. During observation and interview on 11/29/17, at 3:09 p.m. R92 and family member (FM)-B indicated R92 had been missing his right hearing aide since July 2017. FM-B further indicated she visits daily and explained that R92 had his hearing aid one evening and the following morning it was missing. FM-B stated she reported the missing hearing aide but staff were unable to locate the hearing device. FM-B stated she was in the process of purchasing another hearing aid, but was unsure whether she would have to pay for the replacement. FM-B revealed the facility staff had not offered to assist with replacement of the right hearing aide. It was noted at this time that R92 had a hearing aid in the left ear but none	2 560		

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2 560	Continued From page 7 in the right. When interviewed at this time, R92 stated he was having a difficult time hearing normal conversation due to the missing hearing aide in the right ear. FM-B responded it was more difficult to communicate with R92 since the right hearing aide was missing. Review of the Nursing Admission Data Collection form dated 6/20/17, identifies R92 as having left and right hearing aids to aid in the ability to hear. Review of the admission MDS dated 6/27/17, identifies R92 as utilizing hearing aids for hearing. The resident has a BIMS score of "9" (meaning moderately impaired cognition) and the resident is usually understood and understands. Review of R92's current plan of care identifies the resident as having a communication problem related to hard of hearing (HOH) and needs a hearing aide. Interventions listed; monitor effectiveness of communication strategies and assistive devices, ensure left hearing aid is in place and keep in medication cart at bedtime. Although R92 was identified upon admission as having hearing impairment in the right ear and utilizing a hearing aid, this was not included in the plan of care. Interview on 11/30/17, at 7:52 a.m. licensed practical nurse (LPN)-A confirmed R92 was HOH in the right and left ears and had hearing aids for both ears. Interview on 11/30/17, at 8:07 a.m. the DON confirmed R92 was HOH in the left and right ears and utilized hearing aids in both ears to assist with hearing and communication. The DON verified R92's HOH and use of an assistive device should have been in the plan of care.	2 560		

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2 560	Continued From page 8 R36, admitted on 10/26/17, with diagnoses including depressive episodes and unspecified dementia with behavioral disturbance. When admitted the physician ordered Paxil 10 milligrams daily. The physician progress note dated 11/16/17, indicated: [R36] is on Paxil which is a good antidepressant but in the elderly that of forgetfulness and may make symptoms worse, recommend tapering off the Paxil. Subsequently, the physician ordered the Paxil 10 mg daily dose be decreased for a week with discontinuation of the medication. The medication administration record (MAR) identified that Paroxetine HCl (Paxil) 10 mg tablet was administered daily related to other "specified depressive episodes". A fax dated 11/21/17, from facility staff was communicated to the physician, which documented the following: having some inappropriate comments and unable to sleep since Paxil was discontinued? Can we restart at 10 mg daily? Also memory is no better and worse since meds were changed. The physician response included: restart Paxil 10 mg per oral at HS (bedtime) x 1 month; Dx dementia; dated 11/22/17. The plan of care indicated R36 had impaired cognitive function with a BIMS score of 8/15, as identified on the MDS dated 11/1/17. The depression score identified on the PHQ-9 dated 11/1/17, was 1/27. The identified intervention dated 11/14/17, related to the depression diagnosis included: attempt non-pharmacological interventions, allow to vent feelings. The care plan lacked any interventions related to the behaviors noted related to inappropriate sexual comments to staff during cares.	2 560		

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2 560	Continued From page 9 During review of mood/behavior documentation since admission on 10/26/17, nursing documentation identified that R36 made inappropriate sexual comments to female staff on 11/19, 11/20 (twice), 11/22 (twice), 11/24 and 11/29/17. When interviewed on 11/30/17, at 8:00 a.m. clinical manager (CM)-B explained that Paxil was restarted due to an increase in sexual comments made by R36 to female staff. When interviewed on 12/1/17, at 10:06 a.m. NA-B indicated that R36 usually made inappropriate comments in the evening but it can be anytime during the day. NA-B also stated that R36 makes comments that one does not want to hear and some staff are scared of R36 and worry about providing care due to the sexual comments. During interview with a male NA-D on 12/01/17, at 10:13 a.m. it was stated that R36 talks inappropriate with the female staff and when he attempts to take care of him, R36 becomes upset if the "girls" don't provide care. When interviewed on 12/01/17, at 10:46 a.m. the licensed social worker (LSW) and the administrator were unable to verify whether the rationale for the administration of the Paxil was for depressive episodes and/or sexually inappropriate comments. The LSW acknowledged she was aware of the sexually inappropriate behaviors exhibited by R36 and indicated she had talked with staff to verbally instruct them how to respond (provide cares with 2 staff) but confirmed she not identified specific interventions on the plan of care. The LSW verified she had just made a revision to the care	2 560		

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2 560	Continued From page 10 plan today 12/1/17, which included the following: Resident displays/has displayed inappropriate sexual advances toward staff R/T [related to] cognitive impairment E/B [evidenced by] sexual comments-initiated 12/1/17 -Interventions were: Contact health care provider to report new behavior and seek input (dated initiated 12/1/17) SEXUALLY INAPPROPRIATE- attempt non-pharmacological interventions. When questioned further related to how staff know what interventions to implement, a response was not communicated. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee, could develop and implement policies and procedures related to the development of the care plan. The DON or designee, could provide training for all nursing staff related to care plan development. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 560		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident	2 830		1/8/18

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2 830	Continued From page 11 prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure nursing care was coordinated with the hospice agency to meet individual needs for 1 of 2 residents (R41) reviewed who received hospice services and failed to properly assess/reassess the continued need for a Wanderguard device after hospitalization to ensure adequate supervision for 1 of 1 resident (R20) reviewed who was identified with wandering behavior prior to hospitalization. Findings include: Electronic medical record (EMR) review identified R41 was admitted on 8/10/17, with a diagnosis of cancer of the brain. Subsequent admission to hospice was dated 8/22/17, and remained until the time of death (9/22/17). A note dated 9/23/17, in the EMR by the hospice nurse identified that at 11:42 a.m., the hospice nurse (HN)-B received a call from R41's sister asking whether hospice had come to see the resident yet. She stated another nurse was going to make a visit later today and asked if he was doing ok. R41's sister replied to her "No, he can't breathe." HN-B went to the facility to see R41. Upon entering his room, his respirations were 44 per minute (normal = 16 to 20), they were rapid, short, and labored. HN-B placed a call to [the physician] to obtain an order to schedule Morphine [controls pain and shortness of breath during the dying process]. An order was received	2 830	Corrected R 41 on 1-2-18 Corrected R 20 on 12-19-17	

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2 830	Continued From page 12 for scheduled Morphine and as needed morphine. HN-B administered the first dose at that time. R41's respirations decreased to 35 per minute and the nursing staff was instructed to give morphine if R41's respirations exceeded 24 breaths/minute and/or if they were labored. The facility nurse verbalized understanding. R41 was able to open his eyes but was not able to communicate his needs; not restless or anxious. Documentation was lacking to indicate that facility nursing staff had contacted and/or communicated with the hospice nurse to report abnormal vital signs and impending death. During the period R41 received the hospice benefit, limited communication was documented between facility staff and the hospice nurse related to R41's care; documentation revealed only 5 nursing notes entered between 8/22/17 and 9/24/17, related to health status and/or care plan. . Interview on 12/1/17, at 9:14 a.m. with hospice nurse (HN)-B indicated R41's family member (FM) had contacted her on 9/24/17, regarding R41's shortness of breath (SOB). The family member told HN-B that contact with the director of nursing (DON) about symptom control that morning had been communicated. HN-B explained the Morphine dose was due to be administered, but staff had not yet administered at the time of arrival and no notification of the SOB symptoms had been communicated. HN-B stated she understood from the family they were in charge of contacting her about R41's condition. HN-B explained a verbal report from the facility nurse only occurred while she was onsite, no documentation related to status was entered in the EMR on days she was not onsite for her to review. HN-B confirmed the EMR lacked documentation related to resident health status	2 830		

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2 830	Continued From page 13 prior to death and it was difficult to determine whether nursing assessments had been performed. HN-B further indicated communication was not good between the staff and hospice. HN-B stated that PRN doses of medication were not always administered when needed as staff assume the symptoms were part of the dying process and to provide symptom relief during the process. Review of the R41's nursing progress notes identified that no PRN Morphine, (initiated 8/22/17 to be given orally or under the tongue every 2 hours as needed for pain or SOB) had been administered prior to the hospice nurse arriving at the facility on 9/23/17. Documentation was lacking that a nursing assessment of R41's condition had been performed even though routine medications had been administered prior to the hospice nurse arrival. Review of R41's facility care plan, identified facility staff were to monitor, document, and report to health care providers any changes. Review of R41's 8/22/17, hospice care plan indicated nursing staff were to monitor for client's respiratory status. Staff were instructed on administration, schedule, route and side effects of medication for respiratory status, including the use of Morphine. Medication ordered on 8/22/17, as part of the plan of care was Morphine, 0.25 milliliters (ml)/5 milligrams (mg) PRN oral or sublingual (under the tongue) every 2 hours PRN for pain or SOB. Review of the R41's nursing progress notes identified that no PRN Morphine, (initiated 8/22/17 to be given orally or under the tongue every 2 hours as needed for pain or SOB) had been administered prior to the hospice nurse arriving at	2 830		

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2 830	Continued From page 14	2 830		

the facility on 9/23/17. Documentation was lacking that a nursing assessment of R41's condition had been performed even though routine medications had been administered prior to the hospice nurse arrival.

Interview and record review on 12/1/17, at 12:53 p.m. with the administrator (A) related to R 41 and the events leading up to his death indicated she agreed documentation was lacking related to cares provided. The administrator verified it was staff responsibility to contact hospice not FM and agreed there was a lack of communication between nursing staff and hospice staff. The administrator commented that additional education with nursing staff was required to ensure documentation reflected cares provided and timely communication with the hospice staff.

When interviewed on 12/1/17, at 1:30 p.m. the DON indicated she met the R41's FM in the parking lot that day and was aware of their concerns and was aware they were going to contact the hospice nurse. The DON agreed staff should have contacted hospice to report a change in condition, not the family. The DON concurred documentation was lacking in the record to support that staff contacted and/or communicated with hospice staff while R41 received the hospice benefit.

Review of the facility's 11/2016 Care Plan policy indicated resident's will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment.

Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments,

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2 830	Continued From page 15 comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented. R20 had been readmitted to the facility on 11/9/17, after a brief discharge to a psychiatric facility for behaviors associated with her dementia. Diagnoses included Alzheimer's, dementia with behavioral disturbances and restlessness and agitation. When interviewed on 11/28/17, at 2:12 p.m. licensed practical nurse (LPN)-A indicated R20 had recently returned from a psychiatric hospital after approximately 2 weeks. LPN-A stated that R20's behaviors had improved and was cooperative with cares. LPN-A explained that prior to hospitalization, R20 had experienced hallucinations, new meds had been started and some medications discontinued. LPN-A indicated that prior to hospitalization, R20 remained in her room to eat and since medication adjustments, had been participating with eating meals in the dining room and visiting with other residents. Observations were noted as follows: (1) On 11/28/17, at 4:01 p.m. R20 was wearing a Wanderguard on her right wrist, was pleasant in conversation and moved independently about the room with the use of her walker. (2) On 11/29/17, at 2:30 p.m., R20 seated in a wheelchair enjoying coffee and a snack in the dining room with other residents; no behaviors and a Wanderguard was noted on the right wrist. (3) On 11/30/17, at 8:15 a.m. R20 was seated in a recliner located in her room, walker in front of her and Wanderguard on her right wrist. No behaviors noted. (4) Later at 11/30/17, at 12:36 p.m. R20 was	2 830		

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2 830	Continued From page 16 seated in a dining chair in the dining room with her walker beside her; Wanderguard was attached to the walker and not on her wrist. When interviewed on 11/30/17, at 12:40 p.m. trained medication aide (TMA)-B explained that any resident with a Wanderguard, required a physician order with documentation on the treatment administration record (TAR). Upon review of R20's TAR, TMA-B was unable to locate documentation to indicate the battery had been checked to ensure it was working properly. TMA-B indicated the night staff may have checked it's functioning and then proceeded to check the device which had been placed on the R20's walker. It was noted the battery was functional. However, TMA-B was unclear the reason the device had been removed from R20's wrist and placed on the walker. Review of the Minimum Data Set (MDS) assessment dated 10/5/17, prior to R20's psychiatric stay, indicated she wandered 1 to 3 days during the lookback period of 7 days at that time. The MDS dated after her return on 11/16/17, indicated she had made no attempts to wander. When interviewed on 11/30/17, at 1:30 p.m. the director of nursing (DON) confirmed no assessment related to elopement or wandering was available for review. She explained the social worker was responsible for adding any information to the MDS assessment related to elopement or wandering. Review of the medical record for R20 indicated an elopement from the facility occurred on 10/17/17. There were no witnesses to the incident, but staff summarized the "Resident was	2 830		

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2 830	Continued From page 17 confused- thought there was a fire due to alarm sounding. The resident had more recent confusion. Staff took [R20] out for a walk outside to calm her. Dr. reviewing her medications. Currently has WanderGuard, reviewed meds." The report made no mention of the care plan being amended and/or revised. When interviewed on 12/1/17, at 10:18 a.m. RN case manager (CM)-B indicated she was aware of R20 had a Wanderguard placed since she has been employed with the facility (June 2017) and the registered nurse/health information manager (RN/HIM)-C inputs into the computer all the physician orders after a readmission which is reviewed with another case manager (CM-A). CM-B stated that when a resident is immobile, meaning confined to a wheelchair, a Wanderguard device is placed on the device and not the resident. CM-B clarified that since R20 was mobile with the use of the walker, the device should be placed on the wrist and not the walker. Upon reviewing the care plan, CM-B agreed it lacked any mention of wandering behaviors nor did it address the use of a Wanderguard device. CM-B stated she was unaware of an assessment related to wandering and/or elopement risk as it was the social worker's responsibility to assess wandering. She further stated only medication orders were double checked for accuracy upon return from hospitalization and not anything else (device). Document review for R20 revealed there was no physician order for the use of a wander guard and no assessment related to elopement risk nor wandering. The MDS assessment notes were unclear whether R20 wandered throughout the facility, into other resident's rooms and/or whether attempts to leave the facility with exit-seeking	2 830		

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2 830	Continued From page 18 behavior. Interview on 12/1/17, at 11:48 a.m. and again at 12:39 p.m. with the administrator confirmed it was the expectation that R20 should have been periodically assessed for placement of a Wanderguard to re-evaluate the necessity of the device, elopement risk and supervision needs. The administrator also agreed a physician order for the device was necessary and when previous orders were followed post hospitalization, accuracy should be verified prior to input into the EMR. The administrator confirmed that staff also needed to monitor the device to ensure it was working correctly. The facility had no WanderGuard or Elopement policy. Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could educate staff on policies and procedures related to the coordination/communication of Hospice services related to resident care and with monitoring and assessing residents that are at risk for wandering and elopement. The DON or designee could conduct audits tools for compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		

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21495	Continued From page 19	21495		
21495	MN Rule 4658.1005 Subp. 5 Social Services; Providing Social Services Subp. 5. Providing social services. Social services must be provided on the basis of identified social service needs of each resident, according to the comprehensive resident assessment and comprehensive plan of care described in parts 4658.0400 and 4658.0405. This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to provide assistance and/or arrangements to obtain a replacement hearing device after it was reported missing for 1 of 2 residents (R92) reviewed who had missing property. Findings include: During observation and interview on 11/29/17, at 3:09 p.m. R92 and family member (FM)-B indicated R92 had been missing his right hearing aid since July 2017. FM-B further indicated she visits daily and explained that R92 had his hearing aid one evening and the following morning it was missing. FM-B stated she reported the missing hearing aid but staff were unable to locate the hearing device. FM-B stated she was in the process of purchasing another hearing aid, but was unsure whether she would have to pay for the replacement. FM-B revealed the facility staff had not offered to assist with replacement of the right hearing aid. It was noted at this time that R92 had a hearing aid in the left ear but none in the right. When interviewed at this time, R92 stated he was having a difficult time hearing normal conversation due to the missing hearing	21495	Corrected R 92 12-1-17	1/4/18

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21495	Continued From page 20	21495		

aid in the right ear. FM-B responded it was more difficult to communicate with R92 since the right hearing aid was missing. Review of the admission Minimum Data Set (MDS) assessment dated 6/27/17, identifies R92 as utilizing hearing aids for hearing. The resident has a Brief Interview of Mental Status (BIMS) score of "9" (meaning moderately impaired cognition) and the resident is usually understood and understands.

Review of the Nursing Admission Data Collection form dated 6/20/17, identifies R92 as having left and right hearing aids to aide in the ability to hear.

Review of R92's current plan of care identifies the resident as having a communication problem related to hard of hearing (HOH) and needs a hearing aid. Interventions listed: monitor effectiveness of communication strategies and assistive devices, ensure left hearing aid is in place and keep in medication cart at bedtime. Although R92 was identified upon admission as having hearing impairment in the right ear and utilizing a hearing aid, this was not included in the plan of care.

Review of the facility lost and found document dated 9/16/17, indicated R92 was missing his right hearing aid which had been reported to the facility licensed social worker (LSW).

Review of the nursing notes from admission on 6/20/17 to 12/4/17, indicated the staff stored R92's right and left hearing aids in the medication cart each evening. The nurses note dated 7/7/17, indicated only the left hearing aid was stored in the medication cart on that date. There was no further documentation related to the right hearing aid.

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21495	Continued From page 21 R92's treatment record since admission on 6/27/17 to 12/4/17 was reviewed. The signed treatment record for July and August indicated R92's right and left hearing aids had been stored in the medication cart each night. Review of the signed treatment record for September, October and November, indicated only the left hearing aid had been stored in the medication cart. There was no documentation addressing why the right hearing aid was no longer being stored on the medication cart for the past 3 months. When interviewed on 11/29/17, at 3:14 p.m. clinical manager (CM)-A indicated shortly after admission, R92's right hearing aid was missing. CM-A confirmed R92 has not utilized the right hearing aid since that time, and consequently, has had a difficult time hearing without an assistive device. During interview with the LSW on 11/29/17, at 3:20 p.m. indicated she was not aware of R92's missing right hearing aid and was unable to find a missing personal item report. The LSW confirmed R92's right hearing was documented as missing in the lost and found record on 9/19/17, but failed to investigate the whereabouts of the missing right hearing aid. When interviewed on 11/30/17, at 7:52 a.m. licensed practical nurse (LPN)-A, indicated she was aware of R92's missing right hearing aid and confirmed it had been missing for several months. LPN-A further indicated she thought the LSW had followed through and had discussed the missing item with the resident/family. LPN-A confirmed R92 was HOH and had difficulty hearing normal conversation without his right hearing aid.	21495		

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21495	Continued From page 22 Interview on 11/30/17, at 8:07 a.m. the director of nursing (DON) and the administrator confirmed staff initially was aware of R92's missing right hearing aid on 7/7/17, when it was first documented and the LSW should have followed through with resolving the missing item as the facility policy directs. Review of the facility policy and procedure for Missing Items dated 4/16, included reporting missing items to the supervisor immediately, start a search for the item, if the item is not found and is of nominal value, complete a suggestion/concern form and social services (SS) will report to the resident/family or responsible party on the attempts to locate the item. A record is kept in the SS office no less than 15 months. SUGGESTED METHOD OF CORRECTION: The administrator could re-educate the social service staff on the policy and procedures related to missing items. The administrator could then audit to ensure compliance and bring forth to the QAA committee for review. Missing items could be reviewed during the care conference. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21495		
21540	MN Rule 4658.1315 Subp. 2 Unnecessary Drug Usage; Monitoring Subp. 2. Monitoring. A nursing home must monitor each resident's drug regimen for unnecessary drug usage, based on the nursing home's policies and procedures, and the pharmacist must report any irregularity to the resident's attending physician. If the attending physician does not concur with the nursing	21540		1/5/18

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21540	Continued From page 23 home's recommendation, or does not provide adequate justification, and the pharmacist believes the resident's quality of life is being adversely affected, the pharmacist must refer the matter to the medical director for review if the medical director is not the attending physician. If the medical director determines that the attending physician does not have adequate justification for the order and if the attending physician does not change the order, the matter must be referred for review to the Quality Assurance and Assessment (QAA) committee required by part 4658.0070. If the attending physician is the medical director, the consulting pharmacist shall refer the matter directly to the QAA. This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to identify adequate indications for the use of Gabapentin (anti-seizure medication) to ensure adequate monitoring for it's effectiveness for 1 of 5 resident (R20) reviewed for unnecessary medications and failed to evaluate, monitor and justify the continued use of a psychoactive medications and/or failed to include parameters for the use of the as needed (PRN) antianxiety medication for 2 of 5 residents (R11, R36) reviewed for unnecessary medications. Findings include: R20 had been readmitted to the facility on 11/9/17, after a brief discharge to a psychiatric facility for behaviors associated with her dementia. Diagnoses included Alzheimer's and dementia with behavioral disturbances and restlessness and agitation.	21540	Corrected R 11 on 12-6-17 Corrected R 36 on 12-22-17 Corrected R-20 on 12-11-17	

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21540	Continued From page 24 When interviewed on 11/28/17, at 2:12 p.m. licensed practical nurse (LPN)-A indicated R20 had recently returned from a psychiatric hospital after approximately 2 weeks. LPN-A stated that R20's behaviors had improved and was cooperative with cares. LPN-A explained that prior to hospitalization, R20 had experienced hallucinations, new meds had been started and some medications discontinued. LPN-A indicated that prior to hospitalization, R20 remained in her room to eat and since medication adjustments, had been participating with eating meals in the dining room and visiting with other residents. Review of the electronic medical record (EMR) for R20 indicated Gabapentin was initiated during the psychiatric hospital stay prior to return to the facility. The physician's orders inputted into the EMR by nursing staff were: (1) Gabapentin 300 milligrams (MG) give 1 capsule by mouth in the evening related to restlessness and agitation. (2) Gabapentin 100 MG, give 2 capsule by mouth two times a day related to pain, unspecified. The original telephone physician order signed by the nurse dated 11/8/17, received from the psychiatric hospital and provided upon R20's return, indicated the reason for the administration of Gabapentin was to treat nerve pain. Documentation was lacking in the EMR that R20 had a diagnosis related to nerve pain. In addition, the telephone order had not yet been countersigned by the ordering physician. Review of R20's mood and behavior notes indicated there was only one documented nurses' note dated 11/15/17, when R20 exited the bed and independently went to the bathroom.	21540		

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21540	Continued From page 25 Documentation indicated she was assisted back to bed and stayed in bed for the remainder of the night. No other documentation was noted relative to mood/behavior notes in the EMR per the DON on 12/1/17, when requested. Review of the Minimum Data Set (MDS) assessment dated 10/5/17, prior to R20's psychiatric stay, indicated she wandered 1 to 3 days during the lookback period of 7 days at that time. The MDS dated after her return on 11/16/17 indicated she had made no attempts to wander. When interviewed on 12/1/17, at 10:54 p.m. with clinical managers (CM)-B and CM-A regarding the Gabapentin order, it was learned they were unaware the Gabapentin had been identified as being administered for nerve pain. A note from the psychiatric hospital dated 10/26/17, identified the Gabapentin was administered for anxiety and agitation. CM-A agreed the conflicting information regarding the need for the Gabapentin should be clarified with the physician especially due to the fact the returning telephone order had not been countersigned by the ordering physician. In addition, facility staff could not monitor the effectiveness of the medication when unsure the rationale for the administration of this medication. CM-A was unaware the original order received from the psychiatric facility had not been countersigned by a physician. CM-A agreed R20 never had a diagnosis related to nerve pain. Interview on 12/1/17, at 12:39 p.m. with the administrator confirmed the expectation for staff to clarify physician orders and corresponding diagnosis be accurate, especially upon initiation of a new medication. Review of the facility's November 2016	21540		

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21540	Continued From page 26 Physician/Practitioner Orders policy indicated its purpose was to provide individualized care to each resident and provide staff a procedure by obtaining appropriate, accurate, and timely physician's orders. Telephone orders will be signed and dated by the physician within the time period required by state law. Nursing orders must be documented as care plan approaches, not as a physician order. When a resident returns from the hospital, physician's orders must be updated to reflect the resident's current needs. Clarification orders are needed when reviewing any type of physician order that is incomplete or raises questions. Never assign a diagnosis to an order, even if a diagnosis appears obvious. Only a physician may diagnose. Review of the facility's September 2012 Documentation policy indicated physical health observations, assessments, reassessments, comprehensive care plan, physician's orders, medications and completion of orders, and information related to emotional and mental aspects will be clearly documented. R11's diagnosis information obtained in the medical record included: Major depressive disorder, dementia with lewy body disease, Parkinsons and generalized anxiety disorder. R11 was admitted on 10/18/16. During observation on 11/28/17, at 7:00 p.m. R11 appeared calm and pleasant, seated by her room door waiting for staff to assist her into bed. When interviewed at this time, R11 indicated feeling tired and wanted to get into bed. During morning cares on 11/29/17, at 9:00 a.m. R11 appeared pleasant but slightly restless/fidgety, asking staff repetitive questions	21540		

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	00697	A. BUILDING: _____ B. WING _____	12/04/2017

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even when redirected. When interviewed at this time, R11 indicated she thought staff assisting with cares had been talking about her and that she felt bad.

Interview on 11/30/17, at 9:00 a.m. with nursing assistant (NA)-A, indicated R11 will become paranoid and restless at times, but is usually pleasant and cooperative.

Review of the significant change Minimum Data Set (MDS) assessment dated 8/30/17, R11 was identified as having a Brief Interview of Mental Status (BIMS) score of "4" (meaning cognition is severely impaired). The MDS indicated R11 exhibited moods of having trouble falling asleep or sleeping too much 12-14 days during the assessment period. The MDS further indicated R11 exhibited behaviors of delusions.

Review of R11's current physicians orders included: Ativan 0.5 milligrams (mg) four times daily (QID) and 0.5 mg tablet (1) as needed (PRN) during the night (for generalized anxiety disorder). Review of the medication administration record (MAR) indicated R11 had not received PRN Ativan since 10/27/17 (34 days prior). The resident was admitted with these orders on 10/18/16.

Review of R11's current plan of care did not include the use of Ativan nor did it include any monitoring of target behaviors or side effects/adverse reactions related to the Ativan use.

Review of the consulting pharmacist drug regimen review for R11 included the following recommendations:
(1) dated 12/15/16, discontinue R11's Ativan

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orders and avoid prolonged daily use due to adverse reactions in the elderly. The physician responded with no changes and to reassess in 6 months;
(2) dated 2/15/17, discontinue the scheduled Ativan use due to R11 falling. The physician responded with no changes due to family request;
(3) dated 8/13/17, discontinue the scheduled Ativan order and address the Ativan use in R11's plan of care. The report also included a justification and duration of use was needed for the continued use of the PRN Ativan following the initial 14 days. The physician responded to continue the current Ativan order due to family request; and
(4) dated 10/20/17, document a justification for continued use of the PRN Ativan as well as the duration for use following the initial 14 days. The physician responded to continue the current Ativan order due to husband request.

Review of the physicians dictated notes dated 11/22/16, 12/12/16, 1/9/17, 3/13/17, 4/10/17, 6/20/17, 8/14/17 and 10/9/17, addressed R11's history of falls, Parkinson's, Lewy body disease, depression/anxiety. The physician did not address R11's current Ativan use or the justification for the continued use.

Review of the progress notes for R11, did not included any documented mood or behaviors in the past 6 months other than exhibiting 2 episodes of being identified as "needy" and not wanting certain staff in her room.

Interview on 11/30/17, at 3:00 p.m. with the director of nursing (DON), indicated R11 does become restless and anxious often and is difficult to redirect, but confirmed the medical record lacked documentation confirming these behaviors

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nor the frequency they occurred. The DON also confirmed there were no behaviors identified for the use of the Ativan to establish efficacy, and a gradual dose reduction had not been attempted in the past year.

Interview on 12/01/17, at 9:11 a.m.. with licensed practical nurse (LPN)-A, indicated R11 did not exhibit any behaviors of anxiety or restlessness that she has observed or that the NA's have reported in the past several weeks. LPN-A could not recall the last time R11 was observed to exhibit these behaviors.

R36, admitted on 10/26/17, had diagnoses including depressive episodes and unspecified dementia with behavioral disturbance and had physician ordered Paxil 10 milligrams daily. The physician progress note dated 11/16/17, indicated: [R36] is on Paxil which is a good antidepressant but in the elderly that if forgetful, may make symptoms worse, recommend tapering off the Paxil. Subsequently, the physician ordered the Paxil 10 mg daily dose be decreased for a week with discontinuation of the medication. The medication administration record (MAR) identified that Paroxetine HCl (Paxil) 10 mg tablet was administered daily related to other "specified depressive episodes".

A fax dated 11/21/17, from facility staff was communicated to the physician, which documented the following: having some inappropriate comments and unable to sleep since Paxil was discontinued? Can we restart at 10 mg daily? Also memory is no better and worse since meds were changed. The physician response included: restart Paxil 10 mg per oral at HS (bedtime) x 1 month; Dx dementia; dated 11/22/17.

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21540	Continued From page 30 The plan of care indicated R36 had impaired cognitive function with a BIMS score of 8/15, as identified on the MDS dated 11/1/17. The depression score identified on the PHQ-9 dated 11/1/17, was 1/27, indicating depressive symptoms minimal. The identified intervention dated 11/14/17, related to the depression diagnosis included: attempt non-pharmacological interventions, allow to vent feelings. The plan of care lacked any reference to sexually inappropriate comments and effectiveness of Paxil monitoring. During review of mood/behavior documentation since admission on 10/26/17, nursing documentation identified that R36 made inappropriate sexual comments to female staff on 11/19, 11/20 (twice), 11/22 (twice), 11/24 and 11/29/17. When interviewed on 11/30/17, at 8:00 a.m. clinical manager (CM)-B explained that Paxil was restarted due to an increase in sexual comments made by R36 to female staff. However, the physician note identified the medication had been utilized for depression. When interviewed on 12/01/17, at 10:46 a.m. the licensed social worker (LSW) and the administrator were unable to verify whether the rationale for the administration of the Paxil was for depressive episodes and/or to reduce sexually inappropriate comments. When questioned how they tracked and monitored the effectiveness of the medication based on the rationale for the administration of the medication , they were unable to respond. When further requested documentation to identify the rationale for the continued administration of Paxil, none was	21540		

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21540	Continued From page 31 provided. SUGGESTED METHOD OF CORRECTION: The director of nursing could education staff on the importance of ensuring the correct diagnosis is identified so that appropriate monitoring for drug effectiveness can be performed. A system to ensure the accurate diagnosis and medication dose is entered into the EMR could be developed. An audit could be developed to monitor medications for adequate indications for use and the results reported to the QAA committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21540		