DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2022

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 18, 2022, we notified you a remedy was imposed. On April 13, 2022 the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of April 2, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective June 3, 2022 did not go into effect. (42 CFR 488.417 (b))

The CMS Region V Office may notify you of their determination regarding any imposed remedies.

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 23, 2022

CMS Certification Number (CCN): 245593

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Dear Administrator:

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 April 2, 2022 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/or Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Melissa Poepping, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

Electronically delivered
March 18, 2022

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: March 3, 2022

Dear Administrator:

On March 3, 2022, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

As a result of the survey findings and in accordance with survey and certification memo 16-31-NH, this Department recommended the enforcement remedy(ies) listed below to the CMS Region V Office for imposition. The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Directed plan of correction (DPOC), Federal regulations at 42 CFR § 488.424. Please see electronically attached documents for the DPOC.

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective June 3, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective June 3, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective June 3, 2022.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial

compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved. The failure to submit an acceptable ePOC can lead to termination of your Medicare and Medicaid participation (42 CFR 488.456(b)).

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, Minnesota 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. 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 - Health Regulation Division staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

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.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by September 3, 2022 if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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.

APPEAL RIGHTS

If you disagree with this action imposed on your facility, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Departmental Appeals Board (DAB). Procedures governing this process are set out in 42 C.F.R. 498.40, et seq. You must file your hearing request electronically by using the Departmental Appeals Board's Electronic Filing System (DAB E-File) at https://dab.efile.hhs.gov no later than sixty (60) days after receiving this letter. Specific instructions on how to file electronically are attached to this notice. A copy of the hearing request shall be submitted electronically to:

Tamika.Brown@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those

circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

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: https://mdhprovidercontent.web.health.state.mn.us/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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:

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

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 _____	03/03/2022

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 000	INITIAL COMMENTS On 2/28/22, to 3/3/22, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5593040C (MN81370), however NO deficiencies were cited due to actions implemented by the facility prior to survey: The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments 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 onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R5) reviewed who was observed to have medications at the bedside, had been	F 554	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts	4/2/22

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

Electronically Signed | 03/28/2022

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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F 554	Continued From page 1 appropriately assessed and deemed appropriate to self-administer medications. Findings include: R5's Admission Record printed 3/3/22, identified diagnoses including anxiety disorder and unspecified mental disorder. R5's quarterly Minimum Data Set (MDS) assessment dated 12/9/21, identified R5 had moderately impaired cognition and required one personal physical assist with bed mobility, dressing, toilet use, transfers, and personal hygiene. R5's care plan printed, identified R5 had chronic pain/discomfort related to arthritis in knees and needed routine pain meds and indicated R5 was able to call for assistance when in pain, reposition self, and ask for medication. The care plan lacked any dictation or interventions pertaining to R5 self-administration of medications. R5's Order Summary Report printed 3/3/22, identified an order for Tylenol arthritis pain tablet extended release 650 mg (acetaminophen ER) give 650 mg by mouth at bedtime. R5's record review did not include an assessment or physician order for self-administration of medication. On 2/28/22, at 2:59 p.m. R5 was observed and interviewed in her room. R5 was seated in a recliner with a table next to her. A clear cup with three white oblong pills imprinted with "L544 "were observed on resident's table. R5 stated the pills were Tylenol and R5 indicated she would take the pills at night if she could not sleep.	F 554	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 provisions of federal and state law. For the purposes 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 Operations Manual. F554 1. A referral was made to the CNP to assess the need for the Tylenol on 3/10/2022. This was the medication that was being left in the resident room. The new order instructions were for the nurses to give the medication and resident is unable to self-administer. Due to resident refusing at this time, CNP discontinued and made medication PRN. 2. All residents have the potential to be affected by the same deficient practice. An audit was performed on all current residents to ensure care plan is up to date regarding resident self-administration of medications to and findings were taken to IDT. Referrals were made to physician as appropriate. 3. Education was provided to licensed nurses and medication aides Director of Nursing and Nurse Educator on the policy and procedure for administering medications. 4. An audit was initially completed to identify if there are medications left in resident rooms. Audits will be completed	

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F 554	Continued From page 2 On 3/01/22, at 1:36 p.m. registered nurse (RN)-A was notified of R5's medication in her room. (RN)-A and verified the 3 pills were Tylenol and indicated the medications were not expected to be at the bedside. RN-A confirmed R5 did not have a physician order for self-administration of medications and removed the medications from R5's room. On 3/02/22, at 7:44 a.m. an interview with the director of nursing (DON) stated staff were provided education regarding administration of resident's medications and further indicated R5's medications were not expected left at the bedside. The DON verified R5 did not have an order to self-administer meds and further indicated she expected the resident to be assessed for self-administration of medications if medications were left with resident. The facility policy titled Medication: Administration Including Scheduling and Medication Aide-Rehab/Skilled, dated 4/6/21, indicated -Self administration: the resident has a right to self-administer medications if the interdisciplinary team determines that this practice is safe for the individual resident and is documented in the care plan. An order from the provider is required for this activity. Nursing employees will be aware medications kept in the room and responsible for recording self-administration doses in the resident's medication record.	F 554	by Director of Nursing or designee on medication administration 1x/week for 4 week then 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse	F 578		4/2/22

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 578	Continued From page 3 to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by:	F 578		

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F 578	Continued From page 4 Based on interview and document review, the facility failed to ensure resident current wishes for resuscitation status were accurately documented and signatures obtained by resident or resident health care agent in the medical record for 2 of 29 residents (R8, R10) reviewed for advanced directives. Findings include: R8's quarterly Minimum Data Set (MDS) assessment dated 12/22/21, identified R8 had intact cognition. R8's face sheet, printed on 3/2/22, identified diagnoses of chronic kidney disease-stage 3, chronic pain, schizoaffective disorder (a mood swing disorder), Alzheimer's disease (a condition that affects the brain and memory), idiopathic progressive neuropathy (a condition causing nerve damage of unknown origin), major depressive disorder, recurrent, severe with psychotic symptoms (a mood/mental disorder causing disconnection from reality), visual hallucinations (a condition having seen something not actually there). R8's face sheet, identified advance directive as do not attempt resuscitation/do not resuscitate (DNR)-patient has no pulse and is not breathing. (Allow Natural Death). R8's Provider Orders for Life-Sustaining Treatment (POLST), dated 1/6/20, identified "Do not attempt resuscitation/DNR (Allow Natural Death)," if no pulse and not breathing. The POLST, dated 1/6/20, was signed by physician on 1/6/20, signed by nurse on 1/3/20, but not signed by resident or resident's health care agent.	F 578	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by 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 provisions of federal and state law. For the purposes 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 Operations Manual. F578 1. Residents R8 and R10 were presented their current POLST on file, reviewed their wishes, and signatures were received. 2. An audit of all current resident POLSTs was completed to ensure signatures were received by the resident and/or the POA. 3. A change in our current admission process will include having the resident, family member/POA, or guardian sign the POLST during the admission process. Education was provided to all licensed nurses and social worker on 3/16/2022 on our new process. 4. Audits will be completed 1x/week for 4 weeks of all new admits or current residents during this time. We will then complete audits 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	

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F 578	Continued From page 5	F 578		

R8's Health Care Directive, dated 12/14/06, indicated R8's husband as health care agent, children alternate health care agents if health care agent is not reasonably available to make health care decisions. Health Care Directive, dated 12/14/06, indicated R8's wishes if there was a reasonable chance of recovery, to have the necessary aid administered for recovery.

R8's order summary report, printed on 3/2/22, identified code status as do not attempt resuscitation/DNR-patient has no pulse and is not breathing. (Allow Natural Death).

During an interview, on 3/1/22 at 6:51 p.m., R8's daughter indicated she could not recall whether or not she signed a POLST form when R8 was admitted to facility. R8's daughter indicated she thought she had, stated R8 does have a health care directive signed from several years ago.

R10
R10's significant change in condition assessment dated 1/6/22, identified R10 had mild cognitive deficits.

R10's face sheet, printed on 3/2/22, identified diagnoses of chronic kidney disease-stage 3, hemiplegia/hemiparesis (paralysis of one side of the body), Type 2 diabetes, aphasia (a condition that causes loss of ability to understand speech or express speech from brain damage), cerebral infarction (a condition that causes a portion of brain to die; a stroke), occlusion and stenosis of left carotid artery (a condition blocks blood flow in the neck), and repeated falls. R10's face sheet, identified advance directive as do not attempt resuscitation/do not resuscitate (DNR)-patient has no pulse and is not breathing. (Allow Natural

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F 578	Continued From page 6	F 578		

Death).

R10's POLST, dated 1/19/22, identified "Do not attempt resuscitation/DNR (Allow Natural Death)," if no pulse and not breathing. The POLST, dated 1/19/22, was signed by physician and nursing on 1/19/22, but not signed by resident or resident's health care agent.

R10's order summary report, printed on 3/2/22, identified code status as do not attempt resuscitation/DNR-patient has no pulse and is not breathing. (Allow Natural Death).

During interview, on 3/1/22 at 9:28 a.m., R10 indicated having a discussion with staff in regards to POLST, stated he thought he signed it in past.

During an interview on 3/1/22, at 12:14 p.m. registered nurse (RN)-B indicated she would look for a resident's code status in the unit's advance directive book, which upon review indicated R8's code status as do not resuscitate/DNR.

During an interview on 3/3/22, at 11:08 a.m. the director of nursing (DON), indicated staff look in unit's advance directive book to determine code status. The DON indicated being unaware of any discrepancies with residents advance directives or POLST. Upon review of R8's Health Care Directive and POLST, and R10's POLST; DON indicated it is her expectation staff ensure all residents have an advance directive and/or POLST appropriately documented in their medical record. The DON indicated all residents' advance directives and/or POLST should be signed by all parties; residents or health care agent, nursing staff, and physician to make it a legal document.

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F 578	Continued From page 7 The facility policy titled Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED), reviewed/revised on 7/9/21, included: CPR will be initiated unless a valid DNR order is in place, At the time of admission or re-admission, social services or designated staff member asks the resident/healthcare decision-maker whether the resident has prepared an advance directive such as a living will, durable power-of attorney for healthcare decisions, guardianship, portable and enduring order form etc. The designated staff member will meet with the resident/healthcare decision maker to answer questions and determine if the resident/healthcare-decision maker wish to develop or amend advance directives, Advance directive orders are to be reviewed with resident/healthcare decision-maker at each care plan meeting to ensure no changes are needed, If the resident's medical condition or cognitive status changes, review the current advance directive orders with the resident and healthcare decision maker to determine if they wish to make changes.	F 578		
F 641 SS=B	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure the Minimum Data Set (MDS) assessment was accurately coded for restraints and alarms for 4 of 29	F 641	F641 1. The affected residents R5, R9, R12, and R13 have had their MDS modified to reflect an accurate assessment.	4/2/22

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F 641	Continued From page 8 residents (R5, R9, R12, R13) when the MDS indicated the use of bed rail restraints when restraints were not being used. Findings include: R5's Admission Record printed 3/3/22, identified diagnoses including anxiety disorder and unspecified mental disorder. R5's quarterly Minimum Data Set (MDS) assessment dated 12/9/21, identified R5 had moderately impaired cognition, required one personal physical assist with bed mobility, dressing, toilet use, transfers, and personal hygiene. The MDS section restraints and alarms indicated R5 used a bed rail daily. R5's medical record was reviewed and lacked any evidence R5 had used a restraint or bed rails during the MDS' ARD (assessment reference date) ending on 12/9/21. On 2/28/22, at 2:59 p.m. R5 was observed and interviewed in her room. R5 was seated in a recliner with a table next to her, when asked R5 indicated she slept in her recliner per her request and did not have a bed. R5 had no visible restraints, including bed rails, applied to her person, wheelchair or bed; nor were any devices present on R5's person or recliner which could limit access to her own body or restrict her movements. R9 R9's Admission Record printed 3/3/22, identified diagnoses including heart failure (heart does not pump blood effectively) and pneumonia.	F 641	2. An audit was completed by the director of nursing of current residents for correct coding of bed rail. 3. Education was provided to MDS coordinator on coding bed rails in the facility. 4. Audits of accuracy of assessments to be completed 1x/week for 4 weeks then 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	

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F 641	Continued From page 9	F 641		

R9's significant change Minimum Data Set (MDS) assessment dated 2/16/22, indicated R9 had intact cognition, used a wheelchair, did not walk, required staff assist with bed mobility and locomotion on and off the unit, required oxygen therapy. The MDS section restraints and alarms indicated R5 used a bed rail daily.

R9's medical record was reviewed and lacked any evidence R9 had used a restraint or bed rails during the MDS' ARD ending on 2/16/22.

On 3/1/22, at 8:46 a.m. R9 was observed in her bed and had had no visible restraints, including bed rails, applied to her person, wheelchair or bed; nor were any devices present on R9's person, bed, wheelchair, or recliner which could limit access to her own body or restrict her movements. When asked R9 indicated she had no restraints or devices that prevented movement.

R12
R12's facesheet, printed on 3/3/22, indicated a diagnosis of dementia (the loss of cognitive functioning such as thinking, remembering and reasoning).

R12's annual Minimum Data Set (MDS) assessment dated 1/13/22, indicated a BIMS (brief interview for mental status) score of 99, meaning R12 was not able to complete the interview. R12 required assistance of two staff for bed mobility and had total dependence of two staff for transfers. R12 did not walk.

Section P, the restraint assessment of the MDS, indicated R12 used a bed rail restraint daily.

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During an observation on 3/01/22, at 2:27 p.m., R12 was lying in bed sleeping; the bed had grab bars on either side (an assistive device used by a resident to enhance function and/or safety) but no bed rail restraints.

R13
R13's Admission Record printed 3/3/22, identified diagnoses including hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left side and macular degeneration (vision impairment).

R13's quarterly Minimum Data Set (MDS) assessment dated 1/20/22, indicated intact cognition, required one-person physical assist with dressing and personal hygiene, dependent on staff for bathing, no care refusal behaviors. The MDS section restraints and alarms indicated R5 used a bed rail daily.

R13's medical record was reviewed and lacked any evidence R5 had used a restraint or bed rails during the MDS' ARD ending on 1/20/22.

On 2/28/22, at 1:59 p.m. R5 was observed in her bed and had had no visible restraints, including bed rails, applied to her person, wheelchair or bed; nor were any devices present on R9's person, bed, wheelchair, or recliner which could limit access to her own body or restrict her movements. When asked R9 indicated she had no restraints or devices that prevented movement.

On 3/2/22, at 10:52 a.m. an interview with the director of nursing (DON) and administrator, indicated the MDS coordinator completed all resident's MDS assessments and was had her

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F 641	Continued From page 11	F 641		

MDS certification, and was not at the facility during the survey. The DON indicated the MDS coordinator completed the MDS for R5, R9, R12 and R13 and confirmed the MDS coordinator made an error when she coded the MDS section restraints and alarms indicated R5, R9, R12 and R13 used a bed rail daily. She confirmed there were no restraints in the facility. The DON indicated it was important to ensure MDS information was coded correctly as the MDS was used in the care planning process and was expected resident information was accurate and factual. The DON stated she would follow up with the MDS coordinator with education and correction action.

The Centers for Medicare and Medicaid Services (CMS) Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, dated 10/2018, identified a section labeled, "Section P: Restraints and Alarms," which directed to record the frequency a resident was restrained at any time during the 7-day look-back period (assessment reference date; ARD). The directions outlined proper interpretation of the physical restraint definition was necessary to ensure the devices used were being accurately assessed.

Facility policy titled Restraints, dated 10/15/21, indicated a physical restraint was any method or mechanical device, or equipment attached or adjacent to the resident's body that the individual cannot move easily that restricts freedom of movement. Examples included, side rails that a resident could not remove, or using bed rails to keep a resident from voluntarily getting out of bed. The policy did not include grab bars attached to a bed as a method of restraint.

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F 641	Continued From page 12	F 641		

R12's facesheet, printed on 3/3/22, indicated a diagnosis of dementia (the loss of cognitive functioning such as thinking, remembering and reasoning).

R12's annual Minimum Data Set (MDS) assessment dated 1/13/22, indicated a BIMS (brief interview for mental status) score of 99, meaning R12 was not able to complete the interview. R12 required assistance of two staff for bed mobility and had total dependence of two staff for transfers. R12 did not walk.

Section P, the restraint assessment of the MDS, indicated R12 used a bed rail restraint daily.

During an observation on 3/01/22, at 2:27 p.m., R12 was lying in bed sleeping; the bed had grab bars on either side (an assistive device used by a resident to enhance function and/or safety) but no bed rail restraints.

Facility policy titled Restraints, dated 10/15/21, indicated a physical restraint was any method or mechanical device, or equipment attached or adjacent to the resident's body that the individual cannot move easily that restricts freedom of movement. Examples included, side rails that a resident could not remove, or using bed rails to keep a resident from voluntarily getting out of bed. The policy did not include grab bars attached to a bed as a method of restraint.

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F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide routine removal of facial hair for 1 of 1 resident (R13) reviewed for activities of daily living (ADLs) who were dependent on staff for cares. Findings include: R13's Admission Record printed 3/3/22, indicated R13's diagnoses included hemiplegia (paralysis) and hemiparesis (weakness) following cerebral infarction (stroke) affecting left side and macular degeneration (vision impairment). R13's quarterly Minimum Data Set (MDS) assessment dated 1/20/22, indicated intact cognition, required one-person physical assist with dressing and personal hygiene, dependent on staff for bathing, no care refusal behaviors. R13's care plan printed on 3/1/22, indicated R13 had an ADL self-care performance deficit R/T [related to] stroke and needed extensive to total assist of ADL's and intervention indicated personal hygiene and dressing/grooming with extensive assist of one staff; encourage residents' participation with upper body. On 2/28/22, at 1:59 p.m. R13 was observed with varied lengths (approximately 1 inch) white whiskers on her chin. When asked if she was	F 677	F677 1. Resident that was identified, R13, was shaven on 3/3/2022 and a razor was placed in her room. 2. All residents that are dependent on ADL cares were audited for preferences on facial hair and care plans were updated to reflect resident preferences to be shaven or not. New razors were purchased if resident did not already have one. 3. Upon admission, resident will be asked on grooming preferences and this will be added to the care plan. Staff were educated on deficient practice initially on 3/16/2022 with follow up education 3/25/2022. 4. Audits on grooming will be completed 1x/week for 4 weeks and then 1x/month for 3 months to ensure care plans are followed based on resident preferences. All audit findings will be brought to the QAPI Committee for further review and recommendation.	4/2/22

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F 677	Continued From page 14	F 677		

aware of the chin hair, R13 indicated she would like her chin hairs shaved. R13 stated she got a bath once a week and staff had not shaved or offered her to be shaved.

On 3/01/22, at 12:34 p.m. R13 was seated in wheelchair well groomed, clean clothes, with varied lengths of white whiskers on chin, and indicated she had an electric razor somewhere in her room. R13 again indicated staff had not offered to shave her, and further indicated staff should notice when she needed to be shaved.

On 3/02/22, at 8:23 a.m. licensed practical nurse (LPN)-A, confirmed R13 needed extensive assistance with cares and was dependent on staff to assist her with shaving.

On 3/02/22, at 9:19 a.m. a phone interview with family member (FM)-A indicated he had previously visited R13 at the facility and he observed R13 with long chin hairs and indicated he expected staff to assess and shave R13's chin hairs.

On 3/02/22, at 9:53 a.m. an interview with nursing assistant (NA)-A indicated she assisted R13's with morning ADL cares this morning, and indicated R13 was dependent on staff for hygiene cares and shaving. NA-A stated R13 was expected to be shaved during morning cares, indicated R13 chin hairs were long and needed shaving, and further confirmed staff had not completed the task for R13. NA-A verified staff were to shave residents both male and female during cares.

Review of R13's progress notes identified there was no mention of any refusal of care.

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F 677	Continued From page 15 On 3/02/22, 7:52 a.m. interview with the director of nursing (DON) confirmed she would expect residents to be shaved during cares or anytime a resident is identified with facial hair and indicated shaving was a standard of care. Policy titled Activities of Daily Living dated 1/25/22, indicated any resident who is unable to carry out activities of daily living will receive necessary services to maintain good nutrition, grooming and personal and oral hygiene. ADLs are those necessary tasks conducted in the normal course of a resident's daily life. Included l these are the following: general personal, daily hygiene/grooming: care of hair, hands, face, shaving, applying makeup skin nails and oral care.	F 677		
F 688 SS=D	Increase/Prevent Decrease in ROM/Mobility CFR(s): 483.25(c)(1)-(3) §483.25(c) Mobility. §483.25(c)(1) The facility must ensure that a resident who enters the facility without limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable; and §483.25(c)(2) A resident with limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. §483.25(c)(3) A resident with limited mobility receives appropriate services, equipment, and assistance to maintain or improve mobility with the maximum practicable independence unless a	F 688		4/2/22

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F 688	Continued From page 16 reduction in mobility is demonstrably unavoidable. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide services to maintain and prevent further loss of range of motion (ROM) for 1 of 1 residents (R24) reviewed for hand contractures and limited ROM. Findings include: R24's facesheet printed on 3/3/22, indicated a diagnosis of rheumatoid arthritis (RA), a chronic inflammatory disease affecting joints. R24's quarterly Minimum Data Set (MDS) assessment dated 2/3/22, indicated R24 was cognitively intact, was able to eat independently, and required extensive assistance of one staff for bed mobility, transfers, moving about facility in a wheelchair, toileting, dressing and hygiene. R24 did not walk. R24's current plan of care indicated: --Initiated on 1/22/20, R24's care plan indicated R24 had arthritis and would be free of complications related to contractures, joint stiffness or a decline in mobility. --Revised on 5/16/21, R24's care plan indicated R24 had an activity of daily living (ADL) self-care deficit related to RA with contractures in hands and required extensive assistance with ADLs. In addition, the care plan indicated R24 would maintain current level of function. --Revised on 7/27/21, R24's care plan indicated R24 had an alteration in activity pursuits due to hand dexterity limitations. R24's care plan did not identify interventions to	F 688	F688 1. Orders for OT evaluation were received for the affected resident, R24, to treat for therapy and write a restorative program. 2. A review of our current residents was completed to ensure there was a restorative program in place. 3. Any potential resident with a noted decline will be discussed in IDT meeting and put on weekly CNP rounds notification. Staff were educated on our restorative nursing program on 3/16/2022. 4. Auditing of R24 participation in therapy along with other current residents identified in risk team meeting will be completed 1x/week for 4 weeks then 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	

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prevent further loss of ROM of R24's hands.

A provider note dated 2/23/22, indicated R24's pain medication had recently been increased due to joint and muscle pain, and R24 thought it helped her hands. The provider noted R24 had "a lot of arthritis in her hands" and had difficulty using a walker.

R24's last care conference note in the electronic medical record (EMR) was dated 3/11/2021, and was written by social worker (SW)-A. The note read:
All in attendance at the care conference including resident, staff, family members or others: family member (FM)-E and (FM)-F via phone. Registered nurse (RN)-D, SW-A, dietary supervisor (DS)-A and activities supervisor (AS)-A.
Document any significant discussion that occurred during the care conference: Family is seeing an improvement since getting an EC (essential caregiver). She is getting up and has her teeth in and hair done. Dietary reported on intake and weight. Activities reported on participation. Family was asked about the stuffed hash rounds. Nursing reported on health. SS (social services) reported on assessments. Nursing assistants (NA's) voiced that she is a pleasure to work with.

During an interview and observation on 2/28/22, at 2:35 p.m., both of R24's hands were significantly deformed. The fingers of R24's right hand were flexed at an angle and pointed towards her little finger. The middle finger was pressed against the palm of her hand. The fingers of R24's left hand were flexed at an angle and pointed towards her little finger. The ring finger

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pressed against the palm of her hand. R24 stated staff clipped her nails and she had never had an open sore in her palms of her hands from her fingernails pressing into them. R24 stated she used a sponge on a stick to clean under her flexed fingers. R24 was not able to extend her fingers independently; she used one hand to pry open the fingers of the opposite hand. R24 stated she had RA, and "my hands are crippled and getting worse." R24 stated she did not receive therapy and did not use hand splints. R24 stated "there are so many things I can't do."

During an interview on 3/2/22, at 11:34 a.m., licensed practical nurse (LPN)-A stated she was aware of R24's hand contractures, but was not aware of nursing assistants (NA) providing restorative services to R24's hands, stating "I don't think so, not for a long time anyway."

During an interview on 3/2/22, at 11:40 a.m., R24 stated "my hands are getting terrible," and as she was speaking, used one hand to open fingers of the other hand; not able to open any fingers independently. R24 stated staff had not offered to do hand exercises and stated she would like to have exercise as her hands were "getting worse."

During an interview on 3/2/22, at 11:44 a.m., nursing assistant (NA)-A who had worked at the facility for two years and was aware of contractures to R24's hands, stated she did not recall a time when R24 received hand exercises or wore a brace for her hands.

Occupational therapy (OT) notes were reviewed and indicated the following:
--On 3/1/21, R24 had OT services and therapy. Certified occupational therapy assistant

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(COTA)-C wrote that R24 had severe limitation of hands due to arthritis and that R24 was very enthused with developing an exercise program and was educated on various approaches towards treatment.
--On 3/4/21, COTA-C wrote that R24 would like to build hand strength for ambulation. In addition, R24 was educated on the use of putty exercise and stretching of hands and wrists, noting R24 was very enthused about regaining strength and was motivated.
--On 3/11/21, COTA-C wrote that R24 was motivated and pleased with skilled OT so far and stated her ROM had improved in several fingers.
--On 3/18/21, COTA-C wrote that R24 reported that her fingers may be getting more limber. The note indicated a restorative aide was educated to current process. (The note did not identify name of restorative aide).
--On 4/2/21, in a note written by occupational therapist (OT)-G, R24 was discharged from OT when her goal was met. The note indicated a restorative nursing aide would assist R24 to complete restorative exercise program for strength and activity tolerance with supervision. R24 needed verbal cueing but not physical assist, and tactile and verbal instructions/cues. The note further indicated R24 would be discharged from OT with restorative nursing program to improve strength, mobility, and fine motor coordination for feeding and self cares.
--On 4/5/21, (COTA)-D hand-wrote the following orders: Restorative Program: assisted ROM exercise, two sets of 10, fine motor activities, therapy with pegs to pick out of green putty and peg board jumping game.

During an interview on 3/2/22, at 1:45 p.m., the director of nursing (DON) provided OT notes

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regarding R24. The DON stated she was aware of R24 and the deformity of her fingers on both hands. The DON was not aware if R24 received OT or restorative nursing services for her hands. The DON stated the facility had a restorative nursing program, and an aide came in two to three times a week to provide restorative services to residents. The DON was not sure if there was a list of residents who received these services and since the restorative aide was on vacation, was not available to ask. When asked what happened to R24's restorative services after R24 completed OT services on 4/2/21, the DON stated she would try to find out.

During an interview on 3/3/22, at 8:08 a.m., the administrator provided additional OT notes regarding R24. The administrator was informed of the concern that it appeared restorative nursing services were never started or were discontinued for R24 without a documented reason for this. The administrator was also informed nursing staff were not able to say if R24 ever had restorative services, and was also informed R24 would like restorative services in order to increase mobility of her hands. The administrator was unaware of this and suggested speaking to SW-A to see if this was discussed at R24's care conferences.

During an interview on 3/3/22, at 10:46 a.m., SW-A did not recall a discussion about R24's hand contractures at care conferences in the past year. When asked to see notes from care conferences for R24 from the past year, SW-A stated notes were only taken if the the resident or family raised a concern. The last care conference note documented in the EMR for R24 was from 3/11/21. SW-A verified that was the last care conference for R24. SW-A stated residents were

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good about coming up to her and telling her when they had a concern, but admitted information was not sought out from residents and families outside of care conferences. At 10:53 a.m., the administrator joined the conversation and became aware of notes not being taken unless a resident or family raised a concern.

During an interview on 3/3/22, at 12:44 p.m., SW-A stated she was responsible for sending out care conference invitations to family members. SW-A informed residents of the date and time of care conferences when she performed a residents memory and cognition assessment, and asked at that time if the resident would like to attend. Family attended via telephone and residents attended in person. In addition to the social worker, the MDS nurse, dietary supervisor and the activities supervisor attended. If a resident was receiving OT or PT, someone from therapy attended. SW-A stated care conferences were held quarterly, or sooner if a significant change. SW-A stated she did not keep notes for the team discussion, but rather each disciple documented their own notes in the EMR. SW-A stated R24 choose not to participate in her care conferences. If a resident and/or family did not want to attend, a care conference wasn't held. If staff saw something unusual for a resident, they brought it up at morning report (a meeting of facility leaders that occurred Monday through Friday). SW-A acknowledged that if R24 did not attend care conferences and therapy only attended if there were therapy concerns, that R24's hand contractures could have been overlooked.

During an interview on 3/3/22, at 1:36 p.m., the DON stated there had been a period of time when

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the restorative aide was not on the schedule to perform restorative services for residents, and as a result R24 may have fallen through the cracks. The DON stated she wondered if any other residents had fallen through the cracks. The restorative aide, (NA)-E was back on the schedule to provide services to residents. The DON acknowledged that without evidence indicating otherwise, R24 did not receive restorative services of any kind, but in particular to her hands, for the past year. DON acknowledged this oversight may have worsened R24's hand contractures causing further limitation in her ability to use her hands. The DON stated this was a concern and she would look into this further.

Facility policy titled: Nursing Care Implementation and Screening, dated 4/21/21, indicated the purpose was to provide restorative nursing care to each resident and to identify residents appropriate for restorative nursing program. Each resident would receive restorative nursing care to the extent possible, based on needs and problems defined in nursing assessments. Restorative care would be outlined in the the plan of care. Care would include measures to prevent complications and contractures, maintain strength and self-care abilities, promoted mobility and feeling of well-being. The goal of restorative nursing care was to attain and maintain the maximum possible independence through interventions for each resident. The policy further outlined who was responsible for restorative services, ultimately resting with the director of nursing services; the process to identify residents needing restorative services and how to obtain a provider order. Long term goals were to increase a residents ability to function at his or her highest

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F 688	Continued From page 23 practicable level for improved quality of life.	F 688		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.	F 690		4/2/22

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F 690	Continued From page 24 This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to provide physician's diagnosis and continued need for an indwelling urinary catheter for 1 of 1 resident (R14) who was reviewed for urinary catheter. Findings include: R14's face sheet, printed on 3/2/22; did not indicate indwelling catheter or diagnosis for catheter. R14's quarterly Minimum Data Set (MDS) assessment, dated 1/19/22, indicated severe impaired cognition; needed assistance with personal hygiene and toileting, and had an indwelling urinary catheter. Diagnoses indicated; medically complex conditions; did not indicate indwelling urinary catheter or diagnosis. R14's facility "Diagnosis Report," printed on 3/2/22; did not indicate indwelling catheter or diagnosis. R14's facility "Order Summary Report," printed on 3/2/22, indicated orders for catheter; Order date: 4/18/19- catheter: Indwelling foley 16 fr. (french) with 30 cc balloon. Change catheter monthly and PRN(as needed) if dislodged or plugged and unable to clear with irrigation. R14's care plan dated 1/19/19 and revised on 2/4/22, indicated having an indwelling catheter related to urinary retention evidenced by unable to void on own and large amounts of post void residual noted on bladder scan. R14's interventions directed staff to monitor for	F 690	F690 1. A diagnosis or urinary retention was added to affected resident's, R14, diagnosis list. 2. All residents with a catheter were reviewed to ensure there is a diagnosis. 3. Education was given to licensed nursing staff on ensuring the need for a diagnosis for a foley catheter 3/16/2022. 4. Audits will be completed on new catheters 1x/week for 4 weeks then 1x/moth for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	

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pain/discomfort due to catheter, monitor/record/report to health care provider any signs and symptoms of urinary tract infection (UTI), complete catheter care twice daily, leg bag applied during the day covered with white cloth bag and straight drainage bag applied at night, report unusual observations/conditions to nurse.

Review of physician order, provided verbally on 1/12/19, signed by physician on 1/14/19, indicated to bladder scan R14 for urinary retention. Order indicated; if greater than 400cc, straight cath four times a day for urinary retention related to unspecified fracture of sacrum (triangular-shaped bone in the lower back between hip bones), subsequent encounter for fracture with routine healing, type 2 diabetes mellitus with other diabetic neurological complications.

Review of progress notes dated on 1/17/19, indicated provider was contacted by nursing staff and updated on R14's continued difficulty with voiding and needing to be straight-cathed. Physician discontinued orders for straight cath, orders given for indwelling foley catheter, no diagnosis provided.

Review of provider visit notes dated 1/3/22 and 2/23/22, did not mention indwelling catheter or diagnosis.

Review of progress note dated 2/10/22, indicated nursing staff completed monthly routine indwelling catheter change.

During observation and interview, on 02/28/22 at 4:06 p.m., R14 was noted to have a urinary catheter, leg bag attached to side of left leg. Urinary bag observed at time to have pale yellow

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colored urine, tubing appeared patent. R14 indicated having no issues or concerns with catheter at time.

During interview and observation, on 03/01/22 at 1:39 p.m., R14 denied having any recent urinary infections or problems with catheter. R14 indicated she loved having the catheter because she didn't have to get up to go to the bathroom as often.

During interview, on 03/01/22 at 2:39 p.m., registered nurse (RN)-C indicated while reviewing urinary catheter orders in electronic medical record (EMR), indwelling catheter order originated on 4/18/19. RN-C verified no indwelling catheter or diagnosis listed in EMR.

During interview, on 03/02/22 at 8:31 a.m., RN-B indicated, to her knowledge, R14 had not had a history of frequent or recent UTI's. RN-B indicated R14 had an indwelling catheter placed for urinary retention approximately a couple years ago. RN-B indicated, to her knowledge, R14 has not had urinary catheter removed or completed trial for voiding.

During interview, on 03/03/22 at 10:55 a.m., director of nursing (DON) indicated not being aware of reason R14 had indwelling catheter, was aware R14 had one. DON indicated when reviewing provider notes and nursing progress notes, she could not find a diagnosis for indwelling catheter. Interim DON indicated, "I cannot find it, but I know I have seen it listed here before." DON indicated she wasn't sure why R14's indwelling catheter hadn't been removed or why a voiding trial hadn't been attempted in 2 years since being initially placed.

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F 690	Continued From page 27 The facility policy titled, "Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen," date reviewed/revised 5/27/21, which included catheterization is medically necessary and is not to be used solely for nurse/physician convenience, ensure appropriate use and care of urinary catheters, catheter removal is indicated once usage for has been resolved, educate resident and/or family on the risks and benefits of using the indwelling catheter.	F 690		
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 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 ensure oxygen administration was consistently monitored according to physician orders for 2 of 2 residents (R9 and R11) reviewed for oxygen use. Findings include: R9's Admission Record printed 3/3/22, indicated R9 was admitted 11/16/20 and had diagnoses of heart failure (heart does not pump blood effectively) and pneumonia.	F 695	F695 1. Upon identification of residents, R9 and R11, with low oxygen, empty tanks were replaced with full tanks. 2. A review of all residents who use oxygen was completed to identify those who use portable oxygen tanks. 3. Education was provided to nursing staff on the policy and procedure of oxygen use. Education was also provided to include how to change the regulator on the tanks. Signage was placed in each resident room that uses oxygen indicating	4/2/22

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F 695	Continued From page 28 R9's significant change Minimum Data Set (MDS) assessment dated 2/16/22, indicated R9 had intact cognition, used a wheelchair, did not walk, required staff assist with bed mobility and locomotion on and off the unit, and required oxygen therapy. R9's care plan printed 3/2/22, indicated R9 had altered cardiovascular status and an intervention of oxygen therapy 2 LPM (liters per minute) via nasal cannula. The Medication Record printed 3/2/22, indicated R9 had an order for oxygen via nasal cannula 2 liters per minute. On 2/28/22, at 6:27 p.m. R9 was observed seated in a wheelchair in the dining room eating a meal. R9 was observed with an oxygen cannula in her nares, with oxygen tubing attached to a portable oxygen tank. The gauge attached to the tank was turned to 3 LPM and the needle of the gauge was in the red, "REFILL" zone. R9 was breathing easy without respiratory distress. On 3/01/22, at 8:46 a.m. registered nurse (RN)-A stated nurses and nursing assistants were responsible for changing oxygen tanks when the oxygen was empty and further indicated staff were expected to look at the gauge on the oxygen and if in the red, the oxygen was empty in the tank. RN-A stated staff received training on how to change a portable oxygen tank. On 3/02/22, at 7:48 a.m. an interview with the director of nursing (DON) stated staff should replace an oxygen tank when they see it's in the red, refill zone. The DON stated residents' oxygen tanks should not go empty during a meal, and	F 695	to check oxygen levels before transporting. 4. Audits of residents on portable oxygen will be completed to ensure that tanks are full 1x/week for 4 weeks then 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	

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nursing staff and nursing assistants were responsible to assess and change the portable oxygen tank when the oxygen was in the red, refill zone.

On 3/02/22, at 8:24 a.m. licensed practical nurse (LPN)-A stated anyone who noticed an oxygen tank in the red zone were responsible to change the oxygen tank and staff were expected to check resident's oxygen prior to the resident brought to the dining room for a meal. LPN-A further indicated staff were responsible during the meal to ensure resident's with oxygen did not run out of oxygen.

R11
R11's Face sheet printed 3/3/22, indicated R11 was admitted to facility on 11/30/20, and had diagnoses including; cancer, anemia (a condition that causes lack of red blood cells in bloodstream), atrial fibrillation (a condition that causes irregular heart rate and poor blood flow), coronary artery disease (a disease or damage to the hearts major blood vessels), congestive heart failure (a chronic condition of hearts ability to pump blood), and respiratory failure (a condition causing lungs to function poorly).

R11's annual Minimum Data Set (MDS) assessment dated 1/13/22, indicated R11 had intact cognition, used a wheelchair, did not walk, required staff assist with bed mobility, transfers, locomotion on and off unit, and required oxygen therapy.

R11's care plan printed 3/3/22, indicated R11 had congestive heart failure and altered respiratory status, difficulty breathing related to lung cancer; and an intervention of oxygen therapy 3 LPM

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(liters per minute) via nasal cannula at all times.

On 2/28/22, at 5:22 p.m. R11 was observed while in room, sitting upright in bed, with nasal cannula in nares, oxygen tubing connected to nasal cannula and oxygen concentrator, oxygen concentrator was turned in the "Off" position. Nursing assistant (NA)-B presented to R11's room, indicated being on orientation training status, but indicated knowing about R11's cares a little bit. NA-B indicated R11 should be on continuous oxygen therapy. R11 was breathing easy without respiratory distress.

On 2/28/22, at 6:12 p.m., R11 was seated in a wheelchair in the dining room eating a meal. R11 was observed with a nasal cannula in his nares, with oxygen tubing attached to a portable oxygen tank. The gauge attached to the tank was turned to 3 LPM and the needle of the gauge was in the red, "REFILL" zone. R11 was breathing easy without respiratory distress. The interim DON was in the dining room at time of surveyor observation and verified R11's oxygen tank was empty. The interim DON indicated there was a little oxygen in R11's portable tank prior to entering dining room and informed surveyor, "Oxygen tanks don't last too long." The interim DON left dining room.

On 2/28/22, at 6:18 p.m., the DON returned to dining room with a new, full portable oxygen tank for R11. The DON indicated to surveyor, full portable oxygen tanks, will typically last someone on continuous oxygen therapy, approximately 3 hours before tank needs to be replaced; depending upon amount of oxygen liters used . The DON indicated being familiar with R11's care needs, verified R11 was on continuous oxygen

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F 695	Continued From page 31 therapy at 3LPM. During interview on 3/01/22, at 1:21 p.m., NA-C indicated she checks residents on oxygen therapy to ensure oxygen is working appropriately, checks to make sure oxygen tubing is not kinked or visibly damaged. NA-C indicated replacing oxygen tanks when empty or when needed. NA-C indicated oxygen tubing is replaced weekly by nursing staff. When interviewed on 3/01/22, at 1:27 p.m., NA-D indicated all aides are responsible to make sure oxygen is on and working, tubing for oxygen is not kinked or damaged. NA-D indicated if oxygen tank empty, all aides are able to replace. NA-D indicated if gauge on oxygen concentrator is in the "Red" color area, tank is empty and needs to be replaced. NA-D indicated oxygen tubing is changed by nursing staff, but not sure how often. During interview on 3/01/22, at 1:47 p.m., RN-B indicated all aides and nurses have been educated on use of oxygen and equipment during orientation and complete online training annually. RN-B indicated any nurse or aide can check oxygen tank status, and change out empty oxygen tanks. RN-B indicated nursing staff are responsible to change out all oxygen tubing and wipe down respiratory equipment once per week, which is a triggered task in electronic medical record (EMR) system. RN-B indicated empty tanks needing to be replaced are observed when oxygen gauge is in the "Red" range. RN-B indicated going through a lot of tanks recently, staff forget to shut them off when switching residents from portable oxygen tanks to concentrator once in resident's room.	F 695		

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F 695	Continued From page 32 On 3/02/22, at 12:48 p.m., R11 was observed to be sitting in wheelchair at dining room table, portable oxygen tank low, oxygen gauge near "Red" or empty zone. Staff noticed low oxygen level and assisted R11 back to his room, portable oxygen tank was changed. During an interview, on 3/03/22 at 11:19 a.m., DON indicated it is her expectation that all staff replace any oxygen tanks prior to running out, change oxygen tubing from portable oxygen to concentrator when needed, ensure oxygen is running, and oxygen tubing is patent. DON indicated a resident on oxygen therapy should not run out of oxygen at any time. DON indicated all nursing staff are educated on use of oxygen and equipment during orientation and annually. DON provided most recent facility education on oxygen titled Oxygen Safety dated 8/19/21, indicated: - Administer supplemental oxygen safely to a resident, transport oxygen in and off the location. The facility policy entitled Oxygen Administration, Safety, Mask Types dated 5/19/21, indicated the following: 1. Oxygen administration is carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of oxygen will be on duty and is responsible for the proper administration of oxygen to the resident. 2. Continuing education will be provided annually on safety, handling and usage requirements for employees that handle medical gas (oxygen).	F 695		
F 761 SS=D	Label/Store Drugs and Biologicals	F 761		4/2/22

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F 761	Continued From page 33 CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure doses of controlled substances were stored in a manner to reduce the risk of theft and/or diversion in 1 of 2 refrigerators observed in use for medication storage. This had potential to affect 1 of 1 residents who received this medication. Findings include:	F 761	F761 1. A locked box was obtained for refrigerator for medication storage. Locked box is affixed inside refrigerator. 2. All refrigerators were examined to ensure no other medications needed to be placed in a locked box. 3. Education was provided to licensed nurses and medication aids about the policy and procedure on medication	

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F 761	Continued From page 34 During observation and interview on 3/3/22, at 8:58 a.m. in the 500 nurses station the director of nursing (DON) unlocked the medication room and unlocked the medication refrigerator. Inside the refrigerator was a box of diazepam 10 mg suppositories and bottle of lorazepam 2 mg/ml liquid. The medications were in the inside of the refrigerator and were not in a separate compartment or affixed to the inside of the refrigerator in order to prevent theft. The DON indicated she was not aware the lorzaepam or diazepam needed to be permanently affixed to the refrigerator. Facility policy titled Medications: Acquisition Receiving Dispensing and Storage dated 2/8/22, indicated: -Controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in a separate, locked, permanently fixed compartments except when a single unit package drug distribution is used. If the medication requires a refrigerator, these need to be locked in a separate container. These drugs will be reconciled at least daily through an appropriate system of records of receipt and disposition established by the licensed	F 761	storage. 4. Audits will be conducted to ensure medication is in the locked box, in the locked refrigerator, in the locked medication room 1x/week for 4 weeks then 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.	F 880		4/2/22

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F 880	Continued From page 35 §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct	F 880		

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F 880	Continued From page 36 contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an unvaccinated resident socially distanced during congregate dining for 1 of 3 residents (R21). This had the potential to affect all 55 residents who resided in the facility. In addition, the facility failed implement proper infection control measures for catheter care for 1 of 1 resident (R14) who was observed for catheter care. Findings include: Unvaccinated Residents: R21's Admission Record printed 3/3/22, indicated R21 was admitted 12//21, and diagnoses included COVID-19, mild cognitive impairment, and muscle weakness. R21's significant change in status Minimum Data	F 880	F880 Part I. 1. Upon notification of deficiency, a Plexiglas shield was immediately placed at the table of the affected resident. 2. Upon admission, vaccination status will be documented immediately and given to administrator to track vaccination status and ensure CDC guidelines are followed. 3. Initial education was provided to staff on 3/16/22 on infection control practices with follow up education on 3/25/2022. An RCA was conducted on 3/23/22 with findings of lack of vaccination reporting to administrator, who is currently the facility reporter. Education on the CDC guidelines for masking and social distancing was provided to staff with a competency evaluation at the end with a completion date of 4/02/22.	

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F 880	Continued From page 37 Set (MDS) assessment dated 1/19/22, identified R21 had severe cognitive impairment, demonstrated no rejection of care, required extensive assistance with transfers, dressing and required setup help with eating. R21's care plan revised printed 3/3/21, identified R21 had an ADL self-care performance deficit related to weakness post pneumonia and COVID and interventions included cueing with eating and assistance with meal set up. The care plan did not identify interventions of social distancing or wearing a mask. On 3/3//22, at 9:00 a.m. R21 was observed seated in a wheelchair at the dining room at a table, approximately 4 x 4 feet (ft) round table with one other resident seated with him at the table. No residents in the dining room were observed to wear masks. Staff were not observed to offer or coach residents to wear masks or to socially distance six feet or greater as recommenced by CDC. Staff and residents were observed passing by R21 within two to three feet throughout the meal. On 3/3/22, at 8:45 a.m. the director of nursing (DON) stated unvaccinated residents were to be offered a mask, and seated 6 feet apart from other residents to social distance. The DON confirmed R21 was COVID-19 unvaccinated and was not socially distanced during dining and further indicated R21 did not meet CDC requirements for unvaccinated residents during dining. The DON indicated when R21 was admitted to the facility he was in his room for 14 days and was placed him at a dining table with another resident for socialization.	F 880	4. Audits throughout the facility will be completed on each shift to ensure social distancing is maintained by all staff and residents during various activities. These audits will be conducted 7 days/week for four weeks or until 100% compliance is obtained, then 1x/week for 1 month, 1x/month 2 months All audit findings will be brought to the QAPI Committee for further review and recommendation. Part II. 1. All nursing staff were educated on the proper infection control techniques on catheter cares. 2. A review of all residents with a catheter was completed and added to our auditing to ensure compliance with infection control. 3. Initial education was provided to staff of 3/16/22 with follow up education provided on 3/25/2022 to nursing staff and auditing will continue to ensure 100% compliance. An RCA was conducted on 3/23/22 to identify the root cause of the infection control deficiency. Staff competencies and education will be completed by 4/02/22. 4. The technique of changing from overnight bag to leg bag will be observed and audited on all residents with a Foley Catheter. 1x/week for 4 weeks then 1x/moth for 3 months. Audis for proper cleaning of equipment/environmental cleaning will be completed on all shifts every day for one week, then 1/week for 4 weeks and 1x/month for 3 months All audit findings will be brought to the QAPI Committee for further review and	

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F 880	Continued From page 38 On 3/3/22, at 12:07 p.m. the administrator indicated R21 was not vaccinated against COVID-19 and was not seated 6 feet apart from other residents during dining. The administrator indicated she expected the resident seated 6 feet apart and to social distance from other residents. Policy titled Emerging Threats Acute Respiratory Syndromes Coronavirus COVID Enterprise dated 2/8/22, indicated: -Residents should wear a cloth face covering or surgical mask, if supply allows, during direct care, anytime they're outside of their room, and/or within six feet of distance from others cannot be maintained. If residents are unable to wear face covering, staff will attempt to keep the resident at least six feet apart from other residents. Residents may participate in activities and communal dining without masks or social distancing if all resident participants are fully vaccinated. unvaccinated The Center for Disease Control (CDC) "Interim Infection Prevention and Control Recommendations to Prevent SARS-CoV-2 Spread in Nursing Homes" updated 2/2/22, recommended source control and physical distancing (when physical distancing is feasible and will not interfere with provision of care) are recommended for everyone in a healthcare setting. This is particularly important for individuals, regardless of their vaccination status, who live or work in counties with substantial to high community transmission or who have: Are not up to date with all recommended COVID-19 vaccine doses. R14 R14's quarterly Minimum Data Set (MDS)	F 880	recommendation.	

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F 880	Continued From page 39	F 880		

assessment dated 1/19/22, indicated R14 had severe cognitive impairment, needed assistance with bed mobility, transfers, locomotion on and off unit, dressing, toileting, personal hygiene and bathing cares; requires use of wheelchair, didn't ambulate. The MDS further indicated R14 had an indwelling Foley catheter (closed sterile system, with a tube inserted into the bladder and left in place to drain urine).

R14's care plan last revised 2/4/22, indicated indwelling catheter related to urinary retention evidenced by unable to void on own and large amounts of post void residual (PVR) noted on bladder scan. Interventions included catheter care by certified nursing assistant (CNA) twice daily (BID).

On 3/2/22, at 8:10 a.m., R14 was observed sitting on toilet in bathroom; her large (night-time) drainage bag had a clip-on end that was attached to side of toilet paper roll holder, beside R14. Nursing assistant (NA)-A was in bathroom at that time gathering supplies to empty drainage bag. NA-A applied clean gloves and began to empty R14's urine from urinary drainage bag into graduated container. Once the bag was empty, NA-A clamped the tubing on the bottom of the bag, cleaned end of tubing with alcohol wipe and connected into holder attached to bag, detached tubing at top of bag from indwelling catheter tip, then pinched the indwelling catheter tip closed with her gloved fingers. NA-A continued to keep indwelling catheter tip pinched closed with gloved fingers and connected tubing to drainage bag around clip at top of drainage bag to keep off flooring. NA-A opened an alcohol wipe packet, cleansed tip of indwelling catheter with alcohol wipe with right gloved hand, while keeping

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F 880	Continued From page 40	F 880		

indwelling catheter tubing pinched off with gloved fingers of left hand. NA-A discarded alcohol wipe and picked up small (day) drainage bag up off bathroom flooring with gloved right hand. Day bag, tubing, attachment tip for catheter observed to be touching bathroom flooring at time. NA-A proceeded with attaching tip of day bag towards indwelling catheter tip, was then stopped by surveyor due to risk for potential infection. Surveyor asked NA-A about process of catheter and drainage bag care. NA-A indicated she shouldn't have had day bag lying on floor and should have alcohol wiped end of attachment tip from day bag, prior to attempting to connect end to indwelling catheter tip. NA-A confirmed she would have broken infection control process had surveyor not stopped her when surveyor did. NA-A cleaned both indwelling catheter end and attachment tip of day bag with alcohol wipes prior to connecting, then connected leg bag to R14's leg. After completion of catheter and drainage bag cares, NA-A indicated working at facility for 2 years, had completed catheter care training during orientation (on-the-job training), and required to complete online yearly.

During interview, on 3/2/22 at 8:31 a.m., registered nurse (RN)-B indicated all nursing staff, including aides; can provide catheter cares, change drainage bags. RN-B indicated aides received catheter care education during orientation, online, and yearly skills check off list. RN-B indicated if noticing staff are not performing catheter cares correctly, would show them appropriate cares, reminding them of infection control measures. RN-B indicated catheter bags should not be placed on flooring. RN-B stated she expected when cleaning catheter bag attachment end tip and indwelling catheter end tip, staff clean

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F 880	Continued From page 41	F 880		

both ends with alcohol wipes prior to connecting them to reduce risk for infection.

During interview, on 3/3/22 at 10:55 a.m., director of nursing (DON) indicated nursing aides can provide catheter cares, licensed nursing oversees aides to ensure cares completed efficiently. DON indicated all nursing aides at facility were certified and should know when coming to work at facility how to complete clean catheter cares already. DON indicated when nursing aides were hired, they completed online clean catheter care training and completed a check-off list with an aide who was preceptor. DON indicated process for clean catheter care consisted of cleaning peri-area from front to back using soap and water, cleaning hub of indwelling catheter with soap and water, or alcohol wipes, or betadine. DON indicated prior to connecting catheter bag end to hub of indwelling catheter, the catheter bag tip should be cleansed with soap and water, or alcohol wipes, or betadine. DON indicated catheter bags should not be placed on flooring, expectation is if catheter bag is on floor, either replace bag or clean catheter bag tip with soap and water, or alcohol wipes, or betadine, prior to connecting it to hub of indwelling catheter.

Facility policy titled, "Catheter: Care, Insertion & Removal, Drainage Bags, Irrigation, Specimen," revised date, 5/27/21, emptying of drainage bag included; catheter tubing should never be allowed to touch the floor, do not allow tip of tubing to touch sides of measuring container or any surface; when done clean drainage port tip with alcohol wipe and replace in the holder; make sure the drainage bag and tubing are appropriately placed.
Connecting leg bag included; swab attachment

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F 880	Continued From page 42 site of catheter with alcohol pad, clamp catheter, after wiping cap with alcohol pad disconnect catheter and drainage tubing and do not allow ends to touch anything, place cap over the end of the drainage tubing, do not let drainage tubing touch floor, remove leg bag cap and connect catheter, store cap in designated bag or container, unclamp catheter.	F 880		

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	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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K 000	INITIAL COMMENTS FIRE SAFETY An annual Life Safety recertification survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division on 03/01/2022. At the time of this survey, Good Samaritan Society-St James was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: IF PARTICIPATING IN THE E-POC PROCESS, A PAPER COPY OF THE PLAN OF CORRECTION IS NOT REQUIRED.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/28/2022

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/01/2022**

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
K 000	Continued From page 1 Healthcare Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145 St. Paul, MN 55101-5145, OR By email to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A detailed description of the corrective action taken or planned to correct the deficiency. 2. Address the measures that will be put in place to ensure the deficiency does not reoccur. 3. Indicate how the facility plans to monitor future performance to ensure solutions are sustained. 4. Identify who is responsible for the corrective actions and monitoring of compliance. 5. The actual or proposed date for completion of the remedy. Good Samaritan Society-St James is a one-story with partial basement facility that was determined to be of Type V(000) construction and is fully sprinklered throughout. The facility has a fire alarm system with smoke detection in the corridors and spaces open to the corridors, which is monitored for automatic fire department notification. The original building was constructed in 1963 with building additions in 1965, 1993, 1996, 2002.	K 000		

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K 000	Continued From page 2 The facility has a capacity of 51 beds and had a census of 29 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 271 SS=E	Discharge from Exits CFR(s): NFPA 101 Discharge from Exits Exit discharge is arranged in accordance with 7.7, provides a level walking surface meeting the provisions of 7.1.7 with respect to changes in elevation and shall be maintained free of obstructions. Additionally, the exit discharge shall be a hard packed all-weather travel surface. 18.2.7, 19.2.7 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain discharge from exits per NFPA 101 (2012 edition), Life Safety Code, section 7.1.6.2. This deficient finding could have a patterned impact on the residents within the facility. Findings include: On 03/01/2022| between 10:30 AM to 12:30 PM, observation revealed that the outside sidewalk from the Post Acute Emergency Exit was observed to have an approximately 3-inch rise in elevation on the concrete walkway. An interview with the Interim Administrator and the Facility Maintenance Director verified this finding at the time of discovery.	K 271	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by 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 provisions of federal and state law. For the purposes 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 Operations Manual. K9271 1. Due to weather changes, the area is	4/2/22

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K 271	Continued From page 3	K 271	currently level. The sidewalk by the post-acute will be removed and replaced to be a solid base and a flat surface by the exit door walkway. 2. An audit of the facility sidewalks around the facility and exit doors was completed to ensure no raised concrete in other areas. 3. Going forward, weekly grounds checks around the facility sidewalks are to be completed to ensure level walking surfaces free of obstructions. 4. In addition to the weekly grounds checks, auditing of the sidewalks by the exit doors will be completed 1x/week for 4 weeks and 1x/month for 3 months. All audit findings will be brought to the QAPI Committee for further review and recommendation.	
K 928 SS=D	Gas Equipment - Labeling Equipment and Cylind CFR(s): NFPA 101 Gas Equipment - Labeling Equipment and Cylinders Equipment listed for use in oxygen-enriched atmospheres are so labeled. Oxygen metering equipment and pressure reducing regulators are labeled "OXYGEN-USE NO OIL." Flowmeters, pressure reducing regulators, and oxygen-dispensing apparatus are clearly and permanently labeled designating the gases for which they are intended. Oxygen-metering equipment, pressure reducing regulators, humidifiers, and nebulizers are labeled with name of manufacturer or supplier. Cylinders and	K 928		4/2/22

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K 928	Continued From page 4 containers are labeled in accordance with CGA C-7. Color coding is not utilized as the primary method of determining cylinder or container contents. All labeling is durable and withstands cleaning or disinfecting. 11.5.3.1 (NFPA 99) This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain proper oxygen cylinder storage per NFPA 99 (2012 edition), Health Care Facilities Code, section 11.6.2.3 (11). This deficient finding could have an isolated impact on the residents within the facility. Findings include: On 03/03/2022, between 10:30 AM to 12:30 PM, observation revealed that a free-standing oxygen cylinder was sitting on the floor in Resident Room 405. This tank was not in a storage device or secured to the wall to prevent it from falling. An interview with the Interim Administrator and the Facility Maintenance Director verified this finding at the time of discovery.	K 928	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by 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 provisions of federal and state law. For the purposes 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 Operations Manual K928 1. Upon discovery, oxygen tank in resident room was immediately placed into a cart to secure it. 2. An audit of all residents who use oxygen was completed to ensure no loose tanks and all are secured. Education was provided to staff on the use of oxygen tanks and how to properly store them. 3. Weekly checks on oxygen tanks in resident rooms was added to our resident room audit checklist.	

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K 928	Continued From page 5	K 928	4. In addition to the weekly room audit checks, audits will be completed 2x/week for 4 weeks and 1x/month for 3 months to ensure compliance of oxygen tanks. All audit findings will be brought to the QAPI Committee for further review and recommendation.	