DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
June 28, 2022

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: CCN: 245549
Cycle Start Date: April 14, 2022

Dear Administrator:

On May 4, 2022, we notified you a remedy was imposed. On June 21, 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 June 15, 2022.

As authorized by CMS the remedy of:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective July 14, 2022 did not go into effect. (42 CFR 488.417 (b))

In our letter of May 4, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 14, 2022 due to denial of payment for new admissions. Since your facility attained substantial compliance on June 15, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Electronically delivered
May 4, 2022

Administrator
Good Samaritan Society - Mountain Lake
745 Basinger Memorial Drive
Mountain Lake, MN 56159

RE: CCN: 245549
Cycle Start Date: April 14, 2022

Dear Administrator:

On April 14, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby 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 July 14, 2022.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective July 14, 2022. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective July 14, 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.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of

nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by July 14, 2022, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Mountain Lake will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from July 14, 2022. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions.

However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

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 October 14, 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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245549	A. BUILDING _____ B. WING _____	C 04/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 4/11/22 - 4/14/22, a survey for compliance with Appendix Z, Emergency Preparedness Requirements, §483.73(b)(6) was conducted during a standard recertification survey. The facility was IN compliance. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Although no plan of correction is required, it is required that the facility acknowledge receipt of the electronic documents.	E 000		
F 000	INITIAL COMMENTS On 4/11/22 - 4/14/22, 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 H5549021C (MN81958), 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 substantial compliance with the regulations has been attained.	F 000		

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

Electronically Signed | 05/13/2022

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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		5/20/22

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F 550	Continued From page 2 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure infection control measures were implemented in a dignified manner for 1 of 1 resident (R25) who was reviewed for contact isolation precautions related to recent hospitalization for urinary tract infection. Findings include: Centers for Disease Control (CDC) guidance dated 2/2/2022, includes: Empiric use of Transmission-Based Precautions (quarantine) is recommended for residents who are newly admitted to the facility and for residents who have had close contact with someone with Covid-19 infection if they are not up to date with all recommended COVID-19 vaccine doses. In general, quarantine is not needed for asymptomatic residents who are up to date with all COVID-19 vaccine doses or who have recovered from Covid-19 infection in the prior 90 days; potential exceptions are described in the guidance. However, some of these residents should still be tested as described in the testing section of the guidance. R25 undated face sheet indicated initial admission date of 2/28/22, with diagnosis including infectious gastroenteritis (infection of intestines) and colitis (inflammation of of the inner lining of the colon), Clostridium difficile (infection of large intestine caused by antibiotic use) , myasthenia gravis (autoimmune disease affecting communication between nerves and muscles), and urinary tract infection.	F 550	Disclaimer Statement: 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. This disclaimer statement applies to all listed citations on the 2567 received on 5/04/2022. F550-Resident Rights Immediately discontinued quarantine/isolation precaution for resident (R25) per guidance, with CDC guidelines for isolation of residents up-to-date with vaccination status. All residents have the potential to be affected by the same deficient practice. Reviewed all residents in isolation to ensure they meet CDC guidelines and our infection prevention and control policy. Staff were educated on the	

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F 550	Continued From page 3 R25's "Immunization Report" indicated R25 received COVID-19 vaccine on 2/25/2, 3/25/21 and 11/5/21. R25's Medicare 5 day Minimum Data Set (MDS) assessment dated 3/29/22, indicated R25 was cognitively intact with no behaviors, required limited assist of one for transfers and toileting and was frequently incontinent of urine. A progress note dated 3/31/22, indicated R25 had blood in her urine, flushed and diaphoretic and was transferred to the emergency department for further evaluation. A progress note dated 4/5/2022, at 2:25 p.m., indicated R25 returned from the hospital and was alert and oriented. During interview and observation on 4/11/22, at 3:09 p.m., R25 was sitting in her wheelchair in her room. An isolation cart was outside of her room with a sign on her door indicating contact isolation. Nursing Assistant (NA)-A gowned and gloved and entered R25's room. R25 using a raised voice stated "I don't belong in isolation and I have rights." NA-A indicated she would talk to the nurse. During interview on 4/11/22, at 3:17 p.m., R25 indicated she has been in and out of the hospital over the past month with frequent urinary tract infections (UTI). Every time she is hospitalized she has to stay in her room and they quarantine her for a week, "which is a rights violation". R25 indicated she is fully vaccinated and boosted and there is no reason she has to be in her room or have a sign on her door. R25 further added next	F 550	transmission-based precautions for up-to-date and not up to date residents. The organization□s policy on infection prevention and control has been reviewed and is current. All staff have been educated on transmission-based precautions including up-to-date and not up-to-date isolation guidelines per CDC. A random audit on isolation and quarantine will be conducted 3x/week for 4 weeks, then weekly for 4 months and as needed. Findings will be shared with the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits. Correction: 5/20/22 DNS or designee	

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F 550	Continued From page 4	F 550		

time she will just refuse to go to the hospital.

During interview and observation on 4/11/22, at 5:20 p.m., R25 was in the hallway in her wheelchair with a mask on the back of her wheelchair. R25 stated she was told she is all clear now and can be out and about the facility. R25 was smiling and joking with others around her. Cart remained outside of her door, but clean gowns bin was gone along with dirty laundry hamper.

During interview on 4/11/22, at 7:17 p.m., registered nurse (RN)-A indicated R25 was on day seven of quarantine, was tested around 5:00 p.m. and was negative so is no longer in quarantine. RN-A indicated anyone out of the building for 24 hours or more at the hospital are quarantined for 7 days and are tested on admission and day 7 prior to releasing them from quarantine.

During observation on 4/12/22, at 12:36 p.m., R25 was in the lobby waiting for the bus to take her to her infectious disease appointment and was smiling and talkative.

During interview on 4/13/22, at 8:17 a.m., R25 indicated her appointment went very well yesterday. R25 indicated every time she goes to the hospital she has been quarantined to her room on return and complains to staff every time about it but the facility doesn't do anything about it except tell me the Centers for Disease Control (CDC) makes the rules and they have to follow it. R25 added being vaccinated and having had Covid-19 recently, she should not have to stay in her room. R25 stated it makes her feel like a three year old and other residents in quarantine

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F 550	Continued From page 5	F 550		

indicated the same thing. R25 had to eat in her room, wasn't allowed to participate in anything like exercise classes, and was not allowed to go to the chapel. R25 stated she felt like a second class citizen.

During interview on 4/13/22, at 10:09 a.m., RN-B indicated any new admission or resident who comes from the hospital are automatically quarantined for 7 days regardless of vaccination status.

During interview on 4/13/22, at 11:14 a.m., with RN-C and interim director of nursing (DON) indicated an e-mail was received from the parent company which indicated new admission or residents that are hospitalized for 24 hours or greater are placed in quarantine and tested 7 days later. E-mail indicated it did not matter if the resident was vaccinated or not. The interim DON indicated she confirmed this information on the Centers for Medicare and Medicaid Services (CMS) website.

During interview on 4/13/22, at 12:52 p.m., the interim DON indicated upon further review of the e-mail received, it included the CDC recommendations from 2/2/22, which did not include fully vaccinated residents. The interim DON confirmed if residents are up to date on vaccines, they do not need to quarantine upon readmission to the facility and the practice will no longer be used.

Requested policy on resident rights and received "Combined Federal and state Bill of Rights", dated 2/1/17, included:
- The resident has a right to a dignified existence, self-determination, and communication and

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F 550	Continued From page 6 access to persons and services inside and outside of the facility. -A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident.	F 550		
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 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.	F 578		5/20/22

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F 578	Continued From page 7 (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: Based on interview and document review, the facility failed to ensure wishes and directives for emergency treatment (i.e., cardio-pulmonary resuscitation (CPR), was obtained upon admission, to ensure appropriate care would be provided if found without pulse or breathing; as well as facility failed to ensure provider orders for life-sustaining treatment (POLST) was signed by physician in the medical record for 2 of 34 residents (R9, R15) reviewed for advanced directives. Findings include: R9 R9's significant change in status Minimum Data Set (MDS) assessment dated 2/7/22, identified R9 had severely impaired cognition. R9's face sheet, printed on 4/13/22, identified diagnoses of generalized idiopathic epilepsy (a seizure disorder condition), difficulty in walking, history of falling, convulsions (a condition that caused uncontrollable muscle contractions),	F 578	F578-Advanced Directives- POLST POLST for R-15 was signed by the physician. R-9 and family representative were educated on advance directive and POLST. POLST updated to reflect their wish with their culture in regards to death and dying. POLST forms have been reviewed and updated for all residents. All residents have the potential to be affected by the same deficient practice. All residents□ POLST were reviewed to ensure they all have MD/Provider signature. Night shift nurse will verify all code status daily. Organization□s policy on Advance Directive including Cardiopulmonary Resuscitation (CPR) and Automated External Defibrillator (AED) - Rehab/Skilled policy reviewed and are current. The POLST completion has been added to our admission process and the Admission Checklist to ensure that resident POLST is signed by the provider immediately. If not on site, the form will be	

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F 578	Continued From page 8 tuberculosis (serious infectious bacterial disease) of lung, and late syphilitic meningitis (a bacterial infection affecting the brain and spinal cord). R9's face sheet, identified no code status in advance directive. R9 was admitted to facility on 1/2022, was identified to not have a health care directive or POLST form in place upon medical record review on 4/11/22. During an interview, on 4/11/22 at 2:57 p.m., family member (FM)-G indicated he could not recall whether or not there was a health care directive in place or if signed a POLST form when R9 was admitted to facility. FM-G indicated he thought R9 had a health care directive form completed at one time. During interview, on 4/13/22 at 8:43 a.m., licensed practical nurse (LPN)-A was unable to locate R9's code status in resident advance directive binder located at nursing station. LPN-A reviewed R9's electronic medical record (EMR); and was unable to locate R9's code status, health care directive, and POLST form. LPN-A indicated being unaware R9's code status. LPN-A indicated the process of code status completion for residents was at time of admission; resident and/or power of attorney (POA) would provide a completed copy of advance directive and/or POLST form, or if unavailable, licensed nursing staff would assist resident and/or POA in completing questions on POLST form; licensed nursing staff, resident and/or POA would sign and date form, obtain provider's signature and date for order; POLST form placed in resident advance directive binder, signed physician order for code status entered into EMR system. LPN-A	F 578	faxed to provider for timely signature. When changes are made to a POLST, they will be signed immediately or faxed for signature. Nightly code status checks by nursing staff. All resident charts will be audited for signed POLST orders weekly for 3 months, then monthly for 6 months. Audits will be reported at QAPI meeting for recommendations to increase, decrease, or discontinue. Completion: 05/20/2022 DNS or designee	

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indicated if a resident's code status was unknown, CPR would be performed. LPN-A indicated nurses complete facility form titled, New Admission Checklist, for all residents at time of admission. LPN-A indicated facility's New Admission Checklist form has a section titled, Advance Directives; all nurses were to check off when completed.

When interviewed, on 4/13/22 at 8:51 a.m., interim director of nursing (DON) indicated being unaware R9's code status was not in place. Interim DON reviewed resident advance directive book at nursing station and EMR; unable to locate R9's code status. Interim DON indicated for any resident with unknown code status, CPR would be performed. Interim DON verified R9's code status was not completed at time of admission on 1/2022. Interim DON indicated expectation would be for all residents' code status's to be completed at time of admission with licensed nursing staff, reviewed and updated if needed during interdisciplinary team (IDT) meetings, quarterly reviews, and as needed. Interim DON further indicated acceptable documentation included POLST or advance directive forms. Interim DON indicated once advance directives or POLST forms are completed, the expectation would be for licensed nursing staff to update information in advance directive binder at nursing station and EMR. Interim DON indicated all residents' advance directives or POLST forms would be updated by social services (SS)-A going forward.

During interview with interim DON, and LPN-A on 4/13/22 at 9:24 a.m., LPN-A indicated was able to find a code status of CPR for R9, after reviewing a physician visit note in EMR.

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R15
R15's significant change in condition assessment dated 2/18/22, identified R15 had intact cognition.

R15's face sheet, printed on 4/13/22, identified diagnoses of malignant neoplasm of stomach (stomach cancer), Type 2 Diabetes Mellitus (a condition that caused high blood sugar), chronic obstructive pulmonary disease (a chronic lung disease, causing difficulty breathing), a malignant neoplasm of pyloric antrum (cancer of lower end of stomach), and ascites (swelling and fluid build-up in abdomen).

R15's face sheet, identified an advance directive of limited resuscitation (no chest compressions).

R15's POLST, dated 4/11/22, identified "Do not attempt resuscitation/DNR (Allow Natural Death)," if no pulse and not breathing.

The POLST, dated 4/11/22, was signed by FM-I and nursing on 4/11/22, but not signed by the physician.

R15's order summary report, printed on 4/13/22, identified code status as limited resuscitation (no chest compressions).

During an interview, on 4/12/22 at 10:42 a.m., R15 indicated having an advance directive in place, thought this was signed by FM-I

When interviewed, on 4/13/22 at 8:38 a.m., LPN-A indicated R15's code status was noted in EMR, POLST form, and advance directive binder at nursing station; code status identified DNR.

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LPN-A indicated upon review of R15's POLST, signatures were obtained by FM-I and RN-D on 4/11/22, and was not signed by the physician. LPN-A indicated POLST form should have been signed by physician. LPN-A verified POLST form not a valid order without physician signature.

During an interview, on 4/13/22 at 8:51 a.m., interim DON indicated staff look in EMR and advance directive binder at nursing station for resident's code status. Interim DON indicated being aware of discrepancy with R15's POLST form not signed by physician, as nursing brought discrepancy with POLST to her prior to surveyor interview. Upon review of R15's POLST, interim DON indicated it is her expectation nursing staff ensure all residents have an advance directive and/or POLST appropriately documented in their medical record. Interim 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.

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

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F 578	Continued From page 12 resident/healthcare decision-maker wish to develop or amend advance directives. As necessary, physicians will be contacted for orders that reflect the resident's wishes. Completed portable and enduring order forms (POLST) will be treated as physician's orders and placed in the medical record.	F 578		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting,	F 676		5/20/22

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F 676	Continued From page 13 §483.24(b)(4) Dining-eating, including meals and snacks, §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure activities of daily living (ADLs) were provided, including shaving and nail care for 1 of 2 residents (R12) reviewed, who needed staff assistance for supervision to maintain good personal hygiene. Findings include: R12's quarterly Minimum Data Set (MDS) assessment, dated 2/17/22, indicated R12 had moderate cognitive impairment and required supervision from staff for personal hygiene. R12's care plan was revised and printed on 4/13/22; indicated R12 prefers to be clean shaven, except for mustache; staff to assist daily. R12's care plan did not identify nail care needs. During an observation, on 4/11/22 at 4:31 p.m., R12 was observed to have facial hair stubble (short beard growth), mustache, and debris under long jagged fingernails. Family member (FM)-H presented to room at time of observation and was interviewed. FM-H indicated resident liked his mustache, and wanted to be clean shaven every morning to remove facial stubble. FM-H indicated R12 was always noted to have facial stubble when visiting, FM-H started to shave R12	F 676	F676-ADLs/Maintenance The Resident (R12) was addressed immediately and care plan was reviewed with the assigned CNA. Education was provided to the nursing staff immediately. All residents receiving ADLs have the potential to be affected. All staff have been educated to review care plans to ensure they reflect resident preferences during ADLs and document service provided. The organization's policy was reviewed and is current. DNS/designee will review ADL policy and educate all nursing staff on resident ADLs in the Care Plan/Kardex by 5/20/22. Facility will conduct 5 random audits weekly for 2 months, then 5 audits/month for 6 months. Direct feedback to staff providing care and review of care plans to ensure resident care plan. Audits to be shared at local QAPI meeting. Completion: 05/20/22 DNS or designee	

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during visits, a couple times per week. FM-H indicated staff were aware of daily shaving preferences, as FM-H mentioned to staff on previous occasions. FM-H indicated staff should be assisting R12 with nail care, as unable to complete independently, as blind in left eye.

On 4/13/22 at 7:39 a.m., R12 was again observed to have longer facial stubble compared to observation on 4/11/22. R12's nails continued to have debris under long, jagged fingernails.

During an interview, on 4/13/22 at 9:30 a.m., with licensed practical nurse (LPN)-A and interim director of nursing (DON), both indicated expectation for providing shaving and nail care, was completed by resident preference and as care planned. LPN-A indicated aides bathed R12 once per week, and would check and complete nail care on bath days. LPN-A indicated it was her expectation aides notify licensed nursing staff for any nail care that needed to be completed for diabetics, or concerns with shaving or nail cares. LPN-A indicated staff should document if a resident refused any care. Interim DON indicated it is her expectation residents' nails are trimmed by aides on bath days or by licensed nursing staff if diabetic, all staff should be checking resident's nails weekly. Interim DON observed and verified R12 had facial stubble, fingernails were long and jagged with debris; and indicated unacceptable ADL care, and would inform staff to ensure R12 was clean shaven and nail care was completed.

When interviewed, on 4/13/22 at 11:54 a.m., LPN-A indicated R12 was diabetic, and needed licensed nursing staff to assist with nail care. LPN-A indicated R12 was able to shave independently after set-up, and would sometimes

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refuse to complete independently, staff then assisted. LPN-A indicated R12 had informed her on a previous occasion of liking to keep nails longer, liked to use longer nails as a "tool." LPN-A indicated she would ensure R12 was shaven and nail care was completed today.

R12 was observed on 4/13/22 at 12:05 p.m. to be clean shaven, nails were clean and trimmed.

During an interview, on 4/13/22 at 12:07 p.m., nursing assistant (NA)-B indicated being aware of R12's ADL needs; to be shaven daily per R12's preference. NA-B indicated nail care was completed once weekly on resident bath days, R12 was diabetic and nail care was to be completed by licensed nursing staff. NA-B indicated R12 used to be more independent with shaving, became weak 2 months ago due to infection and sores on feet; and required more staff assistance with ADL care, including shaving.

When interviewed, on 4/14/22 at 8:29 a.m., registered nurse (RN)-C indicated being aware of R12's ADL needs. RN-C indicated R12 had increased generalized weakness over past two weeks due to foot problems, required more staff assistance; including shaving daily. RN-C indicated NA's were responsible for assisting with daily shaving, NAs to inform licensed nursing staff to provide nail care due to R12's diabetic history.

Policy titled Activities of Daily Living, revised on 1/25/22, indicated: Residents who are unable to carry out activities of daily living independently will receive the services necessary to maintain good nutrition, grooming and personal and oral hygiene. ADLs are those necessary tasks conducted in the normal course of a resident's

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F 676	Continued From page 16 daily life. Included in these are the following: General Personal, Daily Hygiene/Grooming: Care of hair, hands, face, shaving, applying makeup, skin, nails, and oral care.	F 676		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure services were coordinated with the hospice agency for 1 of 1 resident (R17) reviewed who received hospice services. Findings include: R17's significant change Minimum Data Set (MDS) assessment dated 2/23/22, indicated R17 was totally dependent on staff for locomotion on/off the unit, and required extensive staff assistance with all other activities of daily living. The MDS further indicated a diagnosis of dementia with Lewy bodies; had a condition of life expectancy of less than 6 months, and was receiving hospice services. R17's facility care plan, revised 3/18/22, did not include evidence the resident was receiving	F 684	F684-Hospice (Quality of Care) Resident (R17) care plan was updated to reflect hospice care needs and hospice contact name and number. All residents with hospice services care plan reviewed to ensure they reflect specific interventions for hospice with contact information. The organization's policy on Hospice-Provided Services- R/S, LTC was reviewed and is current. When a resident receives an order for hospice, care plans will be updated in collaboration with hospice team. All nursing staff were educated on hospice policy and care planning by the DNS/designee on 4/28/2022. All resident charts with hospice orders will be audited for care plan completion weekly for 3 months, then monthly for 6	5/20/22

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F 684	Continued From page 17 hospice services or what those services would provide. Further review of R17's medical record did not include a care plan from the hospice agency or progress notes from visits made (services provided) by the hospice staff. R17's (local hospice agency) Home Home Care Service Plan, dated 2/11/22 (start of care) indicated a registered nurse (RN) would provide services 1-2 times times a week (1-2 x/wk) and as needed (prn); the home health aide (HHA) 1-5 x/wk and prn; the social worker 1-2 x/month and prn; and the chaplain 1-2 x/month and prn. The Home Care Service Plan did not include what services would be provided by each of the hospice staff. Review of the facility's hospice binder, located at the nurses station, included a February 2022 calendar indicating when the RN and HHA would be coming to visit R17. The binder did not include a visit schedule for March 2022 or April 2022. On 4/12/22, at 1:33 p.m. R17 was observed seated in recliner in room with feet elevated and blanket over lap. R17's eyes were closed and the resident appeared to be sleeping; call light was within reach and clipped to the arm of the recliner. There was no evidence of a hospice schedule or hospice book observed in R17's room. When interviewed on 4/12/22, at 2:28 p.m. registered nurse (RN)-C confirmed R17 received services from local Hospice. RN-C stated staff really didn't know when the hospice HHA was coming to the facility, "She just comes when she'd able". RN-C further stated the hospice RN	F 684	months. Findings will be shared with the QAPI committee monthly x6 months for input on the need to increase, decrease or discontinue audits. Completion: 5/20/22 DNS or designee	

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usually came to the facility twice a week on Mondays and Thursdays and would call the facility and let staff know if the day/time was going to change. RN-C reviewed the local Hospice binder and confirmed there was no evidence of a hospice care plan or a current schedule for R17. RN-C stated the hospice care plan was probably scanned into R17's electronic medical record.

When interviewed on 4/14/22, at 9:34 a.m. case manager RN-D stated the hospice nurses let the staff know verbally when they would be coming to the facility. RN-D further indicated the hospice RN came one a week and more often by request and was unsure how often the HHA came to the facility. RN-D reviewed R17's electronic medical record and confirmed it did not include a hospice care plan.

When interviewed on 4/14/22, at 12:30 p.m. licensed practical nurse (LPN)-B stated she didn't work at the facility often so usually wasn't present when hospice staff arrived. LPN-B stated there should be a schedule staff could refer too indicating when hospice staff were coming to the facility.

When interviewed on 4/14/22, at 12:45 p.m. hospice RN-G stated she usually came to the facility on Tuesdays and Fridays but if she had a Friday off would come on Tuesday and Thursday instead. When asked if hospice usually provided a hospice care plan, RN-G stated it should be in the local hospice binder at the nurses station. Surveyor informed RN-G the facility did not have a hospice care plan for R17. RN-G stated RN-D had requested a hospice schedule be sent to the facility earlier that day; RN-G confirmed she would send the care plan at that time as well.

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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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F 684	Continued From page 19 RN-G confirmed a HHA also provided services at the facility two days a week and her schedule would be included on the calendar RN-G was sending to the facility. When interviewed on 4/14/22, at 1:40 p.m. interim director of nursing (DON) confirmed staff should be aware of the hospice staff's schedule and residents receiving hospice services should have a hospice care plan in order to coordinate care. Interim DON reviewed R17's facility care plan and confirmed the care plan did not identify the resident received hospice services and what that entailed. The Hospice and Nursing Facility Service Agreement with ... (local hospice) @Home hospice signed 7/3/20, indicated: 1.8 Joint Plan of Care or JPOC means a coordinated joint plan of care for an individual Patient for the palliation or management of the Patient's terminal illness and related conditions that (a) clearly delineates the services to be provided by Hospice and Facility; (b) is consistent with Hospices's philosophy; (c) is based on an assessment of the Patient's current medical, physical, psychological and social needs and unique living situation; (d) reflects the participation of Hospice, Facility, the Patient and the Patient's family, as appropriate; and (e) complies with applicable federal and state laws and regulations. A facility policy on hospice services was requested and not received.	F 684		
F 686 SS=D	Treatment/Svcs to Prevent/Heal Pressure Ulcer CFR(s): 483.25(b)(1)(i)(ii) §483.25(b) Skin Integrity	F 686		5/28/22

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F 686	Continued From page 20 §483.25(b)(1) Pressure ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that- (i) A resident receives care, consistent with professional standards of practice, to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable; and (ii) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection and prevent new ulcers from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to assess, monitor and implement pressure relieving interventions for 1 of 1 resident (R32) reviewed who was at risk for pressure ulcer (PU) development, resulting in R32 acquiring a stage two pressure ulcer to coccyx (area at the base of the spinal column). Findings include: R32's facesheet printed on 4/14/22, indicated an admission date of 7/2021, and included diagnoses of stroke and mild cognitive impairment. R32's quarterly Minimum Data Set (MDS) assessment dated 12/23/21, indicated R32 was cognitively intact; had clear speech, was usually understood and could usually understand. R32 required extensive assistance of one staff for bed mobility, transfers, toileting, and moving about the facility in a wheelchair. R32 was frequently incontinent of bladder and always continent of bowel. R32 was not at risk for PU's and had no	F 686	F686-Pressure Ulcer (Treatment/Svcs to Prevent/Heal Pressure Ulcer Resident (R-32) treatment plan has been reviewed and updated to reflect provider□s orders and nursing staff have been educated on the treatment and care plan updates. All residents with pressure injuries/wounds□ treatment plan and care plan reviewed and updated. All nursing staff educated on new treatment plan. Skin Assessment Pressure Ulcer Prevention and Documentation Requirements- Rehab/Skilled policy has been reviewed and is current. Facility has identified a wound designee nurse who will oversee weekly wound treatment and provider update/notifications and report weekly IDT Risk Management meeting. Wound prevention and Skin care education provided for all nursing staffing by DNS or designee by May 28, 2022. Wound care log will be reviewed at Risk Management IDT meeting weekly. A	

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F 686	Continued From page 21 PU's. Following the identification of a PU, R32's significant change Minimum Data Set (MDS) assessment dated 3/24/22, indicated R32's brief interview for mental status (BIMS) could not be completed as R32 was rarely or never understood. Furthermore, the MDS indicated R32 had unclear speech, was only sometimes understood and could sometimes understand simple, direct communication. R32 was frequently incontinent of bowel and bladder, required extensive assistance of one or two staff for bed mobility, transfers, toileting, and moving about the facility in a wheelchair. The MDS indicated R32 was at risk for development of PU's and had two, stage 2 PU's, not present upon admission. R32's care area assessment (CAA) dated 3/24/22, indicated an increased risk for PU development evidenced by presence of pressure areas, skin breakdown on coccyx, with need for increased assist with bed mobility, frequent bladder/bowel incontinence, and gradual weight loss. Furthermore, the CAA indicated R32 had two pressure areas; a stage 2 open area to coccyx measuring 0.7 cm (centimeters) x 0.9 cm and a blister to right buttocks measuring 1.5 cm x 1.9 cm. The CAA indicated R32 had a memory foam mattress; pressure reducing cushion in wheelchair and recently a turn/reposition every two hours was added to her care plan. Staff managed incontinence and assisted with repositioning due to altered mental status. Skin was monitored daily with cares and areas of concern reported to nurse for further observations and interventions prn (as needed). R32's plan of care was revised on 3/30/22, to add	F 686	random weekly audit will be completed for 4 months and as needed to ensure treatment orders are followed. Findings will be shared with the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits. Completion: 5/28/22 DNS and Wound designee Nurse	

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F 686	Continued From page 22	F 686		

a focus area of PU. The plan of care indicated PU development related to immobility and incontinence of bowel and bladder; that R32 would have intact skin, free of redness, blisters or discoloration. Reposition every two hours; notify the nurse immediately of any new areas of skin breakdown.

A skin check dated 3/19/22, indicated R32 had no observed skin conditions.

R32's progress note dated 3/21/22, at 6:39 a.m., indicated an open area to coccyx; a stage 2 open area measuring 0.7 cm X 0.9 cm and a stage 1 blister to right buttock measuring 1.5 cm X 1.0 cm. Areas were cleansed and border dressing (all-in-one dressing used to create an optimal healing environment) was applied. R32 was positioned onto her side to take pressure off buttocks/coccyx and would be repositioned every two hours and/or as needed. Wounds would be monitored every three days till healed.

Hand-written provider orders for R32 dated 3/23/22, indicated to apply hydrocolloid dressing (a dressing which protects wounds) to pressure ulcer on coccyx and change every three to five days or when soiled. Provider orders in the electronic medical record (EMR) dated 3/31/22, indicated: Wound Care: Sacrum and Coccyx: wound cleanser, pat dry, cavilon skin prep (protects skin from body fluids) over wound, fan dry, cover with foam border dressing, change every three days or sooner if becomes soiled.

A skin check dated 3/26/22, indicated R32 had a stage 2 open wound to coccyx and another on right medial buttocks, both with minimal serous (a thin, clear fluid) drainage, covered with border

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F 686	Continued From page 23	F 686		

dressing.

A skin check dated 4/10/22, indicated R32 had an open wound, stage 2, measuring 0.7 cm X 0.5 cm to coccyx.

During an observation on 4/12/22, at 2:07 p.m., R32 was laying in bed, supine with eyes closed and oxygen on via nasal cannula. Observed cushioned seat in wheelchair.

During an observation and interview on 04/13/22 at 7:42 a.m., nursing assistant (NA)-E verified R32 had sores on her bottom, and they where healing. When asked how R32 may have gotten the sores, NA-E stated maybe from sitting, stating she liked to keep R32 in her wheelchair so she could stay awake, then put her in bed after lunch. When asked if R32 was repositioned periodically to relieve pressure on her bottom, NA-E stated the night shift did that. At 8:07 a.m., NA-E moved R32 from the toilet with the EZ stand (battery powered device used to facilitate transfers) to wheelchair, and took her to the dining room for breakfast.

During an observation on 4/13/22, at 9:11 a.m., R32 was returned to her room by an unidentified activity aide, who read religious material to R32 while she sat in her wheelchair.

During an observation and interview on 4/13/22, at 9:45 a.m., according to family member (FM)-D, she visited R32 every day. FM-D was aware of recently acquired PU's, adding that the director of nursing (DON) had came in and checked to make sure the mattress was okay and that there was a cushion in R32's chair. FM-D stated when she was there visiting, staff did not reposition R32,

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F 686	Continued From page 24	F 686		

adding, "I told my daughter, I wonder if they're repositioning her...I told her when I come to visit, R32 is always on her back."

During an observation and interview on 4/13/22, at 10:22 a.m., R32 was in her wheelchair in her room. FM-D stated R32 had not been repositioned or toileted since she arrived about 9:15 a.m.

During an observation and interview on 4/14/22, at 9:34 a.m., with registered nurse (RN)-F, R32's skin was observed while R32 was standing at the toilet with the aid of an EZ stand. RN-F pulled down R32's slacks, underwear and brief. R32's skin was very damp, with beads of perspiration noted on buttocks. RN-F stated, "It's always like that, that's how it is." Observed the PU in the upper gluteal cleft (butt crack) which was very small, approximately 0.5 cm in length with dark material over top. RN-F stated NA's were supposed to reposition R32 every couple of hours. When asked if she knew for certain if NA's did reposition R32, RN-F stated they did most of the time, depending upon what was going on.

During an interview on 4/14/22, 9:50 a.m., the interim DON stated she was informed of R32's PU on the same day it was noted in R32's record, which was on 3/21/22. The interim DON read out loud the initial nursing progress note describing the discovery of the PU, including the measurements. The interim DON stated she immediately discussed the PU with the nurses, including the plan of care and how to document the wounds. The interim DON stated she did immediate re-education for the nurses, and added pressure ulcers to the QAPI (quality assurance and performance improvement) plan.

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F 686	Continued From page 25 During the same interview, the interim DON stated she assumed staff had been repositioning or off-loading (remove pressure from an area for at least one minute) R32 every two hours. When asked if R32 had been on a repositioning schedule prior to the identification of the PU, the interim DON stated, "It's standard of practice." The interim DON was then asked to review R32's PU CAA dated 3/24/22. The interim DON confirmed that turning and repositioning was added to the CAA on that date, after the identification of R32's PU. The interim DON was asked if R32's care plan prior to the identification of pressure ulcers, included repositioning, the interim DON stated it should have. When informed repositioning was added to R32's care plan on 3/30/22, after the identification of a pressure ulcer, the interim DON stated, "If that's what it says -- I have to go with that." The interim DON stated every resident should be repositioned based on BIMS and comorbidity, otherwise would be at risk for developing a pressure ulcer, and acknowledged R32 had been at risk for developing a pressure ulcer. Facility policy titled Pressure Ulcers, dated 2/8/22, indicated the purpose was to provide appropriate assessment and prevention of ulcers. Based upon a resident's comprehensive assessment, the facility would use prevention and assessment interventions to ensure that a resident entering the facility without pressure ulcers did not develop a pressure ulcer unless the individual's clinical condition demonstrated it was unavoidable.	F 686		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2)	F 761		5/20/22

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F 761	Continued From page 26 §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, interview and document review 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 1 refrigerator observed in use for medication storage. This had potential to affect 1 of 1 resident (R8) who received this medication. Findings include: R8's physician orders printed 4/14/22, included: lorazepam (anitaniety) concentrate 2	F 761	F761-Drug Storage- Labels/Store Drugs and Biologicals Resident R-8□s narcotic was double locked per policy. Maintenance affixed locked box inside the fridge in the Med Room. Keys were placed on both med cart key rings and DNS key ring. All residents with narcotics have the potential to be affected by the deficient practice. All residents□ medications reviewed to ensure they are locked and double locked to meet regulatory	

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F 761	Continued From page 27 milligrams(mg)/milliliter(ml). Give 0.5 ml by mouth every four hours as needed for anxiety, agitation or nervousness related to claustrophobia. On 4/14/22, at 1:56 p.m. the medication room the medication room refrigerator was observed with the interim director of nursing (DON) and the newly hired director of nursing (DON)-E. After unlocking the door to the refrigerator, interim DON and DON-E observed a bottle of lorazepam 2 mg/ml liquid (prescribed to R8) that was on the shelf on the inside door of the refrigerator. The lorazepam was not in a separate compartment or affixed to the inside of the refrigerator in order to prevent theft. Interim DON confirmed the lorazepam should be locked separately in the refrigerator in an affixed container. Facility policy titled Medications: Acquisition Receiving Dispensing and Storage dated 2/8/22, indicated: 10. 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	standards. The organization□s policy on Medications: Acquisition Receiving Dispensing and Storage- Rehab/Skilled for narcotics has been reviewed and is current. All licensed staff have been educated too. Random audits will be conducted on proper use of narc lock box in med room fridge weekly for 3 months, then monthly for 6 months. Findings will be shared with QAPI committee meeting for increase, decrease or discontinue audits. Completion: 5/20/22 DNS or designee	
F 804 SS=D	Nutritive Value/Appear, Palatable/Prefer Temp CFR(s): 483.60(d)(1)(2) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(1) Food prepared by methods that	F 804		5/20/22

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F 804	Continued From page 28 conserve nutritive value, flavor, and appearance; §483.60(d)(2) Food and drink that is palatable, attractive, and at a safe and appetizing temperature. This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to ensure food was served at the proper temperature for palatability for 2 of 2 residents (R11, R19) who complained food (meatballs) were not warm to taste. Furthermore, at the state-facilitated resident council meeting, 3 of 11 residents (R4, R3 and R19) remarked about being served cold food. Findings include: R19's brief assessment for mental status (BIMS), dated 2/12/22, identified resident was cognitively intact. During an interview on 4/11/22, at 2:38 p.m., R19 stated the food wasn't good since they got some new cooks. R19 stated they were recently served Swedish meatballs and some were cold and some were lukewarm, adding "They just heated up the sauce and poured it over the meatballs. And my mashed potatoes were lukewarm too." R19 stated he had been telling the higher-ups about this..."I'm calling them out on it; I'm not happy about it." R19 stated he had told registered nurse (RN)-D about the cold meatballs. R11's BIMS dated 2/17/22, identified resident was cognitively intact. During an interview on 4/11/22, at 2:57 p.m., R11 stated that lately the food had been terrible. R11	F 804	F804 Nutritive Value/Appear, Palatable/Prefer Temp When residents made comments about the dry ham and cold meatballs, staff offered to reheat the plate or make the residents something else. Food and nutrition staff discussed and were trained at an in-service held on May 2nd, 2022 on how to assess all foods prior to serving for adequate palatability and taste. All were instructed to offer alternate foods to residents in a situation such as above. All residents have the potential to be affected by the deficient practice. The dietary manager or designee will attend the monthly Resident Group meeting to respond to concerns and suggestions regarding food palatability and food choices. Also, all residents will have access to the suggestion box to voice concerns on palatability and food choices in the dining room. To ensure systemic changes are made, staff were re-educated on April 25th, 2022 on service of food and drink and food temperature monitoring, reviewing policy, reviewing the policy entitled, Food Temperature Monitoring - Food and Nutrition Services. The food and nutrition supervisor or her designee will monitor that all foods are assessed prior to serving at 5 meals per	

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F 804	Continued From page 29 stated they were recently served Swedish meatballs and they were either frozen or not cooked, "Everything was ice cold that day." R11 stated there was a new male cook; she didn't know his name, but that he was not good. R11 stated she had expressed her concerns to social worker (SW)-A, who said she would check into it. R11 stated she had also talked to the dietary manager (DM)-A who said she'd check into it - but no one had gotten back to her. R11 stated food was talked about at resident council meetings, but it fell on deaf ears. During review of 2/9/22, resident council meeting minutes, an unidentified resident commented food was often cold. During review of 4/6/22, resident council meeting minutes, multiple food complaints were identified, including minutes that read: What's the possibility of the cooks serving warm food? The other night the meatballs where cold/still frozen with hot gravy poured on top. During an interview on 4/14/22, at 8:53 a.m., RN-D was asked if any residents had reported to her about cold food and she stated yes, then removed a small, handwritten note from her desk. RN-D stated R19 had come to her last week about meatballs that were cold and the gravy was hot, and also mentioned a day when the roast beef was cold. RN-D wrote this down and was going to give the note to DM-A but had not done so yet. During the State-facilitated resident council meeting on 4/13/22, at 10:00 a.m., the 11 residents in attendance were asked about the temperature of food served to them. R4, who was	F 804	week for one month and then 3 meals per week for an additional 2 months. To ensure systemic changes are made, random audits will be completed by non-dietary staff on appearance of food and resident satisfaction of food one time weekly for 6 months. All audit results will be reported at the monthly QAPI meeting where it will be determined after 6 months if the audits need to increase, decrease or continue. Completion: May 20, 2022	

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F 804	Continued From page 30	F 804		

cognitively intact per 1/13/22, BIMS, stated, "The food comes cold, not as warm as you'd like." R3 who was cognitively intact per 1/13/22, BIMS, stated "you can send it back and they'll warm it up." R19 talked about receiving frozen Swedish meatballs recently.

During review of menu's, it was noted that Swedish meatballs were served for the evening meal on 3/29/22, along with mashed potatoes, gravy and mixed vegetables. According to the Food Temperature Record for that meal, the meat was temped at 171 degrees F (Fahrenheit), but no food temperatures were documented for the mashed potatoes, gravy and vegetables. In addition, there were no initials on the record to indicate which cook temped this meal.

Additional food temperature records indicated lack of documentation of food temperatures:
3/28/22: No breakfast temperatures were recorded. Menu included Malt O Meal, french toast and sausage links.
3/29/22: No temperatures were recorded for the noon meal. This included chicken and wild rice casserole and broccoli.
3/29/22: For the evening meal, the menu included Swedish meatballs, mashed potatoes, gravy and mixed vegetable. Only the meat temperature was recorded. Residents complained about Swedish meatballs that were served cold or frozen.
4/2/22: No breakfast temperatures were recorded. The menu included cream of wheat, sausage gravy over a biscuit.
4/3/22: No noon meal temperatures were recorded. The menu included mushroom chopped steak, au gratin potatoes and carrots.
4/3/22: No evening meal temperatures were recorded. The menu included BBQ chicken,

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F 804	Continued From page 31 macaroni salad and beets. 4/5/22: No noon meal temperatures were recorded. The menu included honey mustard chicken, baked potato and asparagus. 4/6/22: No breakfast temperatures were recorded. The menu included Malt O Meal, sausage patty and french toast. 4/7/22: No evening meal temperatures were recorded. The menu included hamburger on a bun, baked beans, carrot raisin salad and fruit cup. 4/9/22: No breakfast temperatures were recorded. The menu included Malt O Meal, fried egg and sausage patty. 4/9/22: No noon meal temperatures were recorded. The menu included roast pork loin, parsley potatoes and braised red cabbage. During an interview on 4/14/22, at 11:20 a.m., with the administrator and DM-A, DM-A was asked if she was aware of resident complaints regarding cold Swedish meatballs. DM-A stated yes, she was made aware of that and had spoken to the cook about it, who told her he should have put the frozen meatballs (pre-cooked) into the oven sooner and had not realized they were cold when served to the residents. When asked if the cook verified the temperature of the meatballs prior to serving them to residents, DM-A stated the cook told her he had. When asked what the risk would be of having food temperatures not measured or not measured accurately, DM-A stated the food would be cold and residents would complain. The administrator stated it would be a palatability concerns for residents. Both DM-A and the administrator acknowledged that food served cold which was supposed to be served hot, could result in foodborne illness to residents.	F 804		

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F 804	Continued From page 32 During the same interview, when asked about oversight over cooks and holding them accountable for measuring the temperature of food before serving it to residents, DM-A stated she was responsible for this, but admitted she did not observe cooks when they prepared and served food, which included measuring food temperatures. In addition, DM-A stated she did not review food temperature records after the fact to ensure food temperatures where being documented. DM-A stated she was very behind on everything. DM-A stated she was ultimately responsible to ensure food palatability and food safety for residents. The administrator added it was an accountability issue...holding staff accountable for their specific job duties. When asked who provided training for new cooks, DM-A stated she did, but stated she was not aware of a training checklist to ensure all elements of a cooks role were addressed during training, nor did she monitor their performance after completion of training. During an interview on 4/14/22, at 1:47 p.m., (RN)-C stated there had not been any residents with symptoms of foodborne illness that she could recall. Facility policy titled Food Temperature Monitoring, dated 3/15/22, indicated food was cooked, reheated or cooled to ensure proper holding temperatures before each meal services. Food temperatures were taken and recorded before each meal service. Periodically, temperatures were taken at other times during or at the end of meal service to ensure temperatures were held within acceptable ranges. Food is served at proper serving temperatures. Before meal	F 804		

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F 804	Continued From page 33 service, the cook takes the "cook-to" and the "serve" temperatures of all TCS (time/temperature control for safety) menu items and records it on the Food Temperature Record. The cook monitors TCS foods throughout meal service. To correctly take temperatures, the food thermometer is inserted into the center or thickest part of the food for at least 15 seconds or per instructions on the thermometer. TCS hot foods should be served at 135 degrees F or higher. A chart of Minimal Internal Cooking Temperatures indicated a variety of foods and the required temperature prior to serving. Facility policy titled Service of Food and Drinks dated 5/3/21, was received. The policy indicated definitions for attractive and palatable food, proper serving temperatures which were food temperatures that were appetizing to the resident, and proper holding temperature which were foods held below 41 degrees F or above 135 degrees F. Food was served at proper serving temperatures. Check temperatures before food is placed for service. Re-check as needed to ensure proper temperatures during holding.	F 804		
F 812 SS=F	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent	F 812		5/20/22

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F 812	Continued From page 34 facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to monitor the condition of food storage containers in the walk-in kitchen refrigerator resulting in mold growing on the outside of multiple containers. In addition, the facility failed to date-mark open containers of food stored in the walk-in kitchen refrigerator, and failed to ensure expired food was identified and removed. In addition, the facility failed to prevent cross-contamination when egg shells were stored with whole eggs. In addition, the facility failed to ensure the trained dietary manager oversaw and supervised all aspects of dietary services and ensured dietary cooks received comprehensive training upon hire and on-going. Furthermore, the facility ensure hand hygiene was performed by staff when plating food and delivering meal trays, failed to ensure proper infection control practices were followed when handling resident drinking cups. This had the potential to affect all 34 residents who were served food from the kitchen. Findings include: The initial kitchen observation and interview on 4/11/22, at 1:38 p.m. was provided by kitchen aide (KA)-B, as the dietary manager had been off duty and the cook had been on break.	F 812	F812 Food Procurement, Store/Prepare/Serve-Sanitary The cook who put cracked/used egg shells back in the crate next to unused eggs and who did not use gloves properly was educated on the day of the infraction, April 11th, 2022. The policy and procedure for proper food handling was reviewed with all staff. Education and competencies for proper gloving were completed to food and nutrition staff on April 25th, 2022. Another education was held May 9th for safe food handling and all dietary staff were assigned courses Cross Contamination Action Ideas, Foodborne Illness: The Fork Stops Here!, and Food Preservation Techniques to be completed by May 20th, 2022 . The food containers found in the walk-in cooler with mold growing on the outside were immediately thrown away. To prevent further deficient practice a deep clean of the kitchen and walk-in cooler will be completed by May 20th, 2022. The cleaning schedule has been reviewed and updated as necessary.	

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F 812	Continued From page 35 During an observation of the walk-in freezer, noted a large box of hamburger patties; the patties were inside a bag and the bag was open to the air. Observed the built-in freezer fans had ice on the grates and icicles hanging from them. During an observation of the adjacent walk-in refrigerator, noted the following: 1. Kraft Honey Mustard dressing, 1 gallon. Written on top with black marker "open 8/24." Also written on cover was "3/12." Moldy material - white, gray and fuzzy, was growing on the outside of the container trailing down, and on top of the cover. Manufacturer expiration date not seen. 2. Vinegar, 1 gallon, with manufacturer best by date of 2/14/19. Written on side of container was "open 3-4." On top of cover, was written 3/11 with year of either 17 or 19. Product label was full of dark fuzzy mold, so much so that the label could not be read. KA-B stated there was vinegar in the container. In addition, the container had fine dots of black mold trailing down the side. 3. Jade brand Sweet and Sour Sauce, 1 gallon, had about 3 inches of product left in the container. Fuzzy white and black mold was growing on the outside of the container. The date written on the side with black marker was 2/12, with lines drawn through it. KA-B did not know what the lines through the date meant. Dried sauce and mold were trailing down the side of the container. 4. Real Lemon Juice, 1 gallon, had spotted mold over entire outside surface of the container. Written on outside of container in black marker was 1-15. Manufacturer best by date was 4/19/21. 5. Sysco Reliance brand Sweet Pickle Relish, 1 gallon. One of two manufacturer labels was	F 812	Broken rubber gaskets and sweeps were found on the doors of the walk-in cooler, affecting the temperature and humidity of the walk-in cooler. Mankato Refrigeration was contacted April 18th to order new gaskets and installation was scheduled according to the arrival of the appropriate materials. A gasket and sweep was installed on 1 of 2 doors on April 29th, 2022. The 2nd gasket was installed May 2nd, 2022. A humidistat was placed in the walk-in cooler to monitor humidity levels, to identify and address further issues. All residents have the potential to be affected by the deficient practice. Education was given to dietary staff in the areas of Proper Gloving April 25th, Date Marking, Cleaning Schedule, General Sanitation and Food Temperatures May 2nd, 2022. Competencies on proper gloving were completed April 25th, 2022. Organization□s policy on infection control was reviewed and is current. To prevent further deficient practice a deep clean of the walk-in cooler and kitchen was completed by May 20th, 2022. Competencies of dietary staff in the areas of General Sanitation and Food Temperatures were completed May 2nd, 2022. Education was provided to dietary staff regarding Date Marking, Sanitation, and the Cleaning Schedule, at a department meeting on May 9th. A random audit will be conducted 5x/week for 4 weeks, then 3x/week for 4 weeks, then weekly for 4 months and as needed. Findings will be shared with the QAPI committee monthly x4 months for input on the need to increase, decrease or	

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F 812	Continued From page 36 covered with black mold and the other was partially covered. Date written on top with black marker was 12/28. This container appeared full, possibly unopened. 6. Lea & Perrin's Worcestershire sauce, 1 gallon. Approximately half of manufacturer label had mold on it, as did areas of the container. The manufacturer best by date was 12/29/21. 7. Mrs. Gerry's Dixie Coleslaw, 4 lb (pound) tub was observed in a box on an upper shelf, the plastic cover was ajar and contents were coming out. There was no date mark indicating when it was opened. Manufacturer expiration date was May 2022. 8. Shredded cheddar cheese, 5 lb bag, open to the air. Bag of lettuce open to air. 9. Roast beef in a plastic container with green cover. Tape read "rot [roast] beef 4/6." 10. A small plastic bowl covered with plastic wrap with unidentified contents and no date. Tan in color. Texture was like pudding. 11. Mrs. Gerry's Deli Fresh Macaroni Salad, 5 lb tub, two dates were written on the cover with black marker: "3/31 OP" and "4/3" -- KA-B did not know how long food in opened containers were good for. 12. Plastic container of leftover "Veg soup" dated 4/8, with about 3 inches of product left in the container. Observed two large plastic containers on wheels which KA-B stated held sugar and flour. Contents of containers not labeled or dated. In a double-door refrigerator by the pass-through window was a cardboard tray of eggs. There were 11 egg shells still in the tray, along side eight whole, pasteurized eggs. A small plastic bag of what appeared to be deli ham was also noted;	F 812	discontinue audits. Completion: 05/20/2022	

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F 812	Continued From page 37 contents of the bag were not identified nor was the bag dated. During a interview on 4/11/22, at 1:58 p.m., the administrator was asked to come to the kitchen to observe the findings from the walk-in refrigerator, specifically moldy containers, foods past facility and/or manufacturer expiration date, and from another refrigerator: egg shells with whole eggs. KA-B had removed the containers from the walk-in refrigerator to a stainless steel table in the kitchen. When shown the findings, the administrator stated "oh, that's not good" adding that the facility had been cited in the past for concerns in the kitchen. During an interview on 4/12/22, at 12:59 p.m., dietary manager (DM)-A was asked if she had been informed of finding from the walk-in refrigerator on 4/11/22, and she confirmed she had been, adding that the administrator had shown her photos. When asked how the containers got moldy and went unnoticed by staff, DM-A stated the mold occurred when staff didn't wash off containers before returning them to the refrigerator. DM-A stated she didn't know how the containers were overlooked by staff, and admitted she was the one who received in food orders and put them away, yet didn't notice the moldy containers either. When asked if contents of the refrigerators were inspected for facility and manufacturer expiration dates on a periodic basis, DM-A stated they were not. DM-A stated when a food product came into the facility it was date-marked with the delivery date. When a container was opened, it was date-marked when opened. When informed food containers were marked with a month and day,	F 812		

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but not year, DM-A stated that was what she was told to do. When informed not all open food containers had a date-mark, DM-A stated the facility policy indicated food containers were to be dated when opened, including leftovers, and open containers of food were good for three days. DM-A stated cooks and kitchen helpers were responsible for monitoring this. DM-A stated the bulk containers of sugar and flour on wheels should have had a date on them, and the date must have washed off the lids. DM-A stated she did not review temperature logs to ensure staff were compliant. Together in the walk-in refrigerator, DM-A identified food that had been opened greater than three days and removed them from the refrigerator:
- Tuna salad, 5 lb container, dated 4/7
- Leftover rot [roast] beef, dated 4/6
- Ham slices, dated 4/6
- Macaroni salad, 5 lb container, dated 4/3
- Turkey slices, dated 4/2
- Potato salad, 13 lb container, dated 3/28
- Cottage cheese, 3 lb container, dated 3/24. DM-A opened this container, it was full and on top had a layer of pale yellow gel-like substance and gray fuzzy mold.
- Bologna slices, dated 3/17

During an interview on 4/13/22, at 10:30 a.m., DM-A was asked when food in moldy containers, mostly condiments, were used last. Honey mustard dressing - couldn't recall. Real Lemon Juice - "not often." Worcestershire sauce - used for baked beans which were on lunch menus on 4/7/22, and 3/23/22. Sweet and Sour sauce was used for pork stir fry, but had not been able to get ground pork. Vinegar - used daily to clean the stove. DM-A stated "I guess I missed it" when referring to the moldy containers. DM-A stated

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she contacted the maintenance supervisor about the gasket around the walk-in refrigerator door, adding it had been a problem before, and also new fans had been installed, but didn't seem to make a difference. DM-A stated this could attribute to the mold.

During an interview on 4/14/22, at 8:46 a.m., maintenance supervisor (MS)-A stated he heard there had been mold growing on containers in the walk-in refrigerator. MS-A stated the gasket around the door to the walk-in refrigerator needed to be replaced, and that he planned to replace the door latches to make sure the door always close behind the staff. MS-A stated he noticed the fan inside the walk-in freezer wasn't running so chipped the ice away and had been watching it closely. MS-A stated he called the refrigeration company and they were coming 4/15/22, to check it.

During an interview on 4/14/22, at 11:20 a.m., with DM-A and the administrator, negative findings above were reviewed. When asked how the moldy food containers could go unnoticed, DM-A stated, "I can't figure it out," none of the other staff noticed either. When asked what happened to the food items removed from the walk-in refrigerator on 4/11/22, the administrator stated she directed staff to throw away because it was moldy, expired, and might be served to residents which could cause foodborne illness. DM-A stated she discarded food containers on 4/12/22, because they exceeded the three-day maximum for open containers, and if served to residents could cause foodborne illness. When asked why routine duties in the kitchen were not being done, such as monitoring the condition of food containers, dates of food containers,

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manufacturer expiration dates, DM-A stated, "training." DM-A stated she trained new kitchen staff, but did not utilize a tool such as a training checklist to ensure all elements of each role were addressed during training, nor did she monitor performance after completion of training. DM-A stated she was very behind on everything. The administrator stated it had been a long six months of advertising for a cook and getting no applicants; that DM-A had been burning the candle at both ends and working long hours. For some of these tasks, the administrator and DM-A agreed didn't required a cook to do them. DM-A stated she was ultimately responsible to ensure food safety for residents, and the administrator added that it was an accountability issue...holding staff accountable for their specific job duties.

During the same interview, the administrator and DM-A were reminded about food service deficiencies with past inspections and asked what actions had been taken to ensure sustained improvements. DM-A stated they had done audits, and survey inspection findings had been added QAPI (quality assurance and performance improvement) plans. DM-A stated they shouldn't have stopped auditing and stated she would need to train dietary staff all over again. The administrator stated it seemed like they had done that every year with the same results. Both the administrator and DM-A acknowledged the findings in the kitchen were a significant concern and could result in foodborne illness to residents.

During a telephone interview on 4/14/22, at 12:32 p.m., the registered dietician (RD)-F stated she worked in the facility two times per month, that most of the days were working with resident information and nutritional status. When asked if

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her role included any oversight for the kitchen, RD-F stated company policy said it did, but since returning to onsite visits after the Covid-19 pandemic in the spring of 2021, she had not done any kitchen audits. RD-F stated she checked in with the kitchen staff when she had questions, but had not done any inspections. RD-F stated she had been in the facility on 4/11/22, and had heard about cleanliness issues in the kitchen and stated had she been doing audits, it might have made a difference. When informed of findings, such as mold growing on the outside of condiment containers, RD-F stated that meant food had been left on the outside of the container. When asked about egg shells stored with whole eggs, RD-A stated that was a concern for cross contamination. RD-F stated they had work to do and would meet with the administrator and DM-A and put a plan in place.

Training of new kitchen staff hired in 2022, consisted of on-the-job training with DM-A, however no orientation list/tool was used to verify the content of the training. In addition, new staff completed the following online module titled: Basics of Food Safety in LTC (long term care). Detail of the course included: Three types of hazards to food safety: physical, chemical and biological. Use proper hygiene to prevent contamination. Follow proper protocols to prevent cross-contamination. Maintain safe temperature ranges for food. Use cleaning and sanitizing methods to reduce risk of foodborne illness. Cook (C)-D was hired on 3/23/22, and completed the online course on 3/20/22. Kitchen aide (KA)-B was hired on 1/18/22, and completed the online course on 1/26/22. DM-A holds a certified dietary manager certification with expiration date of 8/31/22. Job description for DM-A indicated

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supervising the quality of performance for employees on the team, assist in training new staff and the development of existing staff members, ensure department meets all regulatory requirements, advises on the appearance, taste and sanitation of food, delegates responsibilities, and supervises staff to be accountable to tasks.

Hand Hygiene

During observation on 4/11/22, at 5:26 p.m., dietary aide (DA)-A took out tray from enclosed cart and entered R14's room, with no observed hand hygiene completed. DA-A set tray down and touched bedside table and moved into position for eating. DA-A then left the room, did not complete hand hygiene and took out tray for R136 and left on table outside of the door and notified nurse the tray was outside of the room, did not complete hand hygiene. DA-A then took out tray for R134 and entered room, touching the bedside table and R134's water glass. DA-A exited room and did not complete hand hygiene. DA-A then took out R25's tray and delivered it to her room, again touching and moving the bedside table. DA-A exited the room and did not complete hand hygiene and returned to the kitchen.

During interview on 4/11/22, at 5:36 p.m., DA-A indicated he does not complete hand hygiene between rooms and no one ever taught him to do that.

During an observation in the kitchen on 4/11/22, from 5:36 p.m. to 5:42 p.m., cook (C)-B was observed handling multiple items and surfaces while wearing black gloves, and at no time during this observation did C-B remove gloves and

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perform hand hygiene. C-B was observed plating food while standing at the pass-through window. C-B handled multiple paper meal slips filled out by staff and residents, placed coleslaw on plates using a scoop, placed half sandwiches on the plates, then covered the plates with a plastic thermal cover and set the plate on the counter of the pass-through window. In addition, while wearing the same gloves, C-B placed food in the microwave to reheat, stirred food on the stove, then reached into a plastic container for the half sandwiches to add to plates. This process was repeated until all resident food orders had been filled.

During an observation on 4/13/22, at 10:38 a.m., observed kitchen aide (KA)-C fill beverage cups for water, milk and juice, and set them on resident trays. When setting the filled cups on the tray or re-arranging the cups, KA-C held the cups by the rims with her bare hands.

During interview on 4/13/22, at 11:10 a.m., the interim director of nursing (DON) confirmed hand hygiene should be completed if touching personal items such as water glass or bedside table in resident's room when delivering trays to residents.

Upon request of hand hygiene education for DA-A, the dietary manager (DM) gave a "Food and Nutrition Competency Checklist for Hand washing and Glove use" competency form dated 7/18. No name was present on competency. A rating of 3 (moderately skilled), completion date of 2/22 was present with no signature of who completed competency present.

An Employee Roster indicated DA-A began

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F 812	Continued From page 44 employment at the facility on 1/6/22. During interview on 4/13/22, at 12:40 p.m., human resources (HR)-A indicated she was trained by previous DON to complete hand hygiene observations on nursing department staff only and was never requested to complete them on dietary staff members. During an interview on 4/14/22, at 11:20 a.m., the dietary manager (DM)-A and administrator were informed of observations of KA-C holding the rim of drinking cups and of C-B wearing the same gloves for multiple tasks, then handling sandwiches. DM-A stated staff should know not to do that. When asked if dietary staff received infection control training related to their specific duties, DM-A stated she thought so, but didn't know who was responsible for providing this training. During an interview on 4/14/22, at 1:47 p.m., registered nurse (RN)-C stated there had been no residents with symptoms of foodborne illnesses. When asked if she had any involvement with infection control oversight in the kitchen, RN-C stated she had done mock surveys in the kitchen in the past, the last time being 9/10/21. RN-C stated the human resource director had also helped with audits and had done one on 1/19/22. These two audit results were reviewed and pertained primarily to equipment and environment. Facility policy titled Date Marking - Food and Nutrition, with revised date 5/3/21, indicated the policy provided guidelines for proper date-marking to ensure that food was handled and stored safely. Best if used by dates were not	F 812		

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F 812	Continued From page 45 expiration dates. Refer to USDA (United States Department of Agriculture) guidance on Shelf Stable Food Safety. When TCS (time/temperature control for safety foods) were received in, employees date-mark the item with the delivery date. Use by date is an expiration date. As much as possible, food items should remain in original containers/packaging; if removed from original packaging, individual items were labeled and dated with date of receiving. Ensure that ready-to-eat TCS foods opened at the location were clearly date-marked for date/time the original container was opened. The date or day by which the food shall be consumed on premises, or discarded. TCS food prepared onsite and held in refrigeration for more than 24 hours shall be clearly marked to indicate the date or day by which the food shall be consumed or discarded. Employees were to count the day of preparation as Day 1. At no time can a TCS prepared food be held more than seven days in a non-frozen state. Facility policy titled Food-Supply Storage, with revised date of 6/23/21, indicated food from approved food sources would be stored in sanitary conditions. Food opened or prepared were placed in an enclosed container, dated, labeled and store properly. Once meal service is over, cover, date and label individually-portioned items. Location-prepared time/temperature control for safety foods are discarded after three days in the refrigerator unless safe storage guidelines are available. In the refrigerator, the temperature was kept between 35 and 40 degrees Fahrenheit (F). In the freezer, the temperature was 0 degrees F or lower. Internal temperatures of all refrigerators and freezers are recorded twice daily.	F 812		

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F 812	Continued From page 46 Facility policy titled Food Temperature Monitoring, with revised date of 3/15/22, indicated food was cooked, reheated or cooled to ensure proper holding temperatures before each meal services. Food temperatures were taken and recorded before each meal service. Periodically, temperatures were taken at other times during or at the end of meal service to ensure temperatures were held within acceptable ranges. Food was served at proper serving temperatures. Before meal service, the cook takes the "cook-to" and the "serve" temperatures of all TCS (time/temperature control for safety) menu items and records it on the Food Temperature Record. The cook monitors TCS foods throughout meal service. To correctly take temperatures, the food thermometer was inserted into the center or thickest part of the food for at least 15 seconds or per instructions on the thermometer. TCS hot foods should be served at 135 degrees F or higher. A chart of Minimal Internal Cooking Temperatures indicated a variety of foods and the required temperature prior to serving.	F 812		
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention	F 880		5/20/22

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F 880	Continued From page 47 and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed	F 880		

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F 880	Continued From page 48 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 follow Centers for Medicare and Medicaid Services (CMS) and Centers for Disease Control (CDC) guidelines by appropriately implementing measures to prevent the spread of infection when the facility failed to ensure personal protective equipment (PPE) was discarded prior to leaving resident rooms, and failed to clean multi-use equipment between uses. The deficient practices had the potential to affect all 34 residents who resided in the facility. Findings include: Sanitizing re-usable equipment During observation and interview on 4/12/22, at 9:23 a.m., nursing assistant (NA)-C and NA-D came out of R31's room after using the mechanical lift to transfer R31 from wheelchair to recliner and went directly into R134's room with lift. NA-C and NA-D then used lift to assist R134 with transfer from wheelchair to the bed. NA-D,	F 880	F880-Infection Prevention- Wiping Equipment Staff were educated to clean equipment□s between uses per CDC and infection control policy guideline. All residents sharing mechanical lifts/equipment have the potential to be affected by the deficient practice. Each mechanical lift equipment will have two bottles of wipes for cleaning after each use. Education provided to staff by Clinical Learning and Development Specialist (CLDS). Our policy on Infection Control reviewed and is current. At the start of each shift, aides will assess their assigned work area for stocked supplies. Education provided to nursing staff on this process change. All nursing assistants will begin attending the start-of-shift report, and charge nurse	

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F 880	Continued From page 49 when asked if the resident lift was cleaned between uses, indicated Purell (hand sanitizer) was used to the clean the machine. When questioned when that was completed, NA-D then stated we run out of things all the time and there were no wipes on the machine. During interview on 4/13/22, at 11:10 a.m., the interim director of nursing (DON) indicated lift equipment should be cleaned using appropriate designated sanitizer, which is not Purell, between uses. During interview on 4/13/22, at 12:52 p.m., the interim DON indicated training is occurring today on proper disinfection of equipment. Personal Protective Equipment: The Centers for Disease Control guidance CS250672-E, undated, indicated "Remove all Personal Protective Equipment (PPE) before exiting the patient room except a respirator". During observation and interview on 4/11/22, 2:55 p.m., R25, R134 and R136 had cart with drawers present next to the door of the rooms with laundry basket full of uncovered yellow gowns on top along with gloves. A covered linen hamper was present on the other side of the cart. Contact Precaution signs were present on R25, R134 and R136's doors. During interview RN-A indicated the laundry basket has clean gowns in it and all three residents are on quarantine currently. RN-A indicated they take gloves off inside the room and then come out of room and remove gown and place in covered linen hamper. During observation on 4/11/22, at 3:08 p.m., NA-A	F 880	confirm with aides that supplies were checked. Will also add a second container of wipes to be available with each mechanical lift. A random audit for two containers with each mechanical lift biweekly x2, weekly x3, then as needed. Findings will be shared with the QAPI committee monthly x4 months for input on the need to increase, decrease or discontinue audits. Completion: 5/20/22 DNS or designee and IP nurse F880-Infection Prevention- Proper Removal of PPE Removed bin and placed in appropriate location per transmission based practice. Immediate education provided to staff. All residents have the potential to be affected by the deficient practice. Reviewed PPE set ups for all residents on transmission-based precautions. Education provided for all staff by CLDS. Our policy on Infection Control: Putting On/Taking Off Personal Protective Equipment PPE (Donning/Removing)- All Service Lines policy reviewed and is current. PPE doffing stations will be placed in proper location so that PPE can be doffed prior to exiting the resident room. Reference guide will be created for PPE isolation room setup and consult the Lead Infection Prevention Team for review and	

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F 880	Continued From page 50 put on gown, then gloves and entered R25's room and assisted her to restroom. NA-A then came out of room with gown on walking past uncovered clean gowns and removed and discarded contaminated gown in linen hamper. During observation on 4/11/22, at 4:02 p.m., registered nurse (RN)-A put on gown from the laundry basket, gloves and entered R133's room. RN-A came out of R133's room without gloves, walked past cart with gowns present on top in uncovered laundry basket and removed gown, discarding into covered dirty linen hamper. During interview on 4/14/22, at 9:01 a.m., RN-C indicated if the policy and procedure says to discard the gown in the work area, that would be inside the room, not in the hallway. During interview on 4/14/22, at 9:23 a.m., RN-E indicated she does the yearly training for staff on donning and doffing PPE. RN-E stated staff were taught to take all PPE off inside the room and dirty linen hamper should be inside the residents room/door even if the resident is only on quarantine. During interview on 4/14/22, at 11:19 a.m., the interim DON confirmed staff should not be coming out of the room to discard the gown. That should be done inside the room. A policy on "Putting on/Taking Off Personal Protective Equipment (PPE) dated 2/15/22 included: -For safe donning and removal of PPE refer to the CDC and Prevention poster. -The Poster indicated Remove all PPE before exiting the patient room except a respirator.	F 880	feedback. Auditing new residents to be placed in transmission based precautions will be done at time of next isolation resident for proper setup, daily audit x5 at time of next isolation resident for proper PPE doffing by staff. Completion: 5/20/22 DNS or designee and IP nurse Documents for DPOC attached on 6/03/2022.	

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F 880	Continued From page 51 - Remove gown (perform gown removal per any isolation requirements) and perform hand hygiene before leaving the contaminated area.	F 880		
F 881 SS=F	Antibiotic Stewardship Program CFR(s): 483.80(a)(3) §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)(3) An antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement a process for antibiotic review in order to determine appropriate indications, dosage, duration, trends of antibiotic use and resistance. This had the potential to affect any residents who had infections requiring antibiotic use. Findings include: When interviewed on 4/13/22, at 11:10 a.m., the interim director of nursing (DON) indicated staff initiate infection monitoring by documenting in the electronic medical record (EMR) which is then reviewed daily by her. The McGeer criteria is used. The interim DON indicated the EMR information including date of onset, date of end of symptoms, diagnosis and antibiotic used is entered into a software program. The interim DON indicated from the software program, reports are run and shared quarterly at quality	F 881	F881-Infection Prevention- Antibiotic Stewardship Analysis Education was provided to IP nurse on tracking and documenting antibiotics. Organization policy Infection Prevention and Control policy has been reviewed and current as it relates to antibiotic stewardship. All residents taking antibiotics will be reviewed and tracking confirmed by ICP nurse with results reviewed at IDT Risk Management meeting weekly. The Infection Prevention and Control policy has been reviewed and is current. Education was provided to the Infection Prevention nurse on antibiotic stewardship, tracking processes and QAPI Committee reporting expectations. Monitor and report weekly at IDT Risk Management meeting for 4 weeks, then	5/20/22

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F 881	Continued From page 52 assurance and performance improvement (QAPI) meetings, which includes the medical director and consulting pharmacist. The interim DON indicated nursing staff monitor resident's culture reports to make sure resident's prescribed antibiotics are on the correct medication. Upon request of reports shared at QAPI meetings, a monthly infection summary was received for January, February and March 2022. Information included on this report was resident name, start date, date symptoms resolved, type of infection (urinary tract infection, pneumonia), antimicrobial used, infection source (community or facility) and surveillance criteria met. Culture or x-ray results were not included. Antimicrobial included medication name and dosage but did not include length of use. The interim DON indicated she is not able to run a report that included chest x-ray and/or culture results that included antibiotic prescribed including length of use, symptoms and onset, and resolution of symptoms. Infection control meeting minutes were requested however the interim DON indicated she was not able to locate and unsure if meetings were held or just reported at QAPI meeting. The interim DON did indicate she has not attended a QAPI meeting since her interim employment began at facility. During interview on 4/13/22, at 12:52 p.m., the interim DON indicated 48 hours after an order is received for an antibiotic, nursing staff are responsible to contact the provider using a form to determine if antibiotics should be continued. Upon request of this form or example of a completed form, none was received. The interim DON did indicate the providers are inappropriately starting antibiotics on residents	F 881	monthly for 3 months. We will review this report regularly at monthly QAPI for increase, decrease or discontinue. Completion: 5/20/22 IP nurse and DNS	

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F 881	Continued From page 53 even if minimal symptoms are present prior to culture results and she has discussed this with them but was unable to identify who, or when this occurred. Upon request, the QAPI meeting minutes were reviewed for 2/15/22, 11/11/21, 8/19/21 and 5/13/21. Infection Control portion included COVID-19 status, testing and vaccine updates. The QAPI meeting minutes did not include a summary of antibiotic use, infectious organisms or multidrug resistant organisms. The interim DON was unable to provide documentation that included a periodic review of antibiotic use, review of laboratory and medication orders, and a system of feedback reports on antibiotic use, antibiotic resistance patterns based on laboratory data and prescribing practices. A policy titled "Antibiotic Stewardship Rehab/Skilled" dated 11/29/21 included: - Purpose is to decrease the incidence of multi-drug resistant organisms, promote appropriate use while optimizing the treatment of infections and reducing the possible adverse events associated with antibiotic use and to provide standard definitions to be used as guidelines when initiating antibiotics.	F 881		
F 883 SS=D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization,	F 883		5/20/22

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	245549	A. BUILDING _____ B. WING _____	C 04/14/2022

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GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	745 BASINGER MEMORIAL DRIVE MOUNTAIN LAKE, MN 56159

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F 883	Continued From page 54 each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the	F 883		

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F 883	Continued From page 55 following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R13, R14, R134) reviewed for immunization status, had been provided education regarding the risks, benefits and potential side effects of the influenza and pneumococcal vaccines in accordance with facility policy and the Centers for Disease Control and Prevention (CDC) recommendations. Findings include: R13's face sheet printed 4/14/22, indicated an admission date of 2/3/22. R13's immunization record identified R13 consented to Influenza vaccine, but was not administered. Pneumococcal vaccines were not present on immunization records. Review of documentation in electronic medical record (EMR) failed to indicate whether the resident/family had been provided education regarding risks, benefits and side effects about the influenza or pneumococcal vaccinations or if resident had received the vaccinations or refused. R14's face sheet printed 4/14/22, indicated an admission date of 2/8/22. R14's immunization record indicated pneumococcal conjugated (PCV13) was given 2/25/16. No documentation	F 883	F883 - Infection Prevention- Influenza and Pneumococcal Vaccinations R13, R14, and R134 has been provided education regarding the risks, benefits, and potential side effects of vaccinations. All residents will be educated on risks, benefits, and potential side effects of vaccinations when vaccines are offered. The Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other, AL, Rehab/Skilled, HBS-Enterprise policy reviewed and is current. The nurses have been trained. The policy for documentation reviewed and is current. Immunization status will be obtained on admission and documented in PCC. HIM staff to maintain resident master immunization list. DNS will monitor immunization status report weekly for 3 months, then monthly for 6 months. Report to QAPI for increase, decrease or discontinue. Completion: 5/20/22 DNS or designee and IP nurse and HIM	

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F 883	Continued From page 56	F 883		

of influenza or pneumococcal polysaccharide (PPSV23) was present regarding provided education on risks, benefits and side effects in the electronic medical record (EMR). No evidence was present the resident had received the vaccinations or refused.

R134's face sheet printed 4/14/22, indicated admission date of 3/22/22. R134's immunization record indicated no immunization history was present. No documentation of influenza, pneumococcal vaccination was present regarding provided education on risks, benefits and side effects was present in the EMR. No evidence was present the resident had received vaccinations or refused.

R134's Minimum Data Set (MDS) dated 3/22/22 was not completed.

During interview on 4/14/22, at 8:25 a.m., R134 indicated he did not receive education on any vaccinations on admission.

During interview on 4/14/22, at 8:36 a.m., registered nurse (RN)-C indicated immunizations are generally completed on admission. If there is no record of immunizations on file and is not completed on the records that are received on admission, they will contact the local provider. RN-C also indicated that the health information management staff will look in their previous medical records and if there are none present will reach out to her or the case managers who then should complete follow-up. RN-C indicated these three residents fell through the cracks and they could improve on the process.

During interview on 4/14/22, at 8:46 a.m., the

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F 883	Continued From page 57 interim director of nursing (DON) indicated there was no documentation found for education on risks, benefits and side effects of influenza, pneumococcal vaccinations for R13, R14, R134 and there should be. Review of Residents Immunization/Vaccinations policy and procedure dated 3/8/22 included: Upon admission each client resident and/or resident representative will receive the vaccination information statements (VIS) for influenza and caregiver for the Covid-19 vaccine. Review current vaccinations, provide and document education on the benefits and potential side effects of the vaccinations for which the client/resident is eligible. If the client, resident and/or the resident representative consent to vaccination..obtain written consent if required by state regulation and administer vaccination. If the resident and or resident representative chooses not to be vaccinated after discussion of benefits, document declination.	F 883		
F 887 SS=D	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine;	F 887		5/20/22

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F 887	Continued From page 58 (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident or resident representative, has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; Note: States that are not subject to the Interim Final Rule - 6 [CMS-3415-IFC], must comply with requirements of 483.80(d)(3)(v) that apply to staff under IFC-5 [CMS-3414-IFC] and (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that includes at a minimum, the following: (A) That staff were provided education regarding	F 887		

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F 887	Continued From page 59 the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure 3 of 5 residents (R13, R14, R134) reviewed for immunization status, had been provided education regarding the risks, benefits and potential side effects of COVID-19 immunization in accordance with facility policy and the Centers for Disease Control and Prevention (CDC) recommendations. Findings include: An immunization report printed 4/11/22, included a hand written note from interim director of nursing (DON) that R13, R14 and R134 refused the COVID-19 vaccine. R13's face sheet printed 4/14/22, indicated an admission date of 2/3/22. R13's immunization record did not include COVID-19 vaccination. Review of documentation failed to indicate whether the resident/family had been provided education regarding risks, benefits and side effects about the COVID-19 vaccination or if resident had received the vaccinations or refused. R14's face sheet printed 4/14/22, indicated an admission date of 2/8/22. R14's immunization record did not include COVID-19 vaccination. No documentation of COVID-19 vaccine was present	F 887	F887&Infection Prevention □COVID Immunizations R13, R14, and R134 has been provided education regarding the risks, benefits, and potential side effects of vaccinations. All residents will be educated on risks, benefits, and potential side effects of vaccinations when vaccines are offered. The Immunizations/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other, AL, Rehab/Skilled, HBS-Enterprise policy reviewed and is current. The nurses have been trained. The policy for documentation reviewed and is current. Immunization status will be obtained on admission and documented in PCC. HIM staff to maintain resident master immunization list. DNS will monitor immunization status report weekly for 3 months, then monthly for 6 months. Report to QAPI for increase, decrease or discontinue. Completion: 05/20/2022	

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F 887	Continued From page 60	F 887		

regarding provided education on risks, benefits and side effects in the electronic medical record (EMR). No evidence was present identifying if resident had received the vaccinations or refused.

R134's face sheet printed 4/14/22, indicated admission date of 3/22/22. R134's immunization record indicated no immunization history was present. No documentation of COVID-19 vaccine was present regarding provided education on risks, benefits and side effects was present in the EMR. No evidence was present the resident had received vaccinations or refused.

R134's Minimum Data Set (MDS) dated 3/22/22 was not completed.

During interview on 4/14/22, at 8:25 a.m., R134 indicated he did not receive education on the COVID-19 vaccination on admission but also indicated he refuses to get the vaccine.

During interview on 4/14/22, at 8:36 a.m., registered nurse (RN)-C indicated immunizations are generally completed on admission. If there is no record of immunizations on file and is not completed on the records that are received on admission, they will contact the local provider. RN-C also indicated that the health information management staff will look in their previous medical records and if there are none present will reach out to her or the case managers to complete follow-up. RN-C indicated R13, R14, R134 fell through the cracks and they could improve on the process.

During interview on 4/14/22, at 8:46 a.m., the interim director of nursing (DON) indicated there was no documentation found for education on

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F 887	Continued From page 61 risks, benefits and side effects of COVID-19 vaccination and there should be. Review of Residents Immunization/Vaccinations policy and procedure dated 3/8/22, included: -Upon admission each client resident and/or resident representative will receive the vaccination information statements (VIS) for influenza and the COVID-19 vaccine. Review current vaccinations, provide and document education on the benefits and potential side effects of the vaccinations for which the client/resident is eligible. If the client, resident and/or the resident representative consent to vaccination..obtain written consent if required by state regulation and administer vaccination. If the resident and or resident representative chooses not to be vaccinated after discussion of benefits, document declination.	F 887		
F 921 SS=E	Safe/Functional/Sanitary/Comfortable Environ CFR(s): 483.90(i) §483.90(i) Other Environmental Conditions The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a sanitary environment in the kitchen when daily cleaning duties were not done, and 1 of 1 fans used in the dishwashing room was observed with dust and debris. This had potential to affect all 34 residents who consumed food prepared in the kitchen. Findings include:	F 921	F921 SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRONMENT The fan in the dishwashing room was cleaned immediately upon surveyor observation on 4/11/2022. All stove surfaces including crevices were cleaned on 4/12/2022 and are on the daily cleaning schedule to be completed by the cook on duty.	5/20/22

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F 921	Continued From page 62 The initial kitchen observation and interview on 4/11/22, at 1:38 p.m. was provided by kitchen aide (KA)-B, as the dietary manager had been off duty and the cook had been on break. In the dishroom, a dirty fan was observed blowing on clean, plastic coffee cups that had come out of the dishwasher and were drying in a plastic crate. The fan was secured to a wall and dust was visible on the grate cover. KA-B was asked to shut the fan off, and dark, fuzzy material was observed on the outer edges of each fan blade. KA-B stated the fan was used for staff comfort as it got hot when doing dishes. On the left side of the stove, greasy material was observed on the flat surface underneath the cast iron burners. On the right side of the stove was a flat, stainless steel griddle. Between the stainless steel edge of the stove which was about four inches wide, to the lip of the griddle, there was a crevice which appeared to have food debris caked all along in the crevice which was approximately 18 to 24 inches long. A white, square drain under the three-compartment sink was observed with dark debris in it. The well-worn sheet vinyl flooring was dull, stained, with dark smudges. In the dry storage room was a three-door stainless steel refrigerator. The outside stainless steel doors were smudged, and the back side of the handle of one door had spongy, moveable material on it. The roll top, stainless steels doors on the steam table were smudged with either hand prints or	F 921	The drain under the three-compartment sink will be sealed/capped and covered by May 20th. The kitchen floor was scrubbed and buffed on May 17th, and is scheduled to be completed twice annually and as needed. Other equipment such as refrigerator door handles, drawer pulls are cleaned on an on-going basis as they become soiled throughout the day All residents have the potential to be affected by the deficient practice. Education and was given to dietary staff in the areas of cleanliness and sanitary conditions of the kitchen on May 9th, 2022. Dietary Staff were in-serviced on maintaining a sanitary environment and the importance of cleaning schedules on May 9th. The schedule was discussed with staff and staff gave input regarding changes to the cleaning schedules as they pertain to their workflow. The policy entitled, General Sanitation □ Food and Nutrition was reviewed with dietary staff. To ensure systemic changes are made random audits will be completed on cleaning schedules and procedures by the dietary manager or designee 3 times weekly for 2 months then weekly for 2 months. To monitor corrective action and the deficient practice is being corrected, all audit results will be reported at the monthly QAPI meeting where it will be determined if the audits need to increase, decrease or continue.	

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F 921	Continued From page 63 food splattering. Daily cleaning logs were observed posted in various parts of the kitchen and dining room for dates 3/28/22, through 4/10/22, and were rarely documented as being completed. Duties varied where identified, including but not limited to, polishing refrigerators and freezers, cleaning salt and pepper shakers, sugar and jelly containers, peanut butter containers. Cleaning the stove top, microwave, grill shelf, can opener, outside of steamer and handle, left oven, right oven, convection oven, sweep and mop. During an interview on 4/14/22, at 11:20 a.m., dietary manager, (DM)-A, stated all kitchen staff were assigned duties, depending upon their role and if they worked during the day or afternoon. DM-A acknowledged that many of the spaces on the forms were blank and she could not verify whether or not the cleaning duties had been carried out, as she did not monitor this. DM-A stated she did a lot of the cleaning herself, but often forgot to sign off that it had been completed. When asked about the food build-up in the crevice on the stove, DM-A stated she recently noticed that and was going to scrape it out. DM-A stated the square, white drain under the three-compartment sink was not hooked up to a drain and the debris in it was from sweeping in and around the drain. DM-A stated staff were responsible for maintaining cleanliness of the kitchen and dining room, and she was responsible to ensure cleaning duties were carried out. DM-A acknowledged that unclean surfaces had the potential for cross contamination causing foodborne illness to residents.	F 921	Completion: 05/20/2022	

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F 921	Continued From page 64 Facility policy titled Cleaning Schedule - Food and Nutrition Services, with revised date of 2/15/22, indicated the purpose was to identify cleaning tasks to be completed. The director of food and nutrition was to post the cleaning assignments and employees were responsible for knowing their assigned duties and carrying them out during the designated work shift. Employees would initial the schedule after completing the cleaning duties. The supervisor was responsible for monitoring employees to ensure that cleaning duties were completed in a satisfactory and timely manner.	F 921		

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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 04/12/2022. At the time of this survey, Good Samaritan Society, Mountain Lake 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 | 05/13/2022

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
	245549	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**04/12/2022**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MOUNTAIN LAKE	**745 BASINGER MEMORIAL DRIVE** **MOUNTAIN LAKE, MN 56159**

(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. The Main Building of Good Samaritan Society Mountain Lake was constructed as follows: The original building was constructed in 1976, is one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction; The 1995 building addition is one-story, has no basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction; The 2000 building addition is one-story, has no	K 000		

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K 000	Continued From page 2 basement, is fully fire sprinkler protected, and was determined to be of Type II(000) construction. The 2013 Link Addition. It is one story in height, has no basement, is fully fire sprinkler protected, and was determined to be of Type II (111) construction. There are no resident sleeping or treatment areas located in Building 02. 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. Main Building is separated from an assisted living facility by a proper two-hour firewall assembly. The facility has a capacity of 50 beds and had a census of 35 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 353 SS=C	Sprinkler System - Maintenance and Testing CFR(s): NFPA 101 Sprinkler System - Maintenance and Testing Automatic sprinkler and standpipe systems are inspected, tested, and maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintaining of Water-based Fire Protection Systems. Records of system design, maintenance, inspection and testing are maintained in a secure location and readily available. a) Date sprinkler system last checked _____ b) Who provided system test _____ c) Water system supply source	K 353		4/25/22

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K 353	Continued From page 3 Provide in REMARKS information on coverage for any non-required or partial automatic sprinkler system. 9.7.5, 9.7.7, 9.7.8, and NFPA 25 This REQUIREMENT is not met as evidenced by: Based on a review of available documentation and staff interview, the facility failed to test and inspect the fire sprinkler system per NFPA 101 (2012 edition), Life Safety Code, 9.7.5, 9.7.7, and 9.7.8, and NFPA 25 (2011 edition), Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, section 5.1.1.2. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/12/2022, between 10:30 AM to 12:30 PM, during documentation review, it was revealed that test reports showing that a 1st quarter fire sprinkler test could not be provided to show that this test was conducted. An interview with the Maintenance Director and Facility Administrator verified this finding at the time of discovery.	K 353	The quarterly sprinkler check that was found to not be completed in quarter one. This simply was missed during the transition of personnel. A makeup Q1 check was conducted by the Chief Maintenance Mechanic on 4/25/2022. To stay on schedule, the quarter two check will also be completed in quarter two. A TELS system reminder is in place to ensure the deficiency does not re-occur. Completion date: 4/25/2022.	
K 372 SS=F	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall.	K 372		4/27/22

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K 372	Continued From page 4 Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier construction per NFPA 101 (2012 edition), Life Safety Code, sections 19.3.7.3 and 8.5.6 through 8.5.6.6. This deficient finding could have a widespread impact on the residents within the facility. Findings include: On 04/12/2022, between 10:30 AM to 12:30 PM, penetrations were observed during the inspection in the smoke barrier wall above the suspended ceiling tiles at Wing 100 and Wing 200. An interview with the Facility Maintenance Director and Facility Administrator verified this finding at the time of discovery.	K 372	The smoke barrier penetrations found on Wing 100 and Wing 200 were re-caulked with appropriate fire-rated caulking on 4/18/2022. A thorough check of all smoke barriers was completed by the Chief Maintenance Mechanic and other areas were re-caulked to ensure there were no other areas penetrated. Completion date: 4/27/2022.	