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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X68M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**
2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/28/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
__ 2. Technical Personnel __ 6. Scope of Services Limit
__ 3. 24 Hour RN __ 7. Medical Director
__ 4. 7-Day RN (Rural SNF) __ 8. Patient Room Size
__ 5. Life Safety Code __ 9. Beds/Room
* Code: **A,1** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Lisa Carey, HFE NEII 01/12/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 01/18/2017 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
01/18/2017
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5550

Good Samaritan Society - Warren has been designated as a Special Focus Facility (SSF)

On December 28, 2016, the Department of Health completed a Post Certification Revisit (PCR) and on January 17, 2017 the Department of Public Safety completed a PCR to verify the facility achieved and maintained compliance with deficiencies issued pursuant to the extended survey completed on November 15, 2016. Based on our revisits we have found the facility achieved substantial compliance with deficiencies issued pursuant to the extended survey, effective January 5, 2017.

As a result of the revisit findings This department discontinued the Category 1 remedy of State monitoring. In addition, we recommended the following actions to the CMS Region V office:

- Civil money penalty for the deficiency cited at F323, be imposed. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492, be imposed. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016, be rescinded.

Refer to the CMS 2567b forms for both health and life safety code.

Effective January 5, 2017, the facility is certified for 45 skilled nursing facility beds.

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245550

March 28, 2017

Ms. Judy Bernat, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

Dear Ms. Bernat:

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

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

Effective January 5, 2017 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

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

Sincerely,

Mark Meath

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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
January 12, 2017

Ms. Judy Bernat, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550028, F5550028

Dear Ms. Bernat:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On December 6, 2016, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective December 11, 2016. (42 CFR 488.422)

In addition, on December 6, 2016, the Department recommended to the Centers for Medicare and Medicaid Services (CMS) that the following enforcement remedies be imposed:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492. (42 CFR 488.430 through 488.444)

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016.

Furthermore, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from November 15, 2016 as a result of the extended survey that identified Substandard Quality of Care (SQC).

This was based on the deficiencies cited by this Department for an extended survey completed on November 15, 2016. At the time of the extended survey conditions in the facility constituted both Substandard Quality of Care (SQC) and Immediate Jeopardy (IJ) to resident health and safety. The most serious deficiencies were found to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

On December 28, 2016, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to an extended survey completed on November 15, 2016. In addition, the life safety code deficiency issued pursuant to the extended survey has not yet been verified. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of January 5, 2017. Based on our revisit, we have determined that your facility has achieved substantial compliance with the health deficiencies issued pursuant to the extended survey completed on November 15, 2016. However, the life safety code deficiency issued pursuant to the extended survey completed November 9, 2016 have not yet been verified. The health deficiency not corrected and life safety code deficiency not yet verified, are as follows:

F0492 - S/S: C - 483.75(b) -- Comply With Federal/state/local Laws/prof Std
K0347 - S/S: E - 483.70(a) -- NFPA 101 Smoke Detection

The health deficiency not corrected was found to be a widespread deficiency that constitute no actual harm with potential for no more than minimal harm (Level C), as evidenced by the attached CMS-2567, whereby corrections are required. The life safety code deficiency issued pursuant to the extended survey completed November 15, 2016 and has not yet been verified as of this notice was found to be a pattern deficiency that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections are required.

As a result of our findings, the Category 1 remedy of state monitoring will remain in effect.

In addition, this Department recommended to the CMS Region V Office the following actions related to the imposed remedies in our letter of December 6, 2016:

- Civil money penalty for the deficiency cited at F323, remain in effect. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492, remain in effect. (42 CFR 488.430 through 488.444)

- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016, remain in effect.

Furthermore, when a facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) requires that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be impose. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 15, 2017. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 15, 2017. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 15, 2017. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

The CMS Region V Office will notify you of their determination regarding the imposed remedies, Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition, and appeal rights.

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

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

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104 ax: (218) 308-2122

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained.

This plan must be implemented, and the corrective action evaluated for itseffectiveness. The plan of correction is integrated into the quality assurance system;

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC and CMS Region V Office approval, a revisit of your facility may be conducted to verify that substantial compliance with the regulations has been attained. The revisit would occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be

discontinued effective the date of the on-site verification. Compliance is certified as of the date of the third revisit.

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 May 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	R 12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS Good Samaritan Society - Warren is designated as a Special Focus Facility (SFF) An on-site post certification revisit (PCR) was completed on 12/28/16, and the facility was found to have corrected all deficiencies issued as a result of the survey exited on 11/15/16. The facility has again achieved full compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form.	{F 000}		
{F 492} SS=C	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was properly registered with the Minnesota commissioner, as required. This had the potential to affect all 30 residents who resided in the facility.	{F 492}	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 corrections is prepared and/or executed solely because the provision of Federal and State Law requires it. For the purpose	1/6/17

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

Electronically Signed | 01/16/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	R 12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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{F 492}	Continued From page 1 Findings include: On 12/27/16, at 2:15 p.m. the administrator confirmed the facility utilized Go-To Healthcare Placement Inc., a staffing agency, to provide a full time registered nurse (RN) as the interim director of nursing (DON) services. The administrator confirmed the DON was a licensed Minnesota RN. The administrator also stated, Go-To Healthcare Placement staffing agency was not currently registered as a SNSA with the state of Minnesota. The administrator explained they had conducted a successful background check for the DON, but did not think the SNSA requirements were applicable because the DON performed administrative nursing duties and was not providing direct care services. The Good Samaritan Society Professional Consulting Services Agreement indicated the facility had entered into an agreement with Go-To Healthcare Placement, Inc. for interim director of nursing services on 11/28/16. The document was signed by both parties.	{F 492}	of any substantial compliance with Federal requirements of participation, this plan of correction constitutes the facility's allegation of compliance in accordance with MN Department of Health. 1. Go-To Healthcare Placement, Inc. will not be used for direct care services. As of 1/6/17 The Go-To Interim DNS was no longer employed in the facility. A new interim DNS was immediately put in place on 1/6/17. 2. Future direct care supplemental nursing agency staff will be hired from agencies on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency. The HR Coordinator will be assuring each supplemental nursing agency staff is currently on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency. A process has been developed to review current supplemental nursing agency staff monthly through QAPI to ensure their agency is still on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency. 3. Education was provided on 12/15/16 by the Workforce Consultant to the Administrator and Human Resources Coordinator that agencies not registered on Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency will not be used	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	R 12/28/2016

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GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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{F 492}	Continued From page 2	{F 492}	for direct care with residents. 4. Each potential supplemental nursing agency will be reviewed to ensure they are on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency prior to allowing staff to work in the facility. Current workers from supplemental nursing agencies were verified on 1/7/17 through the online Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency by the Administrator. Audit results will be tracked and reviewed monthly by the QAPI Committee for further recommendations. 5. 1/6/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245550 Y1	A. Building B. Wing Y2	12/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0225	Correction	ID Prefix F0226	Correction	ID Prefix F0241	Correction
Reg. # 483.13(c)(1)(ii)-(iii), (c)(2) - (4)	Completed	Reg. # 483.13(c)	Completed	Reg. # 483.15(a)	Completed
LSC	12/23/2016	LSC	12/23/2016	LSC	12/23/2016
ID Prefix F0282	Correction	ID Prefix F0323	Correction	ID Prefix F0441	Correction
Reg. # 483.20(k)(3)(ii)	Completed	Reg. # 483.25(h)	Completed	Reg. # 483.65	Completed
LSC	12/23/2016	LSC	12/23/2016	LSC	12/23/2016
ID Prefix F0497	Correction	ID Prefix F0507	Correction	ID Prefix F0513	Correction
Reg. # 483.75(e)(8)	Completed	Reg. # 483.75(j)(2)(iv)	Completed	Reg. # 483.75(k)(2)(iv)	Completed
LSC	12/23/2016	LSC	12/23/2016	LSC	12/23/2016
ID Prefix F0514	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # 483.75(l)(1)	Completed	Reg. #	Completed	Reg. #	Completed
LSC	12/23/2016	LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒	LB/mm	01/11/2017	34985	12/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/15/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245550	A. Building 01 - MAIN BUILDING 01 B. Wing	1/17/2017

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0347	Correction Completed 01/05/2017	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON	
11/9/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered:
January 12, 2017

Ms. Judy Bernat, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

Re: Project # S5550028

Dear Ms. Bernat:

On December 28, 2016, survey staff of the Minnesota Department of Health, Licensing and Certification Program completed a reinspection of your facility, to determine correction of orders found on the survey completed on November 15, 2016.

State licensing orders issued pursuant to the last survey completed on and found corrected at the time of this December 28, 2016, are listed on the electroncally delivered State Form Revisit Report.

Also, at the time of this reinspection completed on December 28, 2016, additional violations were cited as follows:

20005 -- S/S: -- MN Rule 4658.0015 -- Compliance With Regulations And Standards

They are delineated on the attached Minnesota Department of Health Statement of deficiencies-Licensing Orders Form. Only the ID Prefix Tag in the left hand column without brackets will identify these licensing orders. It is not necessary to develop a plan of correction, however, when all orders are corrected, the order should be electronically submitted to this office at:

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

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

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

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

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

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

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

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

Sincerely,

Mark Meath

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

STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
00356 Y1	A. Building B. Wing Y2	12/28/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix 20302	Correction	ID Prefix 20335	Correction	ID Prefix 20565	Correction
Reg. # MN State Statute 144.6503	Completed	Reg. # MN Rule 4658.0130	Completed	Reg. # MN Rule 4658.0405 Subp. 3	Completed
LSC	12/23/2016	LSC	12/23/2016	LSC	12/23/2016
ID Prefix 20625	Correction	ID Prefix 20830	Correction	ID Prefix 21390	Correction
Reg. # MN Rule 4658.0450 Subp. 1 A-P	Completed	Reg. # MN Rule 4658.0520 Subp. 1	Completed	Reg. # MN Rule 4658.0800 Subp. 4 A-I	Completed
LSC	12/23/2016	LSC	12/23/2016	LSC	12/23/2016
ID Prefix 21805	Correction	ID Prefix 21980	Correction	ID Prefix 22000	Correction
Reg. # MN St. Statute 144.651 Subd. 5	Completed	Reg. # MN St. Statute 626.557 Subd. 3	Completed	Reg. # MN St. Statute 626.557 Subd. 14 (a)-(c)	Completed
LSC	12/23/2016	LSC	12/23/2016	LSC	12/23/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
☒ x	LB/mm	01/11/2017	34985	12/28/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
11/15/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	R 12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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) COMPLETE DATE
{2 000}	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: An onsite follow-up visit was completed on December 28-30th 2016. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. Although no plan of correction	{2 000}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	R 12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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) COMPLETE DATE
{2 000}	Continued From page 1 is required, it is required that the facility acknowledge receipt of the electronic documents.	{2 000}		
2 005	MN Rule 4658.0015 COMPLIANCE WITH REGULATIONS AND STANDARDS A nursing home must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in a nursing home. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota (MN) commissioner, as required. This had the potential to affect all 30 residents who resided in the facility and received services from the the supplemental staff. Findings include: According to MN State Statute 144A.71 Subdivision 1, "a person who operates a supplemental nursing service agency (SNSA) shall register with the commissioner." The facility failed to be in compliance with the SNSA requirement as the facility obtained nursing services from Go-To Healthcare Placement Inc., which is not registered by the Department of Health.	2 005	Corrected	1/6/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	R 12/28/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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) COMPLETE DATE
2 005	Continued From page 2 On 12/27/16, at 2:15 p.m. the administrator confirmed the facility utilized Go-To Healthcare Placement Inc., a staffing agency, to provide a full time registered nurse (RN) as the interim director of nursing (DON) services. The administrator confirmed the DON was a licensed Minnesota RN. In addition, the administrator verified Go-To Healthcare Placement Inc., staffing agency was not currently registered as a SNSA with the state of Minnesota. The administrator explained they had conducted a successful background check for the DON, and did not think the SNSA requirements were applicable because the DON performed administrative nursing duties and was not providing direct care services. The Good Samaritan Society Professional Consulting Services Agreement indicated the facility had entered into an agreement with Go-To Healthcare Placement, Inc. for interim director of nursing services on 11/28/16. The document was signed by both parties. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures to ensure staff utilized from SNSAs are from approved registered agencies with the State of Minnesota. The administrator could develop a system to educate staff and develop monitoring. TIME PERIOD FOR CORRECTION: One hundred eight (180) days.	2 005		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: X68M

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00356

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245550**

2.STATE VENDOR OR MEDICAID NO.
(L2) **304842000**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - WARREN**
(L4) **410 SOUTH MCKINLEY STREET**
(L5) **WARREN, MN** (L6) **56762**

4. TYPE OF ACTION: **2** (L8)

1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/15/2016** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

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

FISCAL YEAR ENDING DATE: (L35)
09/30

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jana Bromenshenkel, HFE NEII
01/09/2017
(L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist
01/18/2017
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
03/01/1991
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN: 24 5550

Good Samaritan Society - Warren has been designated as a Special Focus Facility (SSF)

On November 15, 2016, an extended 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. conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required.

As a result of the survey findings the facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

• State Monitoring effective December 11, 2016. (42 CFR 488.422)

In addition, the Department is recommending the enforcement remedies listed below to the CMS Region V Office for imposition:

• Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
• Civil money penalty for the deficiency cited at F492. (42 CFR 488.430 through 488.444)

• Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016.

Refer to the CMS 2567 for both health and life safety code, along with the facility's plan of correction. Post Certificatoin Revisit (PCR) to follow.

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 6, 2016

Ms. Judy Bernat, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, Minnesota 56762

RE: Project Number S5550028

Dear Ms. Bernat:

Please note that this facility has been chosen as a Special Focus Facility (SFF). CMS' policy of progressive enforcement means that any SFF nursing home that reveals a pattern of persistent poor quality is subject to increasingly stringent enforcement action, including stronger civil monetary penalties, denial of payment for new admissions and/or termination of the Medicare provider agreement.

On November 15, 2016, an extended 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.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted **both substandard quality of care and immediate jeopardy** to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted immediate jeopardy (Level J), whereby corrections were required. The Statement of Deficiencies (CMS-2567) are being electronically delivered.

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

> **Removal of Immediate Jeopardy - date the Minnesota Department of Health verified that the conditions resulting in our notification of immediate jeopardy have been removed;**
>
> **No Opportunity to Correct - the facility will have remedies imposed immediately after a determination of noncompliance has been made;**
>
> **Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS);**

Substandard Quality of Care - means one or more deficiencies related to participation requirements under 42 CFR § 483.13, resident behavior and facility practices, 42 CFR § 483.15, quality of life, or 42 CFR § 483.25, quality of care that constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm;

Appeal Rights - the facility rights to appeal imposed remedies;

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

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

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

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

REMOVAL OF IMMEDIATE JEOPARDY

We also verified, on November 15, 2016, that the conditions resulting in our notification of immediate jeopardy have been removed. Therefore, we will notify the CMS Region V Office that the recommended remedy of termination of your facility's Medicare and Medicaid provider agreement not be imposed.

DEPARTMENT CONTACT

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

Lyla Burkman, Unit Supervisor
Bemidji Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: Lyla.burkman@state.mn.us
Phone: (218) 308-2104
Fax: (218) 308-2122

NO OPPORTUNITY TO CORRECT - REMEDIES

Because your facility is designated as a Special Focus Facility (SFF). CMS's policy of progressive enforcement means that your facility would not be given an opportunity to correct before remedies are imposed. Since your facility meets the criterion remedies will be imposed immediately. Therefore, this Department is imposing the following remedy:

- State Monitoring effective December 11, 2016. (42 CFR 488.422)

In addition, the Department is recommending the enforcement remedies listed below to the CMS Region V Office for imposition:

- Civil money penalty for the deficiency cited at F323. (42 CFR 488.430 through 488.444)
- Civil money penalty for the deficiency cited at F492. (42 CFR 488.430 through 488.444)
- Discretionary Denial of Payment for New Medicare and Medicaid Admissions, effective December 26, 2016.

The CMS Region V Office will notify you of their determination regarding our recommendations and your appeal rights.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with §483.13, Resident Behavior and Facility Practices regulations, §483.15, Quality of Life and §483.25, Quality of Care has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. **If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.**

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - Warren is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective November 15, 2016.

This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

APPEAL RIGHTS

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Karen R. Robinson, Director
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. In order for your allegation of compliance to be acceptable to the Department, the PoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for their respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. 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 THIRD OR SIXTH MONTH AFTER THE LAST DAY OF THE SURVEY

If substantial compliance with the regulations is not verified by February 15, 2017 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 15, 2017 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal

dispute resolution policies are posted on the MDH Information Bulletin website at:
http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING _____ B. WING _____	11/15/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS Good Samaritan Society, Warren is a Special Focus Facility (SFF) and a recertification survey was conducted on Novmber 7th through the 15th, 2016. The survey resulted in an Immediate Jeopardy (IJ) at F323 related to the facility's failure to comprehensivley assess accidents and implement interventions which placed a resident who had sustained significant injuries as a result of falls and was at significant risk for repeat falls with significant injury and/or death. The administrator and director of nursing (DON) were notified of the IJ on 11/10/16, at 4:00 p.m. and was removed on 11/15/16, at 3:27 p.m. In addition, an extended survey was conducted on November 14 and 15, 2016. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification	F 000		
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS	F 225		12/23/16

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

Electronically Signed | 12/14/2016

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F 225	Continued From page 1 The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 225	Preparation and execution of this	

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F 225	Continued From page 2 facility failed to immediately report to the State agency (SA), and/or thoroughly investigate incidents of potential mistreatment related to significant injuries and bruises of unknown origin for possible mistreatment and neglect of care for 1 of 1 resident (R23) who had unwitnessed falls with serious injury and had bruises of unknown origin. In addition, the facility failed to timely report to the SA incidents of missing money for 1 of 1 resident (R12) who reported money missing. Lastly, the facility failed to ensure 1 of 5 agency staff members (LPN-A) had a criminal background screening completed. Findings include: R23 sustained bruises of unknown origin and had two unwitnessed falls with significant injury which were not reported to the SA. R23's admission Minimum Data Set (MDS) dated 9/2/16, indicated R23 had severe cognitive impairment, was rarely or never understood, required extensive assistance with activities of daily living (ADLs), had a history of falls with fractures, and received anti-anxiety and diuretic medications which could increase fall risk. R23's Diagnosis Report dated 11/9/16, indicated R23 was admitted to the facility in August 2016, following surgical repair of a fractured femur and diagnoses which included interoperable hemorrhage and hematoma (bleed or bruise) of the musculoskeletal structure, Alzheimer's disease, anxiety, anemia, pain, osteoarthritis,	F 225	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. 1. R23□s fall with injury was filed with the Office of Healthcare Facility Complaints (OHFC) on 12/10/16 by the Administrator. R23□s injury of unknown origin (bruising) was filed with the Office of Healthcare Facility Complaints (OHFC) on 12/10/16 by the Administrator. R12□s incident of missing money was reported to the Office of Healthcare Facility Complaints (OHFC) on 8/15/2016 by the Administrator and the incident was investigated per facility policy/procedure. LPN-A no longer works for The Good Samaritan Society □ Warren. 2. All incident reports since the last survey will be reviewed by the Administrator to ensure that in the incidents that should have been reported were reported to OHFC by 12/23/16. Good Samaritan Society □ Warren	

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F 225	Continued From page 3 hearing loss and weakness. R23's Care Area Assessment (CAA) dated 9/2/16, identified R23 had Alzheimer's disease, cognitive impairment and anxiety. CAA indicated R23 had a functional limitation in range of motion, pain and an inability to perform ADLs without significant physical assistance, was deaf and non-verbal. The CAA further identified R23 had vision problems, restricted mobility, balance problems during transitions, and difficulty sitting due to recent hip fracture and surgery. The CAA further identified R23 had urinary urgency related to diuretic medication use and received anti-anxiety medication (sedative) which increased R23's risk for falls. An incident report noted in R23's medical record revealed on 10/10/16, at 6:07 p.m. indicated R23 was noted to have bruises on lower legs and upper back (in the spine area). The report did not identify the size/coloring of the bruises. The bruises were identified as being of an unknown origin. The facility did not report the bruises of unknown origin to the SA. The facility completed an investigation on 10/14/16, in which they determined the bruises to the lower legs may have been from the wheelchair legs, however, the origin for the bruise to the spine was not identified. On 11/10/16, at 10:30 a.m. the administrator confirmed the bruises identified on 10/10/16, were of an unknown origin and they were not reported to the SA, nor were they investigated to determine the cause of the bruising.	F 225	reviewed the current policy for staffing agencies to staff the facility. All current and future occurrences of staffing needs have opportunity for deficient practice. 3. Good Samaritan Society □ Warren reviewed the current procedure for reporting un-witnessed fall with significant injury. The facility also reviewed the current procedure for reporting injuries of unknown origin. The facility also reviewed the current procedure for reporting incidents to OHFC. We identified gaps in knowledge, which included knowledge deficits of staff, DNS, and Administrator. All current and future residents who have un-witnessed falls with significant injury or injuries of unknown origin will be reported to OHFC per MN and Federal guidelines. a. The reporting process for the Vulnerable Adult Reporting (CMS algorithm) will be posted by the communication boards in the nursing stations and in the break room. This process includes immediate notification of the Administrator and DNS during working hours and placing an immediate call to the Administrator and DNS on evenings and weekends. Completed 12/9/2016 by the DNS b. The internal Vulnerable Adult reporting process will be posted by the communication boards in the nursing stations and in the break room. Completed 12/9/2016 by the DNS. c. Reporting process will be reviewed in the All Staff meeting scheduled 12/15/16 and 12/20/16.The Process will stress the required 2 and 24 hour guidelines for	

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F 225	Continued From page 4 R23's progress note (PN) dated 10/30/16, indicated R23 was found on her buttocks on the 100-hallway floor at 8:30 a.m. R23 was assessed by nursing and assisted back into the wheelchair via a mechanical lift. R23 was noted to be holding her right shoulder and had a large hematoma to her forehead. R23 denied pain and had been previously administered Tylenol with codeine at 7:28 a.m. that morning. R23 was sent to emergency department (ED) for evaluation. R23 returned from the ED at 11:39 a.m. The note indicated R23 had a Cat Scan with no acute pathology noted. The ED recommended staff continue to monitor R23's neurological status and frontal hematoma for skin breakdown and for R23 to follow up with the clinic on 10/31/16. R23's PN dated 10/30/16, indicated at 5:15 p.m. the nurse was informed R23 was found on the dining room floor, lying on her right side with a heavy bloody nose from both nostrils. R23 was assessed and R23 denied pain. R23 was assisted into a dining room chair via a mechanical lift. R23's nose continued to bleed so R23 was removed from the dining area. A follow up noted at 6:30 p.m. indicated the above fall occurred at 4:45 p.m. and while seated in the dining room chair, R23 continued to "head bob" and bleed through the nose, therefore she was assisted to her room and in to bed. An antianxiety medication was given to "settle her." Once settled into bed, a nurse entered R23's room, and observed large amounts of blood on R23's pillow and her nose clotted with blood. R23's blood pressure was 87/54. The on call physician was notified and R23 was taken to the ED.	F 225	reporting an OHFC incident. d. All new employees and agency staff will have a background check completed following Minnesota procedure regarding conducting background checks. e. All current agency/contract employees have been audited to ensure the state specific procedures were followed for obtaining employee background checks. Completed 12/13/2016. All staff will be re-educated via All Staff meeting. A video will be available to watch for those who did not attend the All Staff meeting. A knowledge verification will be required indicating that the video was viewed and understood. All information will be sent to those who did not attend the All Staff meeting or view the video via certified letter. To ensure the education was received and understood staff will take and return a knowledge verification that will be included. This is to ensure their understanding of what constitutes a significant injury and an injury of unknown origin by 12/23/2016. This is also to ensure their understanding of the facility procedures as it relates to the Administrator and DNS notification as well as the 2 and 24 hour required OHFC reporting of significant injuries and injuries of unknown origin will be completed by 12/23/2016. Staff who does not attend the All Staff meeting, views the video, or return the knowledge verification sheet that was sent via registered mail will not be able to return to work until completed. All staff will also be educated on all	

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F 225	Continued From page 5 -A follow up noted at 11:30 p.m. indicated R23 was admitted to the hospital for observation of head injury and possible urinary tract infection. The bleeding had ceased and R23 was receiving fluids. The hospital would continue to monitor R23 and hopefully she would return to the facilty the next day. R23's PN dated 11/7/16, at 2:26 p.m. indicated R23 was found on the floor in her bathroom, next to the sink. No injuries were sustained. R23 was assisted into the wheelchair via a mechanical lift. Although no injuries were sustained, R23's medical record lack documentation of an investigation as to the root cause of the fall and to determine if neglect of care had occurred. Review of the facility vulnerable adult (VA) reports lacked documentation in which the SA had been notified of R23's unwitnessed falls with significant injury. On 11/09/16, at 1:34 p.m. the director of nursing (DON) stated she didn't know if R23's injuries sustained on 10/30/16, should have been reported to the SA or not, however, felt R23's injuries somewhat met the criteria for reporting to the SA. The DON confirmed R23 had sustained a right frontal hematoma, nose bleed, and was hospitalized after the second fall on 10/30/16. The DON stated she didn't previously know why R23 was hospitalized and was unaware until now that R23 had sustained a right frontal scalp hematoma. She stated no one had told her R23 had sustained a hematoma as she had just thought R23 had a bump on her head. She stated	F 225	suspected and actual OHFC reportable incidents which include un-witnessed falls and significant injury and injuries of unknown origin by 12/23/2016 a. By 12/23/2016 all Licensed Nurses will be educated to follow the internal procedure for Vulnerable Adult Reporting which includes notifying the Administrator and DNS about all suspected and actual OHFC reportable incidents once the resident is safe. A phone call to the Administrator and DNS will be made on weekends and evenings to provide notification and reporting. b. The Administrator and DNS were educated on all suspected and actual OHFC reportable incidents including un-witnessed falls with significant injury and injuries of unknown origin by the Rehab/Skilled Consultant on 12/15/2016. c. The Human Resources Coordinator, Staff Development Coordinator, and Administrator were educated on 12/15/2016 by the Workforce Consultant on the state specific procedure for obtaining employee background checks. 4. All incident reports will be audited by the DNS, or designee, to ensure proper notifications to DNS and/or Administrator occurred, documentation is completed, root cause analysis is determined, care plans updated, and OHFC is notified within 2 or 24 hours if required. Any weekend incident reports will be audited for documentation accuracy during the following Monday morning meeting. As noted above, a phone call to the	

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F 225	Continued From page 6 R23's hematoma should have been reported to the SA. On 11/10/16, at 12:43 p.m. The DON and administrator were interviewed. Both confirmed R23's injuries sustained on 10/30/16, were not reported to the SA because they were not aware of how serious R23's injuries actually were, and confirmed the incidents should have been reported to the SA, immediately. The DON and administrator verified they were both notified immediately via text message after both R23's falls on 10/30/16. In addition, the administrator stated she hadn't completed a root cause investigation for R23's fall on 11/7/16, because she felt it needed to be a team effort investigation, and stated she could have completed the investigation but didn't. She stated the staff typically reviewed falls during their morning huddle meeting, and stated because of the survey, they did not hold their morning meetings this week. Due to lack of investigation, it was unknown if R23's care plan was followed/neglect of care occurred. During a facility monitoring visit on 11/11/16, at approximately 12:30 p.m. the occupational therapist (OT) confirmed R23's cognition was limited, she had impaired safety awareness and no instruction/safety measure recall after cued/instructed. The OT stated R23's fall in the bathroom was due to licensed practical nurse (LPN)-B assisting R23 onto the toilet and leaving her unattended. The OT stated R23 does not remember to use the call light to alert staff assistance was needed and would usually turn on	F 225	administrator and DNS will be made on the evenings and weekends to provide notifications and further reporting. Incident audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. The Human Resources, or designee, will audit all new employees and agency/contract employee records to ensure they are in compliance with state specific requirements of background checks weekly x 12 weeks. All audit results will be tracked and reviewed monthly by the Quality Assurance Performance Improvement Committee (QAPI) for further recommendations. 5. 12/23/2016	

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F 225	Continued From page 7 the call light only to shut if off herself, shortly thereafter. On 11/11/16, at 12:45 p.m. LPN-B confirmed she had assisted R23 onto the toilet and had left her unattended, however, wasn't sure if it was Monday 11/7/16, or a previous Monday. LPN-B also confirmed R23 did not always use the call light to request assistance when on the toilet. On 11/14/16, at 11:34 a.m. LPN-B stated she was on the scene for both of R23's falls on 10/30/16. LPN-B stated the facility policy directed them to report major injuries if a resident's care plan wasn't followed. She stated she determined R23's care plan was followed for both R23's falls on 10/30/16, and stated that's why she didn't report R23's major injuries. On 11/15/16, at 10:42 a.m. the DON and administrator were interviewed again. both stated they had completed R23's fall investigation from 11/7/16, and had determined R23 had taken herself to the bathroom after breakfast. The adminstrator stated R23's falls with serious injuries were not reported to the SA because the falls were investigated, the care plan was followed, there was no evidence of maltreatment, and R23 had been seen by a physician. However, both the administrator and the DON stated they were not aware what the facility policy directed staff to do when incidents of unwitnessed falls with injury occurred. The Minnesota Reporting of Maltreatment of	F 225		

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F 225	Continued From page 8 Vulnerable Adults dated, 9/15 indicated if the facility had knowledge that a vulnerable adult had sustained a physical injury which was not reasonably explained, the facility was required to report the incident to the SA. The policy further indicated if the facility had reason to believe an "error," resulting in harm or injury occurred must make a report to the SA. The facility Abuse and Neglect policy dated 2/2013, directed staff to report alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin to be reported immediately to the facility administrator and the State agency. R12's report of missing money was not reported to the SA timely. Review of the VA reports from 6/2016 - 11/2016, included a report dated 8/14/16, in which R12 had reported she was missing one twenty dollar bill, one ten dollar bill, five five dollar bills and three one dollar bills (for a total of $58.00) from her purse. R12 reported the concern to the facility via a suggestion or concern form dated 8/14/16. The facility did not report the concern to the SA until 8/15/16. On 11/10/16, at 12:30 the administrator confirmed R12 had reported the concern on Sunday, 8/14/16, and the SA was not notified until the next day, Monday, 8/15/16. The administrator stated the facility was to report concerns of misappropriation of resident property to the SA	F 225		

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F 225	Continued From page 9 immediately. The Abuse Definitions policy dated 2/2013, identified misappropriation of resident property as abuse and directed the staff to report misappropriation of resident property to the administrator and SA immediately. Background Checks: On 11/8/16, at 10:28 a.m. the administrator confirmed licensed practical nurse (LPN)-A had been contracted and worked at the facility from 5/2/16, through 11/2/16. The administrator stated LPN-A had worked on the nursing units providing direct resident care and as the minimum data set (MDS) coordinator. On 11/9/16, at 11:13 a.m. administrator confirmed the facility had not conducted a back ground check on LPN-A. Background Investigations - Minnesota policy dated 8/15, indicated the facility would follow state specific procedures for obtaining employee back ground checks.	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226		12/23/16

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F 226	Continued From page 10 This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy as directed related to the immediate reporting to the State agency of injures of unknown origin for 1 of 1 resident (R23) identified with bruising of unknown origin; failed to immediately report and thoroughly investigate falls with significant injury for possible mistreatment and neglect of care for 1 of 1 resident who sustained significant injures during unwitnessed falls. The facility failed to report missing money to the State agency for 1 of 1 resident (R12) who had reported missing money and failed to conduct background checks for 1 of 5 agency staff members licensed practical nurse (LPN)-A) who lacked a criminal background check. Findings include: The Abuse and Neglect policy dated 2/2013, directed the staff to report alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin to be report immediately to the facility administrator and the State Agency (SA). The Abuse Definitions policy dated 2/2013, identified misappropriation of resident property as abuse and directed the staff to report misappropriation of resident property to the administrator and SA immediately. Background Investigations - Minnesota policy	F 226	1. R23□s fall with injury was filed with the Office of Healthcare Facility Complaints (OHFC) on 12/10/16 by the Administrator. R23□s injury of unknown origin (bruising) was filed with the Office of Healthcare Facility Complaints (OHFC) on 12/10/16 by the Administrator. R12□s incident of missing money was reported to the Office of Healthcare Facility Complaints (OHFC) on 8/15/2016 by the Administrator and the incident was investigated per facility policy/procedure. LPN-A no longer works for The Good Samaritan Society □ Warren. 2. All incident reports since the last survey will be reviewed by the Administrator to ensure that in the incidents that should have been reported were reported to OHFC by 12/23/16. Good Samaritan Society □ Warren reviewed the current policy for staffing agencies to staff the facility. All current and future occurrences of staffing needs have opportunity for deficient practice. 3. Good Samaritan Society □ Warren reviewed the current procedure for reporting un-witnessed fall with significant injury. The facility also reviewed the current procedure for reporting injuries of unknown origin. The facility also reviewed the current procedure for reporting incidents to OHFC. We identified gaps in knowledge, which included knowledge deficits of staff, DNS, and Administrator.	

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F 226	Continued From page 11 dated 8/15, indicated the facility would follow state specific procedures for obtaining employee back ground checks. Findings include: R23 sustained bruises of unknown origin and had two unwitnessed falls with significant injury which were not reported to the SA. During record review for R23, an incident report dated 10/10/16, at 6:07 p.m. indicated R23 was noted to have bruises on lower legs and upper back in the spine area (the report did not indicate the size of the bruises.) The bruises were identified as being of an unknown origin. The facility completed an investigation on 10/14/16, in which they determined the bruises to the lower legs may have been from the wheelchair legs, however, the origin for the bruise to the spine was not identified. The facility did not report the bruises of unknown origin to the State Agency. The administrator signed the report on 10/14/16. On 11/10/16, at 10:30 a.m. the administrator confirmed the bruises identified on 10/10/16, were of an unknown origin and they were not reported to the SA timely nor were they investigated to determine if abuse had occurred. During record review for R23, an entry in the Progress Note (PN)dated 10/30/16, at 8:30 a.m. R23 was found seated on the floor in the hallway with a large hematomoa on her right forehead.	F 226	All current and future residents who have un-witnessed falls with significant injury or injuries of unknown origin will be reported to OHFC per MN and Federal guidelines. a. The reporting process for the Vulnerable Adult Reporting (CMS algorithm) will be posted by the communication boards in the nursing stations and in the break room. This process includes immediate notification of the Administrator and DNS during working hours and placing an immediate call to the Administrator and DNS on evenings and weekends. Completed 12/9/2016 by the DNS b. The internal Vulnerable Adult reporting process will be posted by the communication boards in the nursing stations and in the break room. Completed 12/9/2016 by the DNS. c. Reporting process will be reviewed in the All Staff meeting scheduled 12/15/16 and 12/20/16.The Process will stress the required 2 and 24 hour guidelines for reporting an OHFC incident. d. All new employees and agency staff will have a background check completed following Minnesota procedure regarding conducting background checks. e. All current agency/contract employees have been audited to ensure the state specific procedures were followed for obtaining employee background checks. Completed 12/13/2016. All staff will be re-educated via All Staff meeting. A video will be available to watch for those who did not attend the All Staff meeting. A knowledge verification will be	

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F 226	Continued From page 12 The fall was unwitnessed. R23 was sent to the emergency room for an evaluation which included a CT of her head. A PN dated 10/30/16, at 5:17 p.m. R23 was found on the floor of the dining room. R23 had sustained a bloody nose. At 6:18 p.m. R23's blood pressure dropped to 87/54, she was then transferred to the hospital to rule out head injury from the falls. R23's PN dated 11/7/16, at 2:26 p.m. indicated R23 was found on the floor in her bathroom, next to the sink. No injuries were sustained. R23 was assisted into the wheelchair via a mechanical lift. Although no injuries were sustained, R23's medical record lack documentation of an investigation as to the root cause of the fall and to determine if neglect of care had occurred. Review of the VA reports lacked documentation in which the SA had been notified of R23's falls with significant injury or an investigation to determine causal factors of unwitnessed fall to determine if neglect of care had occurred. On 11/10/16, at 1:05 p.m. the administrator confirmed R23 had sustained significant injury from unwitnessed falls. The incidents had not been reported to the SA immediately as directed by the policy. R12's report of missing money was not reported to the SA timely.	F 226	required indicating that the video was viewed and understood. All information will be sent to those who did not attend the All Staff meeting or view the video via certified letter. To ensure the education was received and understood staff will take and return a knowledge verification that will be included. This is to ensure their understanding of what constitutes a significant injury and an injury of unknown origin by 12/23/2016. This is also to ensure their understanding of the facility procedures as it relates to the Administrator and DNS notification as well as the 2 and 24 hour required OHFC reporting of significant injuries and injuries of unknown origin will be completed by 12/23/2016. Staff who does not attend the All Staff meeting, views the video, or return the knowledge verification sheet that was sent via registered mail will not be able to return to work until completed. All staff will also be educated on all suspected and actual OHFC reportable incidents which include un-witnessed falls and significant injury and injuries of unknown origin by 12/23/2016 a. By 12/23/2016 all Licensed Nurses will be educated to follow the internal procedure for Vulnerable Adult Reporting which includes notifying the Administrator and DNS about all suspected and actual OHFC reportable incidents once the resident is safe. A phone call to the Administrator and DNS will be made on weekends and evenings to provide notification and reporting.	

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F 226	Continued From page 13 Review of the VA reports from 6/2016 - 11/2016, included a report dated 8/14/16, in which R12 had reported she was missing one twenty dollar bill, one ten dollar bill, five five dollar bills and three one dollar bills (for a total of $58.00) from her purse. R12 reported the concern to the facility via a suggestion or concern form dated 8/14/16. The facility did not report the concern to the SA until 8/15/16. On 11/10/16, at 12:30 the administrator confirmed R12 had reported the concern on Sunday, 8/14/16, and the SA was not notified until the next day, Monday, 8/15/16. The administrator stated the facility was to report concerns of misappropriation of resident property to the SA immediately. Background Checks: The facility failed to ensure background checks had been completed on 1 of 5 agency staff, licensed practical nurse (LPN)-A. On 11/8/16, at 10:28 a.m. the administrator confirmed licensed practical nurse (LPN)-A had been contracted and worked at the facility from 5/2/16, through 11/2/16. The administrator stated LPN-A had worked on the nursing units providing direct resident care and as the minimum data set (MDS) coordinator. On 11/9/16, at 11:13 a.m. administrator confirmed the facility had not conducted a back ground check on LPN-A.	F 226	b. The Administrator and DNS were educated on all suspected and actual OHFC reportable incidents including un-witnessed falls with significant injury and injuries of unknown origin by the Rehab/Skilled Consultant on 12/15/2016. c. The Human Resources Coordinator, Staff Development Coordinator, and Administrator were educated on 12/15/2016 by the Workforce Consultant on the state specific procedure for obtaining employee background checks. 4. All incident reports will be audited by the DNS, or designee, to ensure proper notifications to DNS and/or Administrator occurred, documentation is completed, root cause analysis is determined, care plans updated, and OHFC is notified if required. Any weekend incident reports will be audited for documentation accuracy during the following Monday morning meeting. As noted above, a phone call to the administrator and DNS will be made on the evenings and weekends to provide notifications and further reporting. Incident audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. The Human Resources, or designee, will audit all new employees and agency/contract employee records to ensure they are in compliance with state specific requirements of background checks weekly x 12 weeks.	

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F 226	Continued From page 14	F 226	All audit results will be tracked and reviewed monthly by the Quality Assurance Performance Improvement Committee (QAPI) for further recommendations. 5. 12/23/2016	
F 241 SS=D	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents seated at the same dining table were served at the same time as their tablemates during 2 of 3 meals observed for 1 of 1 resident (R41) who was observed seated without being served the meal while tablemates had been served and were eating. Findings include: R41's quarterly Minimum Data Set (MDS) dated 10/14/16, indicated R41 was diagnosed with nutritional deficiency, had intact cognition, had severely impaired vision, and required assist of one staff for eating for encouragement and	F 241	1. R41 receives her meals when her tablemates receive their meals. In discussion with the resident, the seating arrangement has been changed to ensure she is seated at a table where she can be served with her tablemates. Resident will be checked on by Social Services weekly x 4 weeks to ensure the changes remain acceptable. R41 receives cueing while eating in accordance with her care plan. Resident is able to feed herself. However resident requires cueing. Needs to be told what items are on her plate and where they are located The resident is at an assisted dining table where she will receive cueing from the CNA assisting with dining seated at her table. All current residents who require cueing	12/23/16

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F 241	Continued From page 15 cueing. R14's care plan dated 10/24/16, indicated R41 had a performance deficit related eating due to blindness. The plan directed staff to provide set up with meal tray, assist with meals and to encourage intake. The plan indicated R41 was able to feed self but needed to be told what food items were and where they were located. On 11/9/16, at 7:35 a.m. Nursing assistant (NA)-J was observed to assist R41 to the dining room via her wheelchair and positioned her at her dining room table. Once at the table, NA-J left the dining room. -At 7:38 a.m. dietary aide (DA)-A served R41 water and grape juice. -At 7:43 a.m. R41 was observed drinking her water while a tablemate had been served and was eating the meal. -At 7:59 a.m. licensed practical nurse (LPN)-B was observed to provide R41 with her medications. R41 took her medications and LPN-B returned to her medication cart. -At 8:17 a.m. R41's tablemate had finished her breakfast and left the table. Nursing staff were observed to bring other residents into the dining room and serve them their breakfasts. R41 had not been served her meal yet. -At 8:27 a.m. NA-J was observed to enter the dining room and observe R41 seated at her table. NA-J obtained a breakfast meal of hot cereal and toast for R41. NA-J applied peanut butter and jelly to the toast and added sugar to the cereal then exited the dining room. R41 sat at the dining room table a total of 52 minutes without being served or assisted with her breakfast meal.	F 241	while eating have the potential to be affected. PCC care plan report for intervention will be run to identify who needs cueing. We will conduct audits as outlined in #4 below. 2. Our dining room seating arrangement has been reviewed and changed to ensure residents who require cueing and/or assistance during meal times sit at 2 tables in the dining room. All residents will receive their meals at the same time that their tablemates receive their meals. Dietary and nursing staff will be educated on the expectation that all tablemates will be served at the same time by the Staff Development Coordinator/DNS by 12/23/2016. Nursing Staff will be re-educated on the need to follow care-plan interventions for cueing by the DNS/Staff Development coordinator by 12/23/2016. CNAs, nursing staff and dietary staff will be educated on how to provide cueing by the DNS/ Staff Development coordinator or designee by 12/23/16. 3. Audits will be completed by the Director of Dietary, or designee, to ensure all tablemates who are present receive their meals at the same time at all meals daily for 2 weeks, 5x/week for 2 weeks, and 3x/week for 4 weeks. Audit results will be tracked and reviewed by the QAPI Committee for further recommendations.	

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F 241	Continued From page 16 On 11/9/16, at 11:43 a.m. NA-J assisted R41 to the dining room and positioned at her table. Other residents have been observed arriving to the dining room and seated at other tables and provided meals. -At 11:53 a.m. R41's tablemate was served her lunch meal and began eating. -At 12:03 a.m. NA-K provided R41 with her lunch meal and sat down next to her. R41 sat at her dining table a total of 20 minutes without being served or assisted with her lunch meal after her tablemate had been served. On 11/9/16, at 8:54 a.m. R41 stated most of the time, she had to wait long periods of time for her meals and did not know why it took so long. R41 stated she knew there were a lot of other people to help, but thought staff could take turns so she would not have to wait so long all the time. On 11/9/16, at 9:07 a.m. NA-J verified R41 was not served her breakfast until she returned to the dining room after assisting other residents. NA-J stated, R41 should not have to wait that long to eat. On 11/09/2016, at 12:19 p.m. dietary supervisor stated R41 should not wait that long to be served and she expected all residents at the same table to be served before going to another table. The supervisor stated R41 should not have to wait that long for her meal.	F 241	4. Audit who is requiring cueing and conduct observation audits each meal 2 weeks, 5x/week for 2 weeks, and 3x/week for 4 weeks by DNS or designee. 5. 12/23/2016.	

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F 241	Continued From page 17 On 11/09/2016, at 3:36 p.m. the director of nursing (DON) verfied R41 should have been served her meal timely and stated R41 should not have to wait over 45 minutes to be served, even the 20 minute wait at lunch time was absolutely unacceptable. The DON stated her expectation was for staff to ensure all residents were served timely and did not have to wait to be served meals. The Residents Dignity policy dated 2/2013, directed staff to provide care in a manner that enhanced resident dignity regarding dietary aspects and to serve all residents at the table at the same time, so residents could their meals eat together.	F 241		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide verbal cueing and assistance during dining as directed by the care plan for 1 of 2 (R41) residents reviewed for nutrition who was blind and observed to not be provided with food placement directives/cues. In addition, the facilty failed to implement fall interventions related to the placement of two body pillows as directed by the care plan for 1 of 2 (R23) residents reviewed for accidents, and	F 282	1. Care plan interventions for R41 and R23 have been reviewed and care plans updated to reflect current needs. 2. All current residents dependent on cueing at meal times and all residents with fall interventions will have their care plans reviewed and updated as necessary by 12/23/2016 by DNS or designee. 3. All nursing staff will be educated by the SDC or designee, on placing an	12/23/16

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F 282	Continued From page 18 observed in bed with either one or no body pillows. Findings include: R41's care plan dated 10/24/16, indicated R41 had a performance deficit related eating due to blindness, R41 could feed self after staff explained what foods were served and food placement on the plate. The plan directed staff to provide set up with meal tray, assist with meals and to encourage intake. On 11/9/16, at 7:35 a.m. Nursing assistant (NA)-J was observed to assist R41 to the dining room via her wheelchair and positioned her at her dining room table. Once at the table, NA-J left the dining room. -At 7:38 a.m. dietary aide (DA)-A provided R41 water and grape juice. -At 7:43 a.m. R41 was independently drinking her water. -At 7:59 a.m. licensed practical nurse (LPN)-B was observed to provide R41 with her medications. R41 took her medications and LPN-B returned to her medication cart. -at 8:27 a.m. NA-J was observed to enter the dining room and observe R41 seated at her table. NA-J obtained a breakfast meal of hot cereal and toast for R41. NA-J applied peanut butter and jelly to the toast, added sugar to the cereal. NA-J exited the dining room without informing R41 where who food items were placed in front of her. -At 8:45 a.m. R41 had not eaten her hot cereal or finished drinking her juice. NA-K approached R41 and asked her if she was done, and proceeded to	F 282	intervention on the care plan post fall by 12/23/2016. A formal root cause analysis will be initiated through the QAPI process to identify barriers to the provision of care according to the care plan. 4. The facility will run the incident report for frequent fallers over the last 3 months to determine the number of residents with frequent falls. Residents with frequent falls are described as any resident that had 3 or more falls in a three month period. Audits will be completed by the DNS, or designee, to ensure cueing at meal times and fall interventions are in place daily for 2 weeks, 5x/week for 2 weeks, and 3x/week for 4 weeks. Audit results will be tracked and reviewed by the QAPI Committee monthly for further recommendations. 5. 12/23/2016	

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remove her from the dining area. NA-K was not observed to sit down nor offer or provide assistance with completing the meal. During the observation, staff had not been observed to offer or provide R41 assistance or cueing with the breakfast meal.

On 11/9/16, at 8:54 a.m. R41 stated it would be nice to have someone tell her where her foods were located when served as she had difficulty finding the foods that were placed in front of her.

On 11/09/16, at 12:19 p.m. the dietary supervisor (DS) stated R41 was blind and staff should be providing cues to her during her meal service. The DS stated R41 was able to feed herself but required someone to tell her where her foods were located when placed in front of her. The DS also stated she would expect staff to be assisting R41 at meal time.

On 11/09/16, at 3:36 p.m. the director of nursing (DON) verfied R41 required assistance with meals due to blindness and stated staff were to encourage R41 to eat and inform her where her food items were when placed in front of her. The DON stated, even thought R41 can feed herself, she still needed direction during meal times. The DON confirmed staff should have provided R41 assistance and cues during her meal service as directed by the care plan.

The facility Care Plan policy dated 2/13, indicated residents would receive and be provided the necessary care and services to attain or maintain

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F 282	Continued From page 20 the highest practicable well-being. R23 was identified at risk for falls and two body pillows to be utilized when in bed were not implemented as directed by the care plan. R23's care plan dated 10/25/16, indicated R23 had limited physical mobility related to right hip fracture and weakness and was partial weight bearing to right leg. The plan also indicated R23 had poor balance and unsteady gait and required assistance of one staff to sit up, move in bed, reposition herself, get dressed and groomed, and required stand-by assistance when using her front-wheeled walker, a gait belt for transferring and was at risk for falls. The plan further indicated R23 required cueing and guidance with locomotion in her wheelchair. R23 had bladder incontinence related to confusion and dementia, wore a brief all the time, and used the bed pan at night. The fall interventions identified included physical therapy for strength and mobility, sensor alarm in her room to alert staff of any movement, educate/instruct R23 on safe use of assistive devices, and not to bend over to pick up dropped items but use a grabber or ask for assistance from staff. Additional interventions included bed in lowest position, body pillows to be place on both sides of R23 when she was in bed, a raised edge mattress on her bed, and to observe for signs and symptoms of injury and check range of motion at the time of the fall. On 11/8/16, at 10:14 a.m. R23 was observed asleep in bed on her side with only one body pillow behind her. R23's room was dark, her bedroom door was 3/4 closed, had bilateral grab bars, her bed was in lowest position, she had a	F 282		

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F 282	Continued From page 21 raised edge mattress on her bed, sensor alarm was on, wheelchair next to bed, and walker in the corner of the room across from her bed. On 11/08/16, at 1:33 p.m. R23 was observed asleep in bed on her side with her head on a standard white pillow with one body pillow laying vertical above her head. R23 had no body pillows on either side of her. R23's bedroom door was 3/4 closed, her bed was in lowest position, had bilateral grab bars, she had a raised egged mattress on her bed, sensor alarm was on, wheelchair next to bed, and walker in the corner of the room across from her bed. R23's sensor alarm sounded, human resources and quality assurance coordinator (HR/QA) walked in R23's room, and immediately walked out to the nurses station and turned R23's audio alarm off. On 11/09/16, at 7:30 a.m. R23's sensor alarm sounded. R23 was observed in bed on her left side pulling up covers, with only one body pillow on the floor, bed in lowest position, raised edge mattress, bilateral grab bars, walker in corner of room across from her bed, and her wheelchair by her bed. On 11/09/16, at 2:08 p.m. LPN-B confirmed R23 was in bed and had only one body pillow in place and not two, as directed by the care plan. LPN-B stated R23 had a bloody nose, and the other body pillow was in the laundry. At this time, the DON confirmed R23's care plan and stated R23 should have both body pillows with her in bed at all times. She stated even they were being washed, that was no excuse for R23 to be without her body pillows.	F 282		

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F 282	Continued From page 22 On 11/9/16, at 3:04 p.m. NA-J stated R23 should have two body pillows in bed with her at all times, and confirmed R23 had no body pillows in bed with her at that time and she did not know where they were. On 11/10/16, at 7:30 a.m. R23 observed asleep in bed on her side, and had no body pillows in place. R23's room was dark, her bedroom door was 3/4 closed, her bed was in lowest position, bilateral grab bars, a raised edge mattress on her bed, her audio alarm was on, her wheelchair by her bed, and her walker in the corner of the room across from her bed. On 11/10/16, at 9:02 a.m. R23's sensor alarm was sounding. R23 was observed in bed and had no body pillows in place. LPN-B confirmed R23 did not have any body pillows in bed with her and located one body pillow on top of R23's dresser and looked in several locations in R23's room and confirmed she couldn't find another body pillow in R23's bedroom, and stated she would check with laundry. Review of the facility policy, Optional/Care Planning Training dated 2/14, indicated staff would be trained on resident care plans so they had basic knowledge of the purpose of the care plan and understood how the care plan influenced services provided to residents.	F 282		
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		12/23/16

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F 323	Continued From page 23 environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, thoroughly investigate causal factors and implement interventions in order to minimize the risk of falls and injury for 1 of 1 resident (R23) who had repeated falls with serious injuries which required medical intervention. This resulted in an immediate jeopardy situation for R23. Findings include: The Immediate Jeopardy (IJ) began on 11/7/16, related to the facility's failure to complete a comprehensive assessment to determine causal factors and implement interventions for R23 who had sustained significant injuries from two falls which occurred on 10/30/16, and another fall on 11/7/16. The lack of assessment placed R23 at significant risk for serious injury and/or death. The facility administrator and director of nursing (DON) were notified of the IJ on 11/10/16, at 4:00 p.m. which began on 11/7/16, when R23 had fallen and the facility failed to complete a comprehensive assessment of causal factors related to R23's continued falls, in a effort to implement interventions to minimize the risk of R23's risk for further falls. The IJ was removed on 11/15/16, at 3:27 p.m. however,	F 323	1. R23 had a comprehensive fall assessment completed on 11/13/16 and care plan was updated to include cognition, interventional activities of resident interest, use of a grabber, prompted voiding with staff present, self -release seat belt and bed height reposition at appropriate level for resident transfers. Guided maneuvering of limbs will be utilized to assist with bed mobility. 2. All residents who had falls since August, 2016 were reviewed. Three residents who were identified will have comprehensive fall assessment completed and care plan updated by DNS, or designee. a. Our process for root cause analysis and interventions was reviewed and we identified areas for improvement. We will completely finishing incident reports, hold a fall team huddle, and put appropriate interventions in place after a fall. A root cause analysis will be conducted after each fall to determine the cause of each fall and the appropriate interventions will be initiated. The falls care plan will then be updated appropriately. b. On the weekend, nursing staff will	

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F 323	Continued From page 24 non-compliance remained at a scope and severity level of G, which indicated actual harm for R23 due to a hematoma and epistaxis sustained during a fall which required medical assessment and interventions. R23's Diagnosis Report dated 11/9/16, indicated R23's diagnoses included subsequent right femur fractures, interoperable hemorrhage and hematoma (bleed or bruise) of the musculoskeletal structure, Alzheimer's disease, anxiety, anemia, pain, osteoarthritis, hearing loss and weakness. R23's progress note (PN) dated 8/16, at 8:01 p.m. indicated R23 was admitted from the hospital following surgical repair of a fractured right hip as a result of a fall while at home. R23 was deaf and utilized a white communication board to communicate. R23 did speak, however, was sometimes difficult to understand due to whisper tone speech. R23 was pleasant and alert to person and place. R23 was able to verbalize need to use the bathroom. R23 was currently non weight bearing and would be transferred with staff assist and use of a mechanical lift as directed by physical therapy due to R23 consistently putting weight on restricted right leg with attempted to transfer. Immobilize/brace noted on right leg. R23's admission Minimum Data Set (MDS) dated 9/2/16, indicated R23 had a history of falls with fractures, had severely impaired cognition, and was rarely or never understood. The MDS also indicated R23 required extensive assistance with activities of daily living (ADLs), was incontinent of urine, was not on a toileting program and	F 323	complete the incident reports, conduct a root cause analysis, determine the appropriate intervention, and update the care plan. All weekend and weekday falls will be reviewed at the interdisciplinary morning meeting during the week and the monthly fall□s committee meeting. 3. All staff will be educated by the DNS, or designee, on the process of the fall huddle by 12/23/16. All nursing staff will be educated on the falls program by the DNS, or designee, by 12/23/16. 4. Audits will be completed by the DNS, or designee, to review all falls have a completed root cause analysis and interventions were initiated and care plan updated. Audits will be completed on every incident 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. Audit results will be tracked and reviewed monthly by the QAPI for further recommendations. 5. 12/23/16	

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F 323	Continued From page 25 received anti-anxiety and diuretic medications which could increase fall risk. R23's Falls Care Area Assessment (CAA) dated 9/9/16, indicated R23 had difficulty maintaining sitting balance and impaired balance during transition. R23's Cognitive Loss/Dementia CAA dated 9/9/16, indicated R23 had decreased ability to make self understood, had pain, hearing or vision impairment. R23 was non verbal and communicated to staff via a white board. R23's Physical Therapy Evaluation and Plan of Treatment form dated 9/30/16, indicated R23 was a fall risk, was completely deaf, had fair sitting balance and poor standing balance, poor safety awareness and did not follow through with weight bearing restrictions. R23's care plan dated 10/25/16, indicated R23 had limited physical mobility related to a right femur fracture and weakness and required partial weight bearing to right leg only and one staff assistance with mobility and weight bearing support. R23 utilized a wheelchair for locomotion and required cueing and guidance. R23 had confusion, impaired balance, limited mobility, limited range of motion and musculoskeletal impairment which required extensive staff assist for bathing, bed mobility, dressing, toileting, personal hygiene and stand by assistance of one staff with front wheeled walker and gait belt for transfers. R23 had bladder incontinence with a history of urinary tract infections and staff were	F 323		

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directed to encourage R23 to drink more fluids during morning and afternoon hours and limit fluid in the evening/night, she utilized an incontinent product and staff were to check R23 before and after meals, before and after activities, during the night at least at midnight and 4:00 a.m. R23 would also use the bedpan. The care plan also indicated R23 had a hip fracture following a fall which required surgical repair. Staff were directed to monitor for sign and symptoms of complications, infection, unrelieved pain, and pneumonia. Staff were also directed to reposition R23 as necessary, prevent 90 degree flexion, monitor use of adaptive devices, monitor pain and limb swelling and or skin changes. R23 had an actual fall with no injury related to a history of falls, poor balance, post surgical status and unsteady gait. The care plan indicated R23 was to have a physical therapy (PT) consult for strength and mobility, a motion sensor alarm in room to be on when R23 was in bed to alert staff of any movement, to educate/instruct R23 not to bend over to pick up dropped items and to encourage use of grabber bar or to ask for assistance. Staff were to modify environment in order to maximize safety with bed on lowest position and body pillows on both sides of her while in bed. Staff were also to observe for any sign of injury and check range of motion at the time of a fall.

R23's Visual Bedside Kardex Report dated 11/9/16, (tool nursing assistants use to direct care), indicated R23 was partial weight bearing to right leg, and required the assistance of one staff person for all mobility, transfers, repositioning, toileting, dressing and grooming. The document indicated R23 was to have her bed in lowest

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F 323	Continued From page 27 position, utilize raised edge mattress on her bed, and body pillows on each side of her in bed when in bed for her safety. R23's Falls Tool dated 8/26/16, indicated R23 had one or more falls in last three months, R23 was at high risk for falls due to recent falls, mobility and transfer problems related to muscle weakness, impaired balance, weight bearing ability changes, pain and took high risk medications. R23 also had cognitive risk factors which included restlessness, reduced insight, impulsiveness and a difficult time following instructions. Fall action plan was to refer R23 to therapy and update R23's care plan. Fall incidents: 1. R23's undated Investigation form indicated R23 fell on 9/3/16, at 10:40 a.m. R23 attempted to self transfer and was found on the floor in the doorway of her bathroom. The report indicated R23 had previous injuries from circumstances of this type over the last 30 days, was incontinent of bowel, was not wearing glasses, and had no injuries. Fall interventions included neuro checks, adding a motion sensor alarm to her bed, and update R23's care plan. R23 had anti-anxiety, anti-coagulant, diuretic, cardiovascular medications and a laxative within 8 hours of the fall. R23's care plan was amended to include motion sensor. The administrator and DON signed the form 9/13/16. R23's PN dated 9/3/16, at 11:02 a.m. indicated	F 323		

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R23 was found lying on the floor in her room, in front of her wheelchair in between the bathroom and living area of room. R23 denied pain. No injuries. R23 was assisted into bed via a mechanical lift. Once in bed, R23 was incontinent of bowel and stated she needed to use the bathroom. R23 was wearing shoes at the time of the incident. Call bell was within R23's reach.

R23's Fall Scene Huddle Worksheet (FSHW) dated 9/4/16, at 10:40 a.m. indicated questions 1-7 were to be completed at the time of the fall, during the Fall Huddle. The sheet indicated R23 was found on the floor in her room. R23 had slid out or fell from the wheelchair when attempting to self transfer. A diagram of the location of the fall was included. R23's mobility was identified as bed bound, she had shoes on, she had orientation to room/new admission and was incontinent of bowel. Medications received within the last eight hours identified and neuro checks were initiated. Potential root cause of the fall was identified as "resident attempting to self transfer." R23 had no injuries.

2. R23's PN dated 9/6/16, at 5:51 a.m. indicated R23's motion sensor was alarming, along with another resident's sensor alarm. "Staff chose to answer other alarm first." When entered R23's room, R23 was found lying on the floor. R23 was assisted off the floor. Neuro checks started. No injuries. A subsequent PN at 1:37 p.m. by occupational therapy (OT) indicated R23 had a fall earlier after putting on light. R23 had been rubbing knee and reporting pain.

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F 323	Continued From page 29 R23's Falls Tool dated 9/6/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, impaired balance, restlessness, impaired sleep patterns, cognitive status and took high risk medications. Fall action plan section was blank. R23's Investigation form dated 9/6/16, indicated at 4:00 a.m. R23 was found on the floor in her room. The form indicated this was a repeat incident, R23 had previous injuries or circumstances of this type in the last 30 days. R23 had just been toileted 15 minutes prior to being found on the floor. R23's motion sensor had gone off multiple times throughout the night. Another resident's motion sensor and R23's sensor sounded at the same time. Staff member went to answer the other residents sensor first then responded to R23's. R23's bed was in low position. The corrective action implemented was for R23 to have bed in low position when in it. The administrator and the DON both signed the form on 9/13/16. R23's FSHW dated 9/6/16, indicated R23 was found on the floor, had been attempting to self transfer, had been assisted by staff 15 minutes prior, motion sensor was alarming. R23 was not wearing glasses and was restless. A picture of the scene was drawn. R23 was alert to person and place prior to and after the falls. Potential root cause of the fall was "possible anxiety." No injuries sustained. The Fall Scene Investigation Report form which included root cause analysis was blank.	F 323		

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F 323	Continued From page 30 3. R23's PN note dated 9/11/16, at 9:32 a.m. indicated R23 had been found on the floor in room beside left side of bed, lying on stomach. Bed in lowest position. No injuries noted. R23 indicated non verbally she did not have any pain or injuries. R23 was assisted back to bed. All "reasonable" persons were notified. R23's Falls Tool dated 9/11/16, indicated R23 was at high risk for falls due to recent falls, mobility and transfer problems, impaired balance, weight bearing changes, took high risk medications and moderately impaired cognition. The tool further identified R23 had cognitive risk factors which included reduced insight, impulsiveness and a difficulty following instructions and unsafe use of equipment including alarms. The Action Plan section was blank. R23's Investigation form indicated on 9/11/16, an incident occurred at 8:00 a.m. R23 was found on the floor next to her bed on her stomach, R23 was not wearing her glasses, personal alarms were working and R23 was incontinent of urine. The report indicted this was a repeat incident and R23 had previous injuries or circumstances over the last 30 days, and R23 had rolled out of her bed before. The report also identified R23 was deaf, rarely vocalized and used her call light. R23 had no injuries. Fall interventions included neuro checks, resident and employee education, and body pillows on each side of R23 when she was in bed was implemented. R23 had anti-anxiety, anti-coagulant, diuretic, anti-depressant medications and a laxative within eight hours of the fall. The report was signed by the administrator and DON on 9/13/16.	F 323		

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A second Investigation report on 9/11/16, at 4:10 p.m. indicated R23 had a repeat incident of trying to self transfer which was not investigated until 9/13/16. R23 was restless with multiple falls. Sensor device in place to detect movement, body pillows utilized. R23 inconsistent with call light use. A raised edge mattress was added to R23's bed and R23 along with staff and family were educated by nursing. R23 was alert to person and place and forgetful prior to and after the fall. Neuro checks were initiated. R23 had sustained a bruise/hematoma from the fall. Both the administrator and director of nurses signed this form on 9/13/16.

The undated FSHW indicated R23 was found on the floor in her room. was nonverbal and was last assisted by staff one hour prior. R23's alarms was working, she was not wearing glasses and was incontinent of urine. A description of the scene was drawn on the form. R23 was alert prior to and after the fall. The Comments section indicated "this is a repeat incident." Medication administered in the last 8 hours indicated. Neuro checks initiated. No injury.

4. R23's PN dated 10/20/16, at 5:23 p.m. indicated R23's motion sensor was sounding. Upon entering R23's room, R23 was found sitting on the floor next to her bed. No injuries. R23 was assisted back into bed.

R23's Falls Tool dated 10/20/16, indicated R23 was at medium risk for falls due to recent falls,

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F 323	Continued From page 32 mobility and transfer problems, difficulty seeing objects, impaired balance, weight bearing changes, and took high risk medications. The tool further identified R23 had cognitive risk factors which included, confusion, poor memory, difficulty following instructions and forgot to use the call light and assistive devices. The Action Plan section indicated R23 would be referred to therapy. This was not a new interventions as R23 was currently receiving therapy services. R23's Investigation form dated 10/20/16, at 3:20 p.m. indicated R23 was found on the floor next to her bed. The report indicated R23 did not call for help, and attempted to transfer herself, lost her balance, and her walker tipped over. The report further indicated this was a repeat incident with previous injuries or circumstances over the last 31-180 days. The report identified R23 had difficulties seeing objects, had no injuries, and personal alarms were working. Fall interventions included neuro checks and R23 was re-educated on using call light for help, and reminded R23 she needed assistance for transfers. The continence area of the report was left blank. R23 had received narcotic and diuretic medication within eight hours of the fall. Both the administrator and DON signed this form 10/27/16. R23's FSHW dated 10/20/16, at 5:30 p.m. indicated R23 was found on floor in own room after attempting a self transfer. R23 has difficulty seeing objects, lost balance, walker tipped over and fall alarms were working. A description of the scene was drawn. R23 was alert and oriented to person, place and time, was forgetful prior to and after the fall. meds administered identified. No	F 323		

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F 323	Continued From page 33 injury. Neuro checks initiated. 5. R23's Investigation form dated 10/27/16, at 8:10 a.m. indicated R23 was seated in the wheelchair and witnessed to reach towards her shoe or the floor (unknown) and fell in the dining room. The report further indicated this was a repeat incident with previous injuries or circumstances over the last 30 days. The report identified R23's hand was a little sore. The vision and continence areas of the report was left blank. Fall interventions were R23 was re-educated on calling or asking for assistance, self-releasing seat belt was added to her wheelchair and R23 educated on use and R23 was able to release seat belt. R23 had received diuretic medication within eight hours of the fall. Although the report indicated a seat belt was installed on R23's wheelchair, it was later revealed the seat belt was not applied until she returned from the hospital on 10/31/16, because the facility had to order a belt in which it had finally been delivered. This form was signed by the DON on 11/2/16, and the administrator on 11/3/16. R23's FSHW dated 10/27/16, at 8:10 a.m. indicated R23 was in the dining room, reaching, and was lowered to the floor. No injuries. The scene of the incident was drawn on the form. R23 was alert and oriented to person, place and time prior to and after the fall. Medication used identified. R23 complained hand was a little sore, "hurts a little." Staff to monitor mobility. R23's PN dated 10/27/16, at 9:49 a.m. by physical therapy indicated R23 had fallen out of	F 323		

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her wheelchair in the dining room. R23 had been reaching and leaned too far forward. R23 reported right hand pain at 4 of 10 on a 0-10 scale (10 worst pain). Pain was noted most increased over the 2nd metacarpal area and tender to touch. R23's right knee also continues to have pain. This was reported to nursing. R23 to be seen on physician rounds. Pain created limitations to R23's therapy session. A subsequent PN written by OT at 11:34 a.m. indicated R23 had fallen earlier. R23 was noted to have guarded use of her right thumb and right lower extremity. Wheelchair mobility decreased due to R23 declining to use right hand and foot to propel the wheelchair.

6. R23's PN dated 10/30/16, at 8:30 a.m. indicated R23 was found sitting on the floor of the 100-hallway on her buttocks. R23 was assisted back into the wheelchair via a mechanical lift. R23 was noted to be holding her right shoulder and had a large hematoma to her forehead. R23 denied pain but Tylenol had been previously given at 7:00 a.m. R23 was sent the emergency department (ED) for evaluation. A subsequent PN at 11:39 a.m. indicated R23 returned from the ED with no new orders. R23 had a CT of the head which showed no acute intracranial pathology and a CT of the spine which was also negative. The ED recommended facility staff continue to monitor R23's neurological status and frontal hematoma for skin breakdown and for R23 to follow up with the ED on 10/31/16, as R23 received an X-factor A inhibitor (anticoagulant medication).

R23's Investigation form dated 10/30/16,

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F 323	Continued From page 35 indicated at 9:30 a.m. R23 was found on the floor in the hallway after she had slipped or tripped and she attempted to transfer herself or ambulate. The report indicated this was a repeat incident with previous injuries or circumstances over the last 30 days. The report further identified R23 had no injuries, and R23's wheelchair brakes were not locked. The vision and continence areas of the report was left blank, and did not identify R23's personal alarms were working. Fall interventions included R23 was re-educated on the importance of asking for help, and was re-educated that she needed assistance with all transfers. R23 had received diuretic, cardiovascular and narcotic medications, and a laxative within eight hours of the fall. Both the DON and administrator signed the form 10/31/16. R23's FSHW dated 10/30/16, at 9:50 a.m. indicated R23 was found on the floor in the hallway and had slit or fell out of wheelchair. R23 had slipped and wheelchair brakes were unlocked. A diagram of the scene was drawn. R23 was alert to person and forgetful. Medications administered within previous eight hours identified. No injury. The Comments section indicated R23 does not ask for help and attempted to ambulate and transfer self. A second Investigation form dated 10/30/16, at 5:00 p.m. indicated R23 was leaning too far forward in her chair and fell. R23 was to have a self releasing seat belt installed and R23 was to be reeducated. The Results of Investigation section indicated R23 was reeducated to not lean so far forward and to ask for assistance. Seat belt added to wheelchair. Demonstrated and	F 323		

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educated R23 on use. R23 demonstrated understanding by releasing seat belt per self. Staff will continue to monitor weekly. The DON signed the form on 11/2/16, and the administrator on 11/3/16. Although the form indicated a seat belt was added to R23's wheelchair, further investigation revealed a seat belt had been ordered and had not been delivered to the facility and applied to R23's wheelchair until 10/31/16.

7. R23's PN dated 10/30/16, at 5:15 p.m. indicated R23 was found on the floor in the dining room lying on her right side with a heavy bloody nose from both nostrils. R23 denied pain. R23 was assisted into a dining room chair via a mechanical lift. However, R23's nose continued to bleed. R23 was removed from the dining area. A subsequent PN titled "Late Entry" at 6:30 p.m. indicated R23 fell at 4:45 p.m. and sustained a bloody nose. R23 was assisted into a dining chair however continued to "head bob" and bleed through her nose. R23 was returned to her room and assisted into bed. R23 was given an antianxiety medication to "settle" her. At this time, R23 was found in her bed with with large amounts of blood on her pillow and her nose clotted with blood. R23's blood pressure was 87/54. The on call physician was notified and R23 was taken back to the ED for evaluation. A subsequent note indicated R23 was admitted to the hospital for observation of a head injury and possible urinary tract infection. R23's bleeding had ceased and she was receiving fluids. An earlier CT revealed a hematoma but no hemorrhaging on the brain.

R23's FSHW dated 10/30/16, at 6:00 p.m. indicated R23 slid or fell from wheelchair and was

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F 323	Continued From page 37 found on the floor in the dining room. R23's wheelchair brakes were unlocked. A diagram of the scene was drawn. R23 was alert but forgetful. Medications used within last eight hours were indicated. R23 had a bloody nose. The Comments sections indicated therapy to reevaluate R23's wheelchair for a possible smaller one. R23's Falls Tool dated 10/30/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, impaired balance, and took high risk medications. The tool further identified R23 had cognitive risk factors which included, poor memory, impulsive, difficulty following instructions, forgot to use the call light or assistive devices, and received high risk medications. The Action Plan listed was to refer R23 to therapy, however, R23 was currently receiving therapy services. R23's Falls Tool dated 10/31/16, indicated R23 was at low risk (despite being identified as high risk previously) for falls due to recent falls, and took high risk medications. The tool further identified R23 forgot to use the call light or assistive devices, and was incontinent. The Fall Action plan was to refer R23 to therapy. R23's PN dated 10/31/16, at 11:58 a.m. by physical therapy indicated R23 was admitted to the hospital for observation after having two falls with closed head injury and significant bloody nose.	F 323		

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F 323	Continued From page 38 R23's PN dated 10/31/16, at 3:38 p.m. indicated R23 had a fall the day prior and sustained a bloody nose and did hit her head. R23 had a large lump on her forehead and was seen in the ED/hospitalized. The physician evaluated R23's medications and discontinued a few. R23 is currently resting in bed. Nose is still bleeding lightly. Gauze provided and call light within R23's reach. 8. R23's Falls Tool dated 11/7/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, difficulty seeing objects, not wearing her glasses, impaired balance, and took high risk medications. The tool further indicated R23 had cognitive risk factors which included poor memory, impulsiveness, and was unsafe to use equipment. The Action Plan was to refer R23 to therapy. R23's Investigation form dated 11/7/16, at 8:15 a.m. indicated R23 was found on the floor in her bathroom in front of the toilet and sink. The report indicated R23 did not call for assistance, and transferred herself. The report further indicated this was a repeat incident with previous injuries or circumstances over the last 30 days. The report identified R23 was not wearing her glasses, did not identify if R23's personal alarms were sounding and the continence area of the report was left blank. The report indicated R23 had no injuries, and fall intervention was to re-educate R23. R23 had diuretic medication within eight hours of the fall. The Results of Investigation section was blank. The signature section of the form was also blank. R23's record lacked documentation of a fall investigation in order to	F 323		

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F 323	Continued From page 39 determine causal factors and interventions to be implemented. R23's PN dated 11/7/16, at 10:13 a.m. by physical therapy indicated R23 had a fall in the bathroom with self transferring. She was found on the bathroom floor. R23 stated she had pain in her right knee rated a 5 out of 10. R23's hands appear sore as well as R23 keeps rubbing them together. R23 was agreeable to therapy. R23 was educated on importance of asking for assistance when going to the bathroom. R23 was unaware of poor safety. R23's PN dated 11/7/16, at 12:27 p.m. written by OT indicated OT and nursing both responded to R23's wheelchair alarm and found R23 attempting to self transfer from the wheelchair to the bed. Nursing informed OT of R23's fall that morning. R23's FSHW dated 11/7/16, at 3:30 p.m. indicated R23 was found on the bathroom floor, had attempted self transfer, was not wearing glasses and had slipped. A diagram of the scene was drawn. R23 was alert to person and place and was forgetful. Medication given within previous eight hours identified. No injury and no pain. The Comments section indicated R23 did not use call light and self transferred. No further information identified. On 11/7/16, at 5:31 p.m. R23 was observed in the dining room, seated in her wheelchair. The brakes were off while at the table and R23 had a	F 323		

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self-releasing seat belt fastened around her with the alarm unit attached to the left side of the wheelchair. R23 had a large purple bruise over her right eye which extended down the right side of her nose. R23 also had a large purple goose egg on her right forehead.

On 11/8/16, at 10:14 a.m. R23 was observed in bed, asleep. She had only one body pillow positioned behind her. R23's room was dark, her bedroom door was 3/4 closed, bilateral grab bars were noted on the bed frame, bed was in lowest position, a four wedge mattress was on her bed, the audio alarm was on, her wheelchair was next to the bed, and walker was in the corner of the room across from her bed.

On 11/08/16, at 1:33 p.m. R23 was observed in bed, asleep. One body pillow laid vertically above her head. R23 had no body pillows on either side of her. R23's bedroom door was 3/4 closed, her bed was in lowest position, had bilateral grab bars, four wedge bed mattress, sensor alarm was on, wheelchair was next to bed, and walker in the corner of the room across from her bed. During this observation, R23's audio alarm sounded. The human resources and quality assurance coordinator (HR/QA) walked into R23's room, and immediately walked out to the nurses station and turned R23's audio alarm off.

-At 2:07 p.m. R23's sensor alarm sounded, health information management (HIM) was observed to go into R23's room, immediately walk out and went directly to the nurses station and turned R23's alarm off.

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F 323	Continued From page 41 -At 2:25 p.m. R23's sensor alarm sounded. Nursing assistant (NA)-H was observed to enter R23's room and immediately exit walking directly to the nurses station. On NA-H's way to the nurses station, resident assistant (RA)-A was heard to call out from outside the nurses station to NA-H, "Did she roll over?" NA-H stated, "Yes," and walked over and turned R23's alarm off. -At 2:56 p.m. R23's sensor alarm was sounding. Registered nurse (RN)-B came out of her office which was next to the nurses station. RN-B had witnessed the surveyor exit R23's room and immediately turned the alarm off at the nurses station. RN-B did not go to R23's to check on her. -At 3:31 p.m. R23's sensor alarm sounded. Licensed practical nurse (LPN)-B entered R23's room and turned on R23's call light and immediately walked out of R23's room towards the nurses station and loudly stated to RA-A, "can you help her? RA-A replied, "Yes," LPN-B proceeded to turn off R23's alarm. RA-A entered R23's room and closed the door. On 11/09/16, at 7:30 a.m. R23's motion alarm sounded. R23 was observed in bed on her left side, pulling up covers. One body pillow was noted on the floor, her bed was in lowest position, four wedge mattress on bed, bilateral grab bars, walker in corner of room across from her bed, and her wheelchair was by her bed. -At 7:33 a.m. R23 was observed seated on the edge of her bed, in her night gown. R23's wheelchair was near with the brakes on. LPN-B applied R23's rubber soled slippers, applied a gait belt. R23 slowly rocked back slightly, paused for a	F 323		

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second, and pushed herself slowly up with both of her hands while LPN-B lifted her up with gait belt and assisted R23 into her wheelchair. R23 kept both of her knees bent during the transfer, was hunched/leaned over and leaned forward, was unsteady and did not stand up straight. R23 favored her left leg during the transfer. Once in the chair, LPN-B pointed to R23's left brake handle and R23 pulled the long handle and released it. R23 sat with her head down while LPN-B released her right wheelchair brake. R23 slowly scooted herself back twice in her wheelchair, and pulled the right half of her self-releasing seat belt around her right side while LPN-B pulled the left side strap of her seatbelt Velcro the belt straps together. R23's failed to identify the use of the self releasing seat belt.

-At 7:39 a.m. NA-H was observed to enter R23's bedroom and LPN-B exited. R23 was assisted into the bathroom.

-At 7:48 R23 was observed standing up in front of the toilet while facing the doorway. R23 had both hands on the wheelchair handles and was stretched over the wheelchair seat. R23's legs were bent at her knees. NA-H held on to R23's gait belt and applied a clean brief and then assisted her into the wheelchair. R23 was unsteady and required NA-H to hold onto her and guide her into the wheelchair during the transfer.

Following the observation, NA-H verified R23 was at a high risk for falls and required staff assistance with all ADLs. NA-H stated he was not sure what R23's cognition was because R23 was

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F 323	Continued From page 43 unable to speak and that got in the way. NA-H stated R23 transferred pretty well, however, staff have had to stop her from self-transferring. R23 moved quickly and did not wait for staff. He stated R23 unfortunately always thought about sleep and was also confused sometimes as to why her seatbelt was on. He stated R23's fall interventions were her seat belt and wall alarm. He stated he did not know of any other interventions to prevent R23 from falling. NA-H stated the last time R23 self transferred was on 11/7/16, in which R23 must have fallen when she got off the toilet because there was stool in the toilet bowl and the water was running in the bathroom. He stated he found her on the floor in her bathroom that morning at about 8:00 a.m. with her back against the wall under the towel rack and her legs were out by the toilet and no alarms were sounding. NA-H stated he called the nurse in because he was worried about the bump on her head and he did not know if that fall had caused the bump or another fall had. NA-H pulled R23's small white communication board from a bag in the back of R23's wheelchair and wrote time to eat on it for R23 to read. -At 7:58 a.m. R23 was observed self propelling her wheelchair slowly down the hallway towards the dining room. R23's self releasing seat belt on and fastened correctly. R23 used both arms, and her left leg and foot to propel herself. R23 grabbed the right side hallway rail and pulled herself along until the railing ended and she found her seat at the dining room table. R23 was not supervised by staff as she self propelled from her room to the dining room.	F 323		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 44 On 11/09/16, at 8:53 a.m. physical therapist (PT) was observed to ambulate with R23 in the hallway outside of R23's room. PT applied a gait belt and lifted/assisted R23 to stand up. R23 was stooped over and both legs remained bent at the knee. R23 took small, slow steps. and appeared to favor her left leg. PT held on to R23's gait belt with her left hand, and pushed R23's wheelchair with her right hand. PT stated R23 liked to get ahead of her walker, and her right side tended to buckle. R23 walked stooped over, legs bent and was not standing straight up. R23's eyes looked down to the floor or her feet and R23 did not look ahead. R23 walked like this for approximately 30 feet before she slowed way down, and PT assisted her with gait belt into her wheelchair. Once in the wheelchair, R23 grimaced and rubbed her right leg. PT confirmed R23's signs of pain, and stated she asked R23 before she walked if she had any pain, and R23 had told her no. PT asked R23 if she wanted some pain medication from the nurse, however, R23 was unable to communicate with PT regarding her pain or desire for pain medication. PT stated she did not know what R23's cognition was, and stated communication was a determining barrier and felt R23 had some degree of impairment related to dementia. She stated R23's fall interventions were to educate her to call for help, and walk inside her walker, but R23 just did not follow through. She stated she was not sure if R23 did not follow through after being educated because of her cognition or if it was her choice not to. PT stated R23 did not hold her walker close to her body for safety when using it rather, held it way out. PT also stated R23 was unable to account for improved walking ability when her walker was closer to her. She stated R23 also favored her left leg more because R23 sustained	F 323		

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F 323	Continued From page 45 a right hip fracture in March of 2016, and again in August 2016, and had pain. Pt confirmed R23 was at high risk for falls related to unsafe self transfers and R23 not wanting to wait for staff assistance. PT confirmed R23 continued to self transfer unsafely and without staff assistance and because of R23's impaired ambulation and gait she definitely required staff assistance. She stated she thought the last time R23 self transferred was 11/7/16, at which time, R23 had fallen. PT stated she thought R23 took herself to the bathroom. She stated staff had hoped she would get better and go back to assisted living, but stated she did not feel it was possible now. On 11/09/16, at 11:00 a.m. the PT stated R23's fall interventions included a room sensor to help alert staff when she was trying to self transfer when R23 did not use her call light, staff also added a self-releasing seat belt because R23 had been leaning too far forward in her wheelchair and had fallen out. PT stated despite adding the seat belt, R23 had fallen two more times from her wheelchair. PT stated R23 sustained a head injury after she fell out of her wheelchair and went to the hospital. R23 always attempted to self transfer, always looked down at her feet, and had a history of falls including two hip fractures in March and August of 2106. PT stated R23 had a history of being developmentally delayed and had previously sustained a traumatic injury/skull fracture in a car accident. She stated on 11/7/16, R23 had been put on the toilet by staff and R23 was supposed to use her call light to let staff know when she was done but had not and self transferred from the toilet and fell before staff got back to her room. She stated a restorative nursing program, and staff assistance were	F 323		

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recommended approaches to prevent further falls for R23. PT did not identify R23's reacher, body pillows, grab bars, or bed position and raised mattress as additional fall interventions.

On 11/09/16, at 12:25 p.m. PT confirmed R23 had many barriers to safe ambulation and transfers. She stated R23 was non-weight bearing (NWB) for a long time because R23 was unable to participate in NWB training. PT stated they tried to communicate with R23 and tried written cues, visual demonstration, and manual cues and were unsuccessful. PT stated when R23 was admitted she was not able to bear weight on her right leg related to a repeat right hip fracture, surgical pain, weakness, and impaired cognition and communication. PT stated R23 had slowly improved and would be discharged from therapy on 11/11/16. She stated she was afraid R23 would not be able to return to assisted living because she had poor safety recall and continued falls. She stated R23 had to be cued to put her wheelchair brakes on, and required one staff person to assist her with all transfers and ambulation.

On 11/9/16, at 3:00 p.m. R23's sensor alarm sounded. R23 was observed in bed with a wedged raised mattress, bilateral grab bars in place, no body pillows in place, bed in lowest position, wheelchair by her bed, and her walker in the corner of the room across from her bed.

On 11/10/16, at 7:30 a.m. R23 was observed in bed, asleep. There were no body pillows in place as directed by the care plan. R23's room was

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dark, her bedroom door was 3/4 closed, her bed was in lowest position, bilateral grab bars in place, a raised edge mattress on her bed, her sensor alarm was on her wheelchair by her bed, and her walker in the corner of the room across from her bed.

On 11/10/16, at 9:02 a.m. R23's sensor alarm was sounding. R23 was observed in bed with no body pillows in place. LPN-B confirmed R23 did not have any body pillows in bed with her. LPN-B located one body pillow on top of R23's dresser and also looked in several other locations in R23's room and confirmed she couldn't find the second body pillow and stated she would check with laundry.

On 11/09/16, at 12:58 p.m. the DON stated R23 was admitted from assisted living facility after she had sustained her 3rd fall and broken hip this year. She stated R23's physician was afraid R23 would fall again, get injured, and may never walk again. She stated R23 was deaf and had mild cognitive impairment, and required staff assistance with all ADLs. The DON stated R23 was so impulsive that staff tried to have someone with her at all times. She stated when R23 was admitted they checked on her more frequently, and educated R23 on the use of her call light and she started falling.

At 1:34 p.m. R23's aforementioned falls including incident reports, investigation reports and interventions implemented were reviewed with the DON who stated the following:

-9/3/16, the DON verified the fall information and

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stated she did not think R23 used her call light and felt that was why R23 had so many falls. The DON stated every time after R23 fell, the staff re-educated R23 on the fact that she couldn't get up or walk on her own. She stated staff had initiated neuro checks and added the sensor alarm to her bed and updated her care plan.

-9/6/16, 4:00 a.m. the DON verified the fall information and stated she thought anxiety caused R23 to self-transfer and fall out of bed. She confirmed neuro checks were initiated, and the new fall intervention was to keep bed in low position when R23 was in bed.

-9/11/16, 8:00 a.m. the DON verified the fall information and stated neuro checks were initiated and fall interventions included two body pillows along side the resident when in bed and staff education.

-9/13/16, 4:10 p.m. the DON verified the fall information and stated R23 was inconsistent with call light use. Staff reeducated R23 on call light use. The DON stated fall interventions implemented were neuro checks, resident/employee/family education and the addition of a raised edged mattress to R23's bed.

-10/20/16, 3:30 p.m. fall incident not discussed at this time due to the fall information was not available for review yet. The information was provided on 11/10/16.

-10/27/16, 8:10 a.m. the DON confirmed the fall information and stated R23 was reeducated on calling/asking for help. The DON stated a self releasing seat belt was added to R23's wheelchair and R23 was educated on the use.

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-10/30/16, 9:30 a.m. the DON confirmed the fall information and stated the fall intervention implemented was for R23 to be reeducated on the importance of asking for help and that she needed assistance with all transfers.

-10/30/16, at 5:00 p.m. the DON confirmed the fall information and subsequent hospitalization.

-11/7/16, 8:15 a.m. the DON confirmed the fall information and stated R23 never, never used her call light and verified an investigation was not completed nor were new interventions implemented except for re-educating R23 and reminding her to use the call light to ask for help. The DON stated she had not had a chance to complete the fall investigation report yet. The DON stated she did not know what else to do to minimize R23's continued falls.

On 11/9/16, at 2:50 p.m. trained medication administration (TMA) stated R23 set off her sensor alarm by her bed all the time. She stated R23 also had a seat belt alarm on her wheelchair now. She stated R23 played with the alarm belt, and continued to transferred herself. She stated staff just kept an eye on her. In addition, after meals R23 wanted to go right back to her room.

On 11/9/16, at 3:04 p.m. NA-J stated any movement in R23's room would set off the sensor alarm by R23's bed. She stated R23 could sit up in bed by herself and could also read her white communication board. She stated R23 should have two body pillows in bed with her at all times, and confirmed R23 did not currently have two

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body pillows in bed and was not sure where they were at. She stated R23 had a seat belt and can remove it on her own and liked to grab at the velcro strap on her shoes, but if she did not wear her velcro shoes, she did not reach for her feet. NA-J stated she had been on duty when R23 had fallen and stated R23 usually fell out of her wheel chair. She stated R23 did not fall in her room, but fell in the dining room, and in the hallway. She stated when there were changes to resident care the other NA's would discuss it, and there was also a Kardex in the charting room for staff to review if they needed to. She stated she did not check the Kardex when she was working, but if there was something strange going on with a resident she might.

On 11/10/16, at 7:40 a.m. LPN-B stated R23 was able to be left alone in the bathroom and was pretty good at using her call light. She stated staff usually did not go far when R23 was in her bathroom by herself.

On 11/10/16, at 8:11 NA-L stated she would not leave R23 alone in her bathroom because she would fall. NA-L stated she may just step outside the bathroom when R23 was on the toilet, but did not leave R23's bedroom.

On 11/10/16, at 8:44 a.m. NA-H stated R23 could remove her seat belt, and fiddled with it when she wheeled herself from the dining room and had seen her take it off a couple times. He stated it was not ok for staff to leave R23 unattended on the toilet by herself. NA-H stated he did not leave R23 alone in her bathroom because R23 was

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F 323	Continued From page 51 impulsive and would self transferred. He stated he wasn't sure if R23 was left alone on the toilet on 11/7/16, and stated it was possible because no alarms were going off when he found her on the floor in her bathroom. He also stated R23 hated to waste water and when he found her water faucet on he wasn't sure if a staff person turned the water on for her and left, or if R23 had turned the water on. On 11/10/16, at 12:43 p.m. the DON and administrator were interviewed. The DON confirmed R23 also fell on 10/20/16, at 3:20 p.m. and stated R23 was found on the floor next to her bed after she self transferred and her walker tipped over. She stated R23 had no injury, R23 did not call for help and attempted to self transfer. Fall interventions included were to re-educate R23 on using her call light for help, and reminded R23 she needed assistance for transfers. Neuro checks were also initiated. There was no documentation of whether R23 was incontinent or not. The DON stated she had not had time to investigate R23's fall on 11/7/16, at 8:15 a.m. because she had been working on the medication cart. The DON stated she thought R23 had been put on the toilet after breakfast, was left alone, self transferred, and fell. The DON stated because R23's alarms were turned off, a staff person must have left her alone on the toilet. The DON and administrator confirmed this incident should have been investigated to determine causal factors and interventions to be implemented. The Administrator stated she hadn't completed the investigation for the fall on 11/7/16, because she felt it needed to be a team effort and stated she could have completed the investigation, but did not. She stated staff typically	F 323		

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F 323	Continued From page 52 reviewed falls during their morning huddle meeting and because of the survey, they had not held their morning meetings this week. Additionally, the DON admitted R23's alarming seat belt was ordered on 10/27/16, and did not arrive at the facility until 10/31/16, therefore was not affixed to R23's wheelchair until 10/31/16. The DON stated the next intervention they would try for R23 was to add a sensor alarm in R23's bathroom because R23's current sensor did not reach into the bathroom and other than the bathroom alarm she had no idea what else to do to prevent R23's falls. The DON stated they would order an alarm for R23's bathroom. Lastly, the DON confirmed R23 understood directions but did not have the ability to remember to follow directions. The DON was asked if the facility had completed a comprehensive fall assessment and the DON stated she did not know if they had, but staff had had fall assessment discussions regarding other residents. The DON confirmed the facility had not completed a overall comprehensive fall assessment. During a facility monitoring visit on 11/11/16, at approximately 12:30 p.m. the OT confirmed R23 had impaired cognition, had impaired safety awareness and no instruction/safety measure recall after cued/instructed. She R23 would be discharge from therapy today. The OT stated R23's fall in the bathroom resulted from LPN-B assisting R23 onto the toilet and leaving her unattended. The OT stated R23 did not remember to use the call light to alert staff assistance was needed and would usually turn on the call light only to shut if off herself, shortly thereafter.	F 323		

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F 323	Continued From page 53 On 11/11/16, at 12:45 p.m. LPN-B confirmed she had assisted R23 onto the toilet and had left her unattended, however, was not sure if it was Monday 11/7/16, or a previous Monday. LPN-B also confirmed R23 did not always use the call light to request assistance when on the toilet. The Fall Prevention and Management policy dated 5/2016, indicated the facility was accountable for fall prevention and management. The policy indicated after a fall, a resident may experience impaired function, decreased mobility, loss of independence, sustain injuries or be the cause of their death. Fall risk factors were identified as: vision problems, mobility and transfer problems, cognitive problems, sleep problems, equipment and assistive device problems, environmental problems, medical problems and continence problems. The policy defined an "avoidable" accident (fall) meant that an accident occurred because the facility failed to: identify environmental hazards and individual resident risks of having an accident, evaluate or analyze the hazards and risks, implement interventions, including adequate supervision that was consistent with the residents needs, goals, plan of care and current standards of practice, or monitor the effectiveness of the interventions in order to reduce the risk of an accident. The policy also indicated the facility would take a proactive approach to fall prevention which included identifying a potential risk and taking steps to mitigate the risk before actual harm occurred, and they would predict what might cause a resident to fall and what action can be taken to prevent it. The immediate jeopardy which started on	F 323		

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F 323	Continued From page 54 11/10/16, at 4:00 p.m. was removed on 11/15/16, at 3:27 p.m. after the facility completed the following interventions as part of their removal plan: -R23 was comprehensively assessed for falls -R23's care plan was updated to reflect R23's assessed risks for falls and fall prevention interventions -Staff were educated on R23's fall interventions -On 11/15/16 from 3:03 p.m. to 3:19 P.M. direct care staff, including licensed nursing staff were interviewed regarding R23's safety risks. All of the interviewed staff were aware of R23's risk for falls, and fall prevention interventions to ensure R23's safety.	F 323		
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to	F 441		12/23/16

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F 441	Continued From page 55 prevent the spread of infection, the facility must isolate the resident. (2) 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. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure contact isolation precautions were implemented during the provision of direct resident contact for 1 of 1 resident (R26) observed during personal care and was in contact precautions. Findings include: R26's quarterly Minimum Data Set (MDS) dated 8/10/16, indicated R26 had mild cognitive impairment and required extensive assistance of one staff for bed mobility. On 11/7/16, at 3:00 p.m. during the initial tour, an isolation cart (plastic container with personal	F 441	1. Proper hand hygiene will be utilized. The resident identified as R26 has passed away. 2. All current and future residents will be protected from infection through the use of proper hand hygiene. 3. Nursing staff will be educated by the Staff Development Coordinator, or designee, on proper hand hygiene and contact precautions by 12/23/16. 4. Hand hygiene observation audits will be completed by a trained staff member 2x/day for 2 weeks, 1x/day for 2 week, 4x/week for 2 weeks, and 2x/week for 4 weeks. Audit results will be tracked and reviewed monthly by the QAPI Committee for further recommendations.	

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F 441	Continued From page 56 protective equipment) was observed outside of R26's room. The cart contained a sign which indicated the individual in the room required contact precautions (precautions used during care of patients known or suspected to have a serious illness easily transmitted by direct patient contact or by indirect contact with items in the patient's environment) . Licensed practical nurse (LPN)-A stated R26 had tested positive for methicillin-resistant staphylococcus aureus (MRSA) at his suprapubic catheter (urinary catheter inserted into the bladder from the belly) site. On 11/8/16, at 1:50 p.m. R26 was observed to call for assistance. At 1:53 p.m. nursing assistant (NA)-M entered R26's room, apply gloves and proceeded to empty R26's suprapubic catheter drainage bag. NA-M removed her gloves and washed her hands. Without gloved hands, NA-M proceeded to make R26's bed touching multiple areas of the bed including the covers, bed rails and pillows. When completed the task, NA-M talked to R26 while touching his wheelchair and his body then exited the room. NA-M was not observed to wash her hands or use sanitizer as she left the room and walked into another residents room (R5). NA-M was about to touch R5 when the State Agency staff asked to speak to her. On 11/8/16, at 2:00 p.m. NA-M verified she had not washed her hands prior to leaving R26's room. She confirmed R26 currently required contact precautions related to MRSA and stated she should have washed her hands when she exited the room.	F 441	5. 12/23/16	

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	245550	A. BUILDING _____ B. WING _____	11/15/2016

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F 441	Continued From page 57 On 11/8/16, at 2:10 p.m. registered nurse (RN)-B confirmed R26 had MRSA at the suprapubic catheter cite and the linens on his bed were considered contaminated. She confirmed the nursing assistants were to be washing their hands after caring for R26. On 11/10/16, at 8:40 a.m. the director of nurses(DON) verified R26 required contact precautions for MRSA at his suprapubic catheter site. The DON confirmed NA-M should have washed her hands in an attempt to minimize contamination from R26's prior to leaving the room. A policy related to infection control/hand hygiene was requested and none was provided.	F 441		
F 492 SS=F	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the supplemental nursing service agency (SNSA) utilized by the facility was registered with the Minnesota commissioner, as	F 492	1. Go-To Healthcare Placement, Inc. will not be used for direct care services. LPN-A is no longer a provider of direct care.	12/26/16

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F 492	Continued From page 58 required. This had the potential to affect all 33 residents who resided in the facility and received services from the the supplemental staff. Findings include: During the entrance conference on 11/716, at 3:18 p.m. the administrator and director of nursing (DON) stated the facility utilized the Go-To Healthcare Placement, Inc. staffing agency to provide nursing coverage. The administrator verified by the Minnesota Department of Health's Directory of Registered Supplemental Nursing Services Agency that Go-To Healthcare Placement, Inc. was not one of the approved agencies listed. On 11/8/16, at 10:28 a.m. the administrator confirmed licensed practical nurse (LPN)-A had worked full-time at the facility from 5/2/16 - 11/2/16, and stated LPN-A had provided care on the units and had also functioned as the minimum data set (MDS) coordinator.	F 492	2. Future direct care supplemental nursing agency staff will be hired from agencies on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency. The HR Coordinator will be assuring each supplemental nursing agency staff is currently on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency. A process has been developed to review current supplemental nursing agency staff monthly through QAPI to ensure their agency is still on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency. 3. Education was provided by 12/26/16 by the Workforce Consultant to the Administrator and Human Resources Coordinator that agencies not registered on Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency will not be used for direct care with residents. 4. Each potential supplemental nursing agency will be reviewed to ensure they are on the Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency prior to allowing staff to work in the facility. Current workers from supplemental nursing agency was verified on 12/12/16 through the online Minnesota Department of Health□s Directory of Registered Supplemental Nursing Services Agency	

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F 492	Continued From page 59	F 492	by the Administrator. Audit results will be tracked and reviewed monthly by the QAPI Committee for further recommendations. 5. 12/26/16	
F 497 SS=E	483.75(e)(8) NURSE AIDE PERFORM REVIEW-12 HR/YR INSERVICE The facility must complete a performance review of every nurse aide at least once every 12 months, and must provide regular in-service education based on the outcome of these reviews. The in-service training must be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year; address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff; and for nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were completed for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-E, NA-F) as required. In addition, the facility failed to ensure 12 hours of in-service training was provided for 1 of 5 nursing assistants (NA-C) as required. Findings include:	F 497	1. All Certified Nursing Assistants employed longer than 1 year will have a performance evaluation completed by 12/26/16 by DNS, or designee. All Certified Nursing Assistants that require the 12 hour training will have their required training completed by 12/26/16 by DNS, or designee. 2. All employees have the potential to be affected and will have an annual	12/26/16

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F 497	Continued From page 60 NA-B was hired on 1/23/14. Her personnel file indicated there were no performance evaluations available for this employee. NA-C was hired on 10/8/14. Her personnel file indicated there were no performance evaluations available for this employee. In addition, the undated Completion Report by Employee indicated NA-C had only completed 10 of the required 12 hours of in-service training for 2015. NA-D was hired on 11/5/13. Her personnel file indicated there were no performance evaluations available for this employee. NA-E was hired on 6/13/88. Her personnel file indicated the date of her last performance evaluation was 6/3/14. NA-F was hired on 3/9/89. Her personnel file indicated the date of her last performance evaluation was 3/17/14. On 11/14/2016, at 11:45 a.m. the human resources coordinator (HRC) stated the facility had recognized they had an issue with performance evaluations not being done and confirmed NA-B, NA-C, NA-D, NA-E, and NA-F all lacked a current performance evaluation. HRC also stated NA inservice training was tracked on the calendar year and confirmed NA-C had not received the required 12 hours of training for 2015.	F 497	performance evaluation completed by 12/26/16 if employed more than a year. All Certified Nursing Assistants have the potential to be effected by the requirements of training. All Certified Nursing Assistants that require the 12 hour training will have the required training completed by 12/26/16. 3. All supervisors will be educated on the policy and procedure regarding performance evaluations by 12/26/16 by the Administrator. All staff will be educated on the process regarding performance evaluations by 12/26/16 by Human Resources Coordinator. All Certified Nursing Assistants will be educated regarding the 12 hour required training on 12/26/16 by the DNS. An annual calendar will be provided to the Certified Nursing Assistants by the Staff Development Coordinator to meet the 12 hour training requirement for the year 2017. 4. Performance evaluations will be audited by the Human Resources Coordinator 1x/month for 3 months to ensure completion of annual performance evaluation. The Human Resources Coordinator will audit the training program confirm each Certified Nursing Assistant has completed the 12 hours of required training by 12/26/16. Audit results will be tracked and reviewed by the QAPI Committee for further recommendations. 5. 12/26/16	

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F 497	Continued From page 61 The Performance Evaluation policy dated 3/2014, indicated a job-specific performance evaluation form would be used for post-orientation, annual or more frequent performance evaluations. In addition, the Certified Nursing Assistant job description dated 3/2016 indicated basic responsibilities included: meets requirements for in-services, training and meeting attendance per location policy and state and federal requirements.	F 497		
F 507 SS=E	483.75(j)(2)(iv) LAB REPORTS IN RECORD - LAB NAME/ADDRESS The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure laboratory reports included the address of the performing laboratory for 4 of 4 residents (R12, R2, R30, R41) whose records were reviewed which lacked the identity of the performing laboratory. Findings include: R12's medical record was reviewed and revealed the following laboratory reports dated 11/2/16, lacked the address of the performing laboratory: --Comprehensive Metabolic Panel (CMP) (a	F 507	1. R12□s laboratory reports from 11/16/16 on will include the address of the testing laboratory. R2□s laboratory reports from 11/16/16 on will include the address of the testing laboratory. R30□s laboratory reports from 11/16/16 on will include the address of the testing laboratory. R41□s laboratory reports from 11/16/16 on will include the address of the testing laboratory. 2. All current and future residents□ laboratory reports from 11/16/16 will include the address of the testing	12/26/16

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F 507	Continued From page 62 blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function) --Complete Blood Count with Differential (CBC with diff) (measures the levels of red blood cells, white blood cells, platelet levels, hemoglobin and hematocrit. Many times it is ordered as a screening test as an anemia check or detection of infections) --Thyroid Stimulating Hormone (TSH) (measures the amount of thyroid stimulating hormone in the blood) R2's medical record was reviewed and revealed the following laboratory reports dated 11/2/16, lacked the address of the performing laboratory: --Hemoglobin (Hgb) (test used to screen for, diagnose, or monitor a number of conditions and diseases that affect red blood cells (RBCs) and/or the amount of hemoglobin in blood) --Basic Metabolic Panel (BMP) (blood test that measures sugar (glucose) level, electrolyte and fluid balance, and kidney function) The reports lacked the address of the performing laboratory. R30's medical record revealed the following laboratory reports lacked identification of the performing laboratory's address: - Pro-Time/International Normalization Ratio (PT/INR) (blood test to measure the bloods ability to clot) dated 9/21/16 - Urinalysis dated 9/29/16 - Complete Blood Count with Differential (CBC with diff) dated 9/29/16 - Comprehensive Metabolic Panel (CMP) dated	F 507	laboratory. 3. A discussion was held with involved parties to ensure there will be the address of the testing laboratory on the laboratory reports. We have identified one lab service as the only testing laboratory without an address on the lab reports. The Health Information Coordinator and Licensed Nurses will be educated that all lab reports require an address. This education will be provided by the DNS, or designee, by 12/26/16. If an address is missing on the specific lab reports, an address stamp (or label) will be provided for the Licensed Nurses/HIM to use. 4. Audits will be completed on laboratory report 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. Audit results will be tracked and reviewed monthly by the QAPI Committee for further recommendations. 5. 12/26/16	

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F 507	Continued From page 63 9/29/16 R41's medical record was reviewed and revealed the following laboratory reports dated 9/14/16, lacked the performing laboratory's address: --Comprehensive Metabolic Panel (CMP) (a blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function) --Complete Blood Count with Differential (CBC with diff) (measures the levels of red blood cells, white blood cells, platelet levels, hemoglobin and hematocrit. Many times it is ordered as a screening test as an anemia check or detection of infections) --Brain Natriuretic Peptide (BNP) (a blood test that measures the levels of protein called BNP, made by the heart and blood vessels. Levels are higher when in heart failure) On 11/15/2016, at 11:24 a.m. the health information coordinator (HIC) confirmed the aforementioned reports did not include the address of the performing laboratory. On 11/15/2016, at 2:36 p.m. the administrator confirmed the laboratory reports did not contain the laboratory's address as required. The Laboratory Services policy dated 9/2012 indicated laboratory reports would be dated and filed in the resident's medical record and should contain the name and address of the issuing	F 507		

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F 507	Continued From page 64 laboratory.	F 507		
F 513 SS=D	483.75(k)(2)(iv) X-RAY/DIAGNOSTIC REPORT IN RECORD-SIGN/DATED The facility must file in the resident's clinical record signed and dated reports of x-ray and other diagnostic services. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure X-ray/diagnostic tests were signed and dated by the physician for 1 of 4 (R41) records reviewed. Findings include: R41's quarterly Minimum Data Set (MDS) dated 10/14/16, indicated R41 was diagnosed with nutritional deficiency and pneumonia. R41's Clinic Referral dated 9/14/16, indicated a follow-up chest X-ray was to be completed, in addition to the following labs - with result reports being sent to the nursing home: --Comprehensive Metabolic Panel (CMP) (a blood test that measures sugar (glucose) level, electrolyte and fluid balance, kidney function, and liver function) --Complete Blood Count with Differential (CBC with diff) (measures the levels of red blood cells, white blood cells, platelet levels, hemoglobin and	F 513	1. R41□s X-ray/diagnostic tests will be signed and dated by the physician by 12/26/16. 2. All current and future residents will have X-ray/diagnostic tests signed and dated by the physician as was discussed and agreed upon in a conversation with all parties involved. 3. The HIM and Licensed Nurses will be educated that all X-ray/diagnostic tests require physician signatures and date. This education will be provided by the DNS, or designee, by 12/20/16. 4. Audits will be completed to ensure X-ray/diagnostic tests/report will be signed and dated by the physician 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. Audit results will be tracked and reviewed by the QAPI Committee for further recommendations. 5. 12/26/16	12/26/16

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F 513	Continued From page 65	F 513		

hematocrit. Many times it is ordered as a screening test as an anemia check or detection of infections)

--Brain Natriuretic Peptide (BNP) (a blood test that measures the levels of protein called BNP, made by the heart and blood vessels. Levels are higher when in heart failure)

R 41's Clinic Referral dated 10/6/16, indicated a chest X-ray was completed and was clear, however, R41's medical record lacked an X-ray report.

On 11/15/16, at 11:24 a.m. the health information coordinator (HIC) stated the laboratory/radiology departments sent the results to the ordering provider who then would fax them to the facility. The HIC confirmed the facility received a preliminary report for the 9/14/16, X-ray, which was not signed or dated by the physician. The HIC confirmed no X-ray report was provided for the 10/6/16 visit. The HIC stated they do not receive the final reports.

On 11/15/16, at 2:36 p.m. the administrator confirmed radiology/diagnostic reports were to be signed and dated by the physician and filed in the residents record.

The Radiology and Diagnostic Services policy dated 9/2012, indicated radiology and other diagnostic services will be obtained when ordered by the physician and the reports would be signed, dated and filed in the resident's medical record.

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F 514 SS=E	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record was complete and all diagnostic reports and provider progress reports were readily accessible for 4 of 4 residents (R12, R2, R30, R41) whose records were reviewed which did not include the reports. Findings include: R12's medical record was reviewed on 11/15/16, at approximately 10:00 a.m. The provider progress visit note from a visit dated 10/27/16, was not available. On 11/15/16, at 11:15 a.m. the health information coordinator (HIC) confirmed R12 had been seen by the nurse practitioner (NP) on 10/27/16, however the facility had not received the	F 514	F514 1. R12□s progress notes have been received. R2 progress notes have been received. R30 progress notes have been received. R41 progress notes have been received. 2. A discussion was held with involved parties to ensure progress notes are received. All current and future progress notes will be tracked within 1 week of provider visit by HIM. HIM will call the clinic if progress notes are not received in 1 week. HIM will alert the Administrator if progress notes are not received after 2 weeks and the administrator will follow-up with the clinic. 3. The HIM will be educated by the Administrator on 12/23/16 on the	12/23/16

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F 514	Continued From page 67 documentation of the visit. R2's chart was reviewed on 11/15/16 at approximately 10:20 a.m. The provider progress note from a visit on 10/11/16, was not available. On 11/15/16, at 11:16 a.m. the HIC confirmed R2 was seen by the NP on 10/11/16, but the facility had not yet received the documentation from the visit. The HIC stated they had difficulty receiving the information back in a timely fashion. On 11/15/16, at 2:25 p.m. the HIC stated she had contacted the provider office to obtain copies of the progress notes for R12 and R2's visits, however, the information was not available. R30's clinic referral form dated 7/13/16, indicated R30 was scheduled for a mammogram with results to follow in seven to ten days. R30's medical record was reviewed on 11/15/16, at 1:30 p.m. R30's mammogram results were not accessible in R30's medical record. On 11/15/16, at 1:38 p.m. the HIC confirmed R30's mammogram had been completed on 7/13/16, and the mammogram results were not available to the facility, nor accessible in R30's medical record. R41's clinic referral form dated 9/14/16, indicated R41 was scheduled for a follow up chest X-ray and clinic visit.	F 514	expectations of progress notes received within 1 week of an appointment or visit. A follow up call will be placed to the provider□s facility by the HIM at that time and notification of the administrator, who will follow up with the other facility, will occur after 2 weeks. 4. Audits to ensure progress notes are received within a 1 week after a residents visit. Audits will be completed 5x/week for 4 weeks, 3x/week for 4 weeks, 2x/week for 2 weeks, and 1x/week for 2 weeks. Audit results will be reviewed by the QAPI for further recommendations. 5. 12/23/16	

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F 514	Continued From page 68 R41's clinic referral form dated 10/6/16, indicated R41 was scheduled for a clinic visit. R41's medical record was reviewed on 11/15/16, at 11:00 a.m. R41's provider progress notes, and X-ray results for the above visits were not accessible in R41's medical record. On 11/15/2016, at 11:24 a.m. the HIC confirmed R41's medical record lacked documentation of provider visits and diagnostic reports and stated the provider progress notes were requested from the provider for the visits on the above dates to include the X-ray results. On 11/15/16, at 2:32 p.m. the administrator confirmed the facility had not been receiving medical documentation back in a timely fashion and stated she would expect within two weeks of a visit, the documentation would be available in the resident medical record The Maintenance of Active Medical Records policy dated 9/2013, indicated medical records would be maintained on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible and systematically organized.	F 514		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245550	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**11/09/2016**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	**410 SOUTH MCKINLEY STREET WARREN, MN 56762**

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K 000	INITIAL COMMENTS FIRE SAFETY 01 Main Building THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, State Fire Marshal Division. At the time of this survey Good Samaritan Society Warren 01 Main Building was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		12/14/2016

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

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K 000	Continued From page 1 Or by e-mail to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Facility was inspected as 1 building with the code change as of November 1, 2016 Good Samaritan Society Warren (Marshal Manor) was built in 1968 as a 1-story building without a basement and was determined to be Type II (111) construction. In 1973 a 1-story addition was constructed to the east of the original building and was determined to be Type II (000) construction. In 2010 a kitchen addition was constructed to the north of the original building's dining room. It is 1-story, no basement and Type II(000) construction. In 2013 a connecting link was constructed to the east connecting the new hospital with the facility. This addition is i-1story , no basement and Type II(000) construction. The building is divided into 6 smoke zones with 1/2 hour fire rated barriers. An apartment building is attached to the southwest wing that is separated with a 2-hour fire barrier.	K 000		

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K 000	Continued From page 2 The facility is completely protected with an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems (1999 edition). The facility has a fire alarm system that includes corridor smoke detection, with additional detection in all common areas installed in accordance with NFPA 72 "The National Fire Alarm Code (1999 edition) with automatic fire department notification. Hazardous areas have automatic fire detectors that are on the fire alarm system in accordance with the Minnesota State Fire Code (2007 edition). The facility has a capacity of 45 beds and had a census of 35 at the time of the survey. The requirement at 42 CR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 347 SS=E	NFPA 101 Smoke Detection Smoke Detection 2012 EXISTING Smoke detection systems are provided in spaces open to corridors as required by 19.3.6.1. 19.3.4.5.2 This STANDARD is not met as evidenced by: Based on observations and staff interview the facility failed to install the smoke detection in accordance with NFPA 101 Life Safety Code, (2012) section 19.3.6.1 & 9.6.2.10 and NFPA 72 National Fire Alarm Code (2010) section 17.6.3.1.1 This deficient practice could affect the ability of the alarm system to sound in a timely manner during a fire event which could affect 14 of the 35 residents and an undetermined amount of staff and visitors.	K 347	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	1/5/17

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K 347	Continued From page 3 Findings include: On the facility tour between 8:00 am to 12:00 pm on 11/9/2016 observations and staff interview revealed there were only two smoke detectors, one on each end, in the corridor of wing 200 which exceeded 30 feet apart. This deficient condition was confirmed by the Facility Administrator and the Environmental Service Director.	K 347	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. 1. The facility has contracted with a licensed electrical company to add 7 smoke detectors and move 3 smoke detectors to ensure proper spacing to the 30 foot requirement. The facility identified additional smoke detectors that needed different placement. The placement of these smoke detectors will be installed with the original smoke detectors. Parts for correction have been ordered and the electrician has been contracted. 2. Installation of the additional smoke detectors at the proper 30 foot spacing began on 12/13/2016. 3. Work will be expected to be completed by 1/5/17. 4. The Director of Environmental Services, or designee, will be responsible.	

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
December 6, 2016

Ms. Judy Bernat, Administrator
Good Samaritan Society - Warren
410 South McKinley Street
Warren, MinnesotaqN 56762

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5550028

Dear Ms. Judy Bernat:

The above facility was surveyed on November 7, 2016 through November 15, 2016 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

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

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

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the

"Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

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

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

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, **you should immediately contact Lyla Burkman at (21/) 308-2104 or email: lyla.burkman@state.mn.us**.

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

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

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

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health

Email: mark.meath@state.mn.us
Telephone: (651) 201-4118
Fax: (651) 215-9697

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00356	A. BUILDING: _____ B. WING _____	11/15/2016

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

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On November 7, 8, 9, 10, 11, 13, 14, and 15, 2016, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS	2 000		

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2 000	Continued From page 2 APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 302	MN State Statute 144.6503 Alzheimer's disease or related disorder train ALZHEIMER'S DISEASE OR RELATED DISORDER TRAINING: MN St. Statute 144.6503 (a) If a nursing facility serves persons with Alzheimer's disease or related disorders, whether in a segregated or general unit, the facility's direct care staff and their supervisors must be trained in dementia care. (b) Areas of required training include: (1) an explanation of Alzheimer's disease and related disorders; (2) assistance with activities of daily living; (3) problem solving with challenging behaviors; and (4) communication skills. (c) The facility shall provide to consumers in written or electronic form a description of the training program, the categories of employees trained, the frequency of training, and the basic topics covered. (d) The facility shall document compliance with this section.	2 302		12/26/16

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2 302	Continued From page 3 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide the required Alzheimer's training to 1 of 3 nursing assistants (NA-A) and 1 of 1 dietary assistant (DA-A). This had the potential to affect all 33 residents who resided in the facility. Findings include: NA-A was hired on 5/26/16, and NA-A lacked evidence of having received the required Alzheimer's training. DA-A was hired on 10/11/16, and DA-A lacked evidence of having received the required Alzheimer's training. On 11/8/16, at 8:15 a.m. administrator stated all staff should have completed the Alzheimer's training prior to them starting in their respective departments. On 11/9/16, human resource coordinator (HRC) verified NA-A and DA-A had not completed the required Alzheimer's training. HRC confirmed NA-A and DA-A were current employees of the facility and currently worked in their respective roles at the facility. HRC stated NA-A and DA-A should have completed the training. The Alzheimer's and Related Disorder Training document (undated) indicated all facility staff would complete training on Alzheimer's disease and related disorders in accordance with state requirements. SUGGESTED METHOD FOR CORRECTION:	2 302	Corrected 12/26/16	

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2 302	Continued From page 4 The director of nursing (DON) could develop and implement policies and procedures related to the Alzheimer's training program requirements. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 302		
2 335	MN Rule 4658.0130 Employees' Personnel Records A current personnel record must be maintained for each employee and be stored in a confidential manner. The personnel records for at least the most recent three-year period must be maintained by the nursing home. The records must be available to representatives of the department and must contain: A. the person's name, address, telephone number, gender, Minnesota license, certification, or registration number, if applicable, and similar identifying data; B. a list of the individual's training, experience, and previous employment; C. the date of employment, type of position currently held, hours of work, and attendance records; and D. the date of resignation or discharge. Employee health information, including the record of all accidents and those illnesses reportable under part 4605.7040, must be maintained and stored in a separate employee medical record.	2 335		12/26/16

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2 335	Continued From page 5 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure annual performance evaluations were completed for 5 of 5 nursing assistants (NA-B, NA-C, NA-D, NA-E, NA-F) as required. In addition, the facility failed to ensure 12 hours of in-service training was provided for 1 of 5 nursing assistants (NA-C) as required. Findings include: NA-B was hired on 1/23/14. Her personnel file indicated there were no performance evaluations available for this employee. NA-C was hired on 10/8/14. Her personnel file indicated there were no performance evaluations available for this employee. In addition, the undated Completion Report by Employee indicated NA-C had only completed 10 of the required 12 hours of in-service training for 2015. NA-D was hired on 11/5/13. Her personnel file indicated there were no performance evaluations available for this employee. NA-E was hired on 6/13/88. Her personnel file indicated the date of her last performance evaluation was 6/3/14. NA-F was hired on 3/9/89. Her personnel file indicated the date of her last performance evaluation was 3/17/14.	2 335	Corrected 12/26/16	

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2 335	Continued From page 6 On 11/14/2016, at 11:45 a.m. the human resources coordinator (HRC) stated the facility had recognized they had an issue with performance evaluations not being done and confirmed NA-B, NA-C, NA-D, NA-E, and NA-F all lacked a current performance evaluation. HRC also stated NA inservice training was tracked on the calendar year and confirmed NA-C had not received the required 12 hours of training for 2015. The Performance Evaluation policy dated 3/2014, indicated a job-specific performance evaluation form would be used for post-orientation, annual or more frequent performance evaluations. In addition, the Certified Nursing Assistant job description dated 3/2016 indicated basic responsibilities included: meets requirements for in-services, training and meeting attendance per location policy and state and federal requirements. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and revise policies and procedures and provide education for staff regarding completion of annual performance evaluations and required inservice training. The Quality Assessment and Assurance (QAA) committee could do random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 335		

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2 565	Continued From page 7	2 565		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide verbal cueing and assistance during dining as directed by the care plan for 1 of 2 (R41) residents reviewed for nutrition who was blind and observed to not be provided with food placement directives/cues. In addition, the facilty failed to implement fall interventions related to the placement of two body pillows as directed by the care plan for 1 of 2 (R23) residents reviewed for accidents, and observed in bed with either one or no body pillows. Findings include: R41's care plan dated 10/24/16, indicated R41 had a performance deficit related eating due to blindness, R41 could feed self after staff explained what foods were served and food placement on the plate. The plan directed staff to provide set up with meal tray, assist with meals and to encourage intake. On 11/9/16, at 7:35 a.m. Nursing assistant (NA)-J was observed to assist R41 to the dining room via	2 565	Corrected 12/26/16	12/26/16

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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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2 565	Continued From page 8	2 565		

her wheelchair and positioned her at her dining room table. Once at the table, NA-J left the dining room.
-At 7:38 a.m. dietary aide (DA)-A provided R41 water and grape juice.
-At 7:43 a.m. R41 was independently drinking her water.
-At 7:59 a.m. licensed practical nurse (LPN)-B was observed to provide R41 with her medications. R41 took her medications and LPN-B returned to her medication cart.
-at 8:27 a.m. NA-J was observed to enter the dining room and observe R41 seated at her table. NA-J obtained a breakfast meal of hot cereal and toast for R41. NA-J applied peanut butter and jelly to the toast, added sugar to the cereal. NA-J exited the dining room without informing R41 where who food items were placed in front of her.
-At 8:45 a.m. R41 had not eaten her hot cereal or finished drinking her juice. NA-K approached R41 and asked her if she was done, and proceeded to remove her from the dining area. NA-K was not observed to sit down nor offer or provide assistance with completing the meal. During the observation, staff had not been observed to offer or provide R41 assistance or cueing with the breakfast meal.

On 11/9/16, at 8:54 a.m. R41 stated it would be nice to have someone tell her where her foods were located when served as she had difficulty finding the foods that were placed in front of her.

On 11/09/16, at 12:19 p.m. the dietary supervisor (DS) stated R41 was blind and staff should be providing cues to her during her meal service. The DS stated R41 was able to feed herself but required someone to tell her where her foods

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2 565	Continued From page 9 were located when placed in front of her. The DS also stated she would expect staff to be assisting R41 at meal time. On 11/09/16, at 3:36 p.m. the director of nursing (DON) verfied R41 required assistance with meals due to blindness and stated staff were to encourage R41 to eat and inform her where her food items were when placed in front of her. The DON stated, even thought R41 can feed herself, she still needed direction during meal times. The DON confirmed staff should have provided R41 assistance and cues during her meal service as directed by the care plan. The facility Care Plan policy dated 2/13, indicated residents would receive and be provided the necessary care and services to attain or maintain the highest practicable well-being. R23 was identified at risk for falls and two body pillows to be utilized when in bed were not implemented as directed by the care plan. R23's care plan dated 10/25/16, indicated R23 had limited physical mobility related to right hip fracture and weakness and was partial weight bearing to right leg. The plan also indicated R23 had poor balance and unsteady gait and required assistance of one staff to sit up, move in bed, reposition herself, get dressed and groomed, and required stand-by assistance when using her front-wheeled walker, a gait belt for transferring and was at risk for falls. The plan further indicated R23 required cueing and guidance with locomotion in her wheelchair. R23 had bladder	2 565		

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2 565	Continued From page 10 incontinence related to confusion and dementia, wore a brief all the time, and used the bed pan at night. The fall interventions identified included physical therapy for strength and mobility, sensor alarm in her room to alert staff of any movement, educate/instruct R23 on safe use of assistive devices, and not to bend over to pick up dropped items but use a grabber or ask for assistance from staff. Additional interventions included bed in lowest position, body pillows to be place on both sides of R23 when she was in bed, a raised edge mattress on her bed, and to observe for signs and symptoms of injury and check range of motion at the time of the fall. On 11/8/16, at 10:14 a.m. R23 was observed asleep in bed on her side with only one body pillow behind her. R23's room was dark, her bedroom door was 3/4 closed, had bilateral grab bars, her bed was in lowest position, she had a raised edge mattress on her bed, sensor alarm was on, wheelchair next to bed, and walker in the corner of the room across from her bed. On 11/08/16, at 1:33 p.m. R23 was observed asleep in bed on her side with her head on a standard white pillow with one body pillow laying vertical above her head. R23 had no body pillows on either side of her. R23's bedroom door was 3/4 closed, her bed was in lowest position, had bilateral grab bars, she had a raised egged mattress on her bed, sensor alarm was on, wheelchair next to bed, and walker in the corner of the room across from her bed. R23's sensor alarm sounded, human resources and quality assurance coordinator (HR/QA) walked in R23's room, and immediately walked out to the nurses station and turned R23's audio alarm off.	2 565		

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2 565	Continued From page 11 On 11/09/16, at 7:30 a.m. R23's sensor alarm sounded. R23 was observed in bed on her left side pulling up covers, with only one body pillow on the floor, bed in lowest position, raised edge mattress, bilateral grab bars, walker in corner of room across from her bed, and her wheelchair by her bed. On 11/09/16, at 2:08 p.m. LPN-B confirmed R23 was in bed and had only one body pillow in place and not two, as directed by the care plan. LPN-B stated R23 had a bloody nose, and the other body pillow was in the laundry. At this time, the DON confirmed R23's care plan, and stated R23 should have both body pillows with her in bed at all times. She stated even if they were being washed that was no excuse for R23 to be without her body pillows. On 11/9/16, at 3:04 p.m. NA-J stated R23 should have two body pillows in bed with her at all times, and confirmed R23 had no body pillows in bed with her at that time and she did not know where they were. On 11/10/16, at 7:30 a.m. R23 observed asleep in bed on her side, and had no body pillows in place. R23's room was dark, her bedroom door was 3/4 closed, her bed was in lowest position, bilateral grab bars, a raised edge mattress on her bed, her audio alarm was on, her wheelchair by her bed, and her walker in the corner of the room across from her bed. On 11/10/16, at 9:02 a.m. R23's sensor alarm was sounding. R23 was observed in bed and had no body pillows in place. LPN-B confirmed R23	2 565		

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2 565	Continued From page 12 did not have any body pillows in bed with her and located one body pillow on top of R23's dresser and looked in several locations in R23's room and confirmed she couldn't find another body pillow in R23's bedroom, and stated she would check with laundry. Review of the facility policy, Optional/Care Planning Training dated 2/14, indicated staff would be trained on resident care plans so they had basic knowledge of the purpose of the care plan and understood how the care plan influenced services provided to residents. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and / or revise policies and procedures related to the implementation of the care plan to ensure care is provided as directed by the care plan. Education could be provided to the staff. The quality assurance committee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 565		
2 625	MN Rule 4658.0450 Subp. 1 A-P Clinical Record Contents; In General Subpart 1. In general. Each resident's clinical record, including nursing notes, must include: A. the condition of the resident at the time of admission; B. temperature, pulse, respiration, and blood pressure, according to part 4658.0520,	2 625		12/26/16

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2 625	Continued From page 13 subpart 2, item I; C. the resident's height and weight, according to part 4658.0520, subpart 2, item J; D. the resident's general condition, actions, and attitudes; E. observations, assessments, and interventions provided by all disciplines responsible for care of the resident, with the exception of confidential communications with religious personnel; F. significant observations on, for example, behavior, orientation, adjustment to the nursing home, judgment, or moods; G. date, time, quantity of dosage, and method of administration of all medications, and the signature of the nurse or authorized persons who administered the medication; H. a report of a tuberculin test within the three months prior to admission, as described in part 4658.0810; I. reports of laboratory examinations; J. dates and times of all treatments and dressings; K. dates and times of visits by all licensed health care practitioners; L. visits to clinics or hospitals; M. any orders or instructions relative to the comprehensive plan of care; N. any change in the resident's sleeping habits or appetite; O. pertinent factors regarding changes in the resident's general conditions; and P. results of the initial comprehensive resident assessment and all subsequent comprehensive assessments as described in part 4658.0400.	2 625		

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2 625	Continued From page 14 This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure the medical record was complete and all diagnostic reports and provider progress reports were readily accessible for 4 of 4 residents (R12, R2, R30, R41) whose records were reviewed which did not include the reports. Findings include: R12's medical record was reviewed on 11/15/16, at approximately 10:00 a.m. The provider progress visit note from a visit dated 10/27/16, was not available. On 11/15/16, at 11:15 a.m. the health information coordinator (HIC) confirmed R12 had been seen by the nurse practitioner (NP) on 10/27/16, however the facility had not received the documentation of the visit. R2's chart was reviewed on 11/15/16 at approximately 10:20 a.m. The provider progress note from a visit on 10/11/16, was not available. On 11/15/16, at 11:16 a.m. the HIC confirmed R2 was seen by the NP on 10/11/16, but the facility had not yet received the documentation from the visit. The HIC stated they had difficulty receiving the information back in a timely fashion. On 11/15/16, at 2:25 p.m. the HIC stated she had	2 625	Corrected 12/26/16	

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2 625	Continued From page 15 contacted the provider office to obtain copies of the progress notes for R12 and R2's visits, however, the information was not available. R30's clinic referral form dated 7/13/16, indicated R30 was scheduled for a mammogram with results to follow in seven to ten days. R30's medical record was reviewed on 11/15/16, at 1:30 p.m. R30's mammogram results were not accessible in R30's medical record. On 11/15/16, at 1:38 p.m. the HIC confirmed R30's mammogram had been completed on 7/13/16, and the mammogram results were not available to the facility, nor accessible in R30's medical record. R41's clinic referral form dated 9/14/16, indicated R41 was scheduled for a follow up chest X-ray and clinic visit. R41's clinic referral form dated 10/6/16, indicated R41 was scheduled for a clinic visit. R41's medical record was reviewed on 11/15/16, at 11:00 a.m. R41's provider progress notes, and X-ray results for the above visits were not accessible in R41's medical record. On 11/15/2016, at 11:24 a.m. the HIC confirmed R41's medical record lacked documentation of provider visits and diagnostic reports and stated	2 625		

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2 625	Continued From page 16 the provider progress notes were requested from the provider for the visits on the above dates to include the X-ray results. On 11/15/16, at 2:32 p.m. the administrator confirmed the facility had not been receiving medical documentation back in a timely fashion and stated she would expect within two weeks of a visit, the documentation would be available in the resident medical record. The Maintenance of Active Medical Records policy dated 9/2013, indicated medical records would be maintained on each resident in accordance with accepted professional standards and practices that were complete, accurately documented, readily accessible and systematically organized. SUGGESTED METHOD OF CORRECTION: The DON and/or designee could could review and revise policies and procedures related to the maintenance of accurate, complete, and organized clinical information about each resident. The DON or designee could also perform audits of resident records and report findings to the quality assurance committee. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 625		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General	2 830		12/26/16

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2 830	Continued From page 17 Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess, thoroughly investigate causal factors and implement interventions in order to minimize the risk of falls and injury for 1 of 1 resident (R23) who had repeated falls with serious injuries which required medical intervention. This resulted in an immediate jeopardy situation for R23. Findings include: The Immediate Jeopardy (IJ) began on 11/7/16, related to the facility's failure to complete a comprehensive assessment to determine causal factors and implement interventions for R23 who had sustained significant injuries from two falls which occurred on 10/30/16, and another fall on 11/7/16. The lack of assessment placed R23 at significant risk for serious injury and/or death. The facility administrator and director of nursing (DON) were notified of the IJ on 11/10/16, at 4:00 p.m. which began on 11/7/16, when R23 had	2 830	Corrected 12/26/16	

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2 830	Continued From page 18	2 830		

fallen and the facility failed to complete a comprehensive assessment of causal factors related to R23's continued falls, in a effort to implement interventions to minimize the risk of R23's risk for further falls. The IJ was removed on 11/15/16, at 3:27 p.m. however, non-compliance remained at a scope and severity level of G, which indicated actual harm for R23 due to a hematoma and epistaxis sustained during a fall which required medical assessment and interventions.

R23's Diagnosis Report dated 11/9/16, indicated R23's diagnoses included subsequent right femur fractures, interoperable hemorrhage and hematoma (bleed or bruise) of the musculoskeletal structure, Alzheimer's disease, anxiety, anemia, pain, osteoarthritis, hearing loss and weakness.

R23's progress note (PN) dated 8/16, at 8:01 p.m. indicated R23 was admitted from the hospital following surgical repair of a fractured right hip as a result of a fall while at home. R23 was deaf and utilized a white communication board to communicate. R23 did speak, however, was sometimes difficult to understand due to whisper tone speech. R23 was pleasant and alert to person and place. R23 was able to verbalize need to use the bathroom. R23 was currently non weight bearing and would be transferred with staff assist and use of a mechanical lift as directed by physical therapy due to R23 consistently putting weight on restricted right leg with attempted to transfer. Immobilize/brace noted on right leg.

R23's admission Minimum Data Set (MDS) dated 9/2/16, indicated R23 had a history of falls with

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2 830	Continued From page 19 fractures, had severely impaired cognition, and was rarely or never understood. The MDS also indicated R23 required extensive assistance with activities of daily living (ADLs), was incontinent of urine, was not on a toileting program and received anti-anxiety and diuretic medications which could increase fall risk. R23's Falls Care Area Assessment (CAA) dated 9/9/16, indicated R23 had difficulty maintaining sitting balance and impaired balance during transition. R23's Cognitive Loss/Dementia CAA dated 9/9/16, indicated R23 had decreased ability to make self understood, had pain, hearing or vision impairment. R23 was non verbal and communicated to staff via a white board. R23's Physical Therapy Evaluation and Plan of Treatment form dated 9/30/16, indicated R23 was a fall risk, was completely deaf, had fair sitting balance and poor standing balance, poor safety awareness and did not follow through with weight bearing restrictions. R23's care plan dated 10/25/16, indicated R23 had limited physical mobility related to a right femur fracture and weakness and required partial weight bearing to right leg only and one staff assistance with mobility and weight bearing support. R23 utilized a wheelchair for locomotion and required cueing and guidance. R23 had confusion, impaired balance, limited mobility, limited range of motion and musculoskeletal impairment which required extensive staff assist for bathing, bed mobility, dressing, toileting,	2 830		

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2 830	Continued From page 20 personal hygiene and stand by assistance of one staff with front wheeled walker and gait belt for transfers. R23 had bladder incontinence with a history of urinary tract infections and staff were directed to encourage R23 to drink more fluids during morning and afternoon hours and limit fluid in the evening/night, she utilized an incontinent product and staff were to check R23 before and after meals, before and after activities, during the night at least at midnight and 4:00 a.m. R23 would also use the bedpan. The care plan also indicated R23 had a hip fracture following a fall which required surgical repair. Staff were directed to monitor for sign and symptoms of complications, infection, unrelieved pain, and pneumonia. Staff were also directed to reposition R23 as necessary, prevent 90 degree flexion, monitor use of adaptive devices, monitor pain and limb swelling and or skin changes. R23 had an actual fall with no injury related to a history of falls, poor balance, post surgical status and unsteady gait. The care plan indicated R23 was to have a physical therapy (PT) consult for strength and mobility, a motion sensor alarm in room to be on when R23 was in bed to alert staff of any movement, to educate/instruct R23 not to bend over to pick up dropped items and to encourage use of grabber bar or to ask for assistance. Staff were to modify environment in order to maximize safety with bed on lowest position and body pillows on both sides of her while in bed. Staff were also to observe for any sign of injury and check range of motion at the time of a fall. R23's Visual Bedside Kardex Report dated 11/9/16, (tool nursing assistants use to direct care), indicated R23 was partial weight bearing to right leg, and required the assistance of one staff	2 830		

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2 830	Continued From page 21 person for all mobility, transfers, repositioning, toileting, dressing and grooming. The document indicated R23 was to have her bed in lowest position, utilize raised edge mattress on her bed, and body pillows on each side of her in bed when in bed for her safety. R23's Falls Tool dated 8/26/16, indicated R23 had one or more falls in last three months, R23 was at high risk for falls due to recent falls, mobility and transfer problems related to muscle weakness, impaired balance, weight bearing ability changes, pain and took high risk medications. R23 also had cognitive risk factors which included restlessness, reduced insight, impulsiveness and a difficult time following instructions. Fall action plan was to refer R23 to therapy and update R23's care plan. Fall incidents: 1. R23's undated Investigation form indicated R23 fell on 9/3/16, at 10:40 a.m. R23 attempted to self transfer and was found on the floor in the doorway of her bathroom. The report indicated R23 had previous injuries from circumstances of this type over the last 30 days, was incontinent of bowel, was not wearing glasses, and had no injuries. Fall interventions included neuro checks, adding a motion sensor alarm to her bed, and update R23's care plan. R23 had anti-anxiety, anti-coagulant, diuretic, cardiovascular medications and a laxative within 8 hours of the fall. R23's care plan was amended to include motion sensor. The administrator and DON signed the form 9/13/16.	2 830		

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2 830	Continued From page 22 R23's PN dated 9/3/16, at 11:02 a.m. indicated R23 was found lying on the floor in her room, in front of her wheelchair in between the bathroom and living area of room. R23 denied pain. No injuries. R23 was assisted into bed via a mechanical lift. Once in bed, R23 was incontinent of bowel and stated she needed to use the bathroom. R23 was wearing shoes at the time of the incident. Call bell was within R23's reach. R23's Fall Scene Huddle Worksheet (FSHW) dated 9/4/16, at 10:40 a.m. indicated questions 1-7 were to be completed at the time of the fall, during the Fall Huddle. The sheet indicated R23 was found on the floor in her room. R23 had slid out or fell from the wheelchair when attempting to self transfer. A diagram of the location of the fall was included. R23's mobility was identified as bed bound, she had shoes on, she had orientation to room/new admission and was incontinent of bowel. Medications received within the last eight hours identified and neuro checks were initiated. Potential root cause of the fall was identified as "resident attempting to self transfer." R23 had no injuries. 2. R23's PN dated 9/6/16, at 5:51 a.m. indicated R23's motion sensor was alarming, along with another resident's sensor alarm. "Staff chose to answer other alarm first." When entered R23's room, R23 was found lying on the floor. R23 was assisted off the floor. Neuro checks started. No injuries. A subsequent PN at 1:37 p.m. by occupational therapy (OT) indicated R23 had a fall earlier after putting on light. R23 had been rubbing knee and reporting pain.	2 830		

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2 830	Continued From page 23 R23's Falls Tool dated 9/6/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, impaired balance, restlessness, impaired sleep patterns, cognitive status and took high risk medications. Fall action plan section was blank. R23's Investigation form dated 9/6/16, indicated at 4:00 a.m. R23 was found on the floor in her room. The form indicated this was a repeat incident, R23 had previous injuries or circumstances of this type in the last 30 days. R23 had just been toileted 15 minutes prior to being found on the floor. R23's motion sensor had gone off multiple times throughout the night. Another resident's motion sensor and R23's sensor sounded at the same time. Staff member went to answer the other residents sensor first then responded to R23's. R23's bed was in low position. The corrective action implemented was for R23 to have bed in low position when in it. The administrator and the DON both signed the form on 9/13/16. R23's FSHW dated 9/6/16, indicated R23 was found on the floor, had been attempting to self transfer, had been assisted by staff 15 minutes prior, motion sensor was alarming. R23 was not wearing glasses and was restless. A picture of the scene was drawn. R23 was alert to person and place prior to and after the falls. Potential root cause of the fall was "possible anxiety." No injuries sustained. The Fall Scene Investigation Report form which included root cause analysis was blank.	2 830		

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2 830	Continued From page 24 3. R23's PN note dated 9/11/16, at 9:32 a.m. indicated R23 had been found on the floor in room beside left side of bed, lying on stomach. Bed in lowest position. No injuries noted. R23 indicated non verbally she did not have any pain or injuries. R23 was assisted back to bed. All "reasonable" persons were notified. R23's Falls Tool dated 9/11/16, indicated R23 was at high risk for falls due to recent falls, mobility and transfer problems, impaired balance, weight bearing changes, took high risk medications and moderately impaired cognition. The tool further identified R23 had cognitive risk factors which included reduced insight, impulsiveness and a difficulty following instructions and unsafe use of equipment including alarms. The Action Plan section was blank. R23's Investigation form indicated on 9/11/16, an incident occurred at 8:00 a.m. R23 was found on the floor next to her bed on her stomach, R23 was not wearing her glasses, personal alarms were working and R23 was incontinent of urine. The report indicted this was a repeat incident and R23 had previous injuries or circumstances over the last 30 days, and R23 had rolled out of her bed before. The report also identified R23 was deaf, rarely vocalized and used her call light. R23 had no injuries. Fall interventions included neuro checks, resident and employee education, and body pillows on each side of R23 when she was in bed was implemented. R23 had anti-anxiety, anti-coagulant, diuretic, anti-depressant medications and a laxative within eight hours of the fall. The report was signed by the administrator and DON on 9/13/16.	2 830		

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2 830	Continued From page 25 A second Investigation report on 9/11/16, at 4:10 p.m. indicated R23 had a repeat incident of trying to self transfer which was not investigated until 9/13/16. R23 was restless with multiple falls. Sensor device in place to detect movement, body pillows utilized. R23 inconsistent with call light use. A raised edge mattress was added to R23's bed and R23 along with staff and family were educated by nursing. R23 was alert to person and place and forgetful prior to and after the fall. Neuro checks were initiated. R23 had sustained a bruise/hematoma from the fall. Both the administrator and director of nurses signed this form on 9/13/16. The undated FSHW indicated R23 was found on the floor in her room. was nonverbal and was last assisted by staff one hour prior. R23's alarms was working, she was not wearing glasses and was incontinent of urine. A description of the scene was drawn on the form. R23 was alert prior to and after the fall. The Comments section indicated "this is a repeat incident." Medication administered in the last 8 hours indicated. Neuro checks initiated. No injury. 4. R23's PN dated 10/20/16, at 5:23 p.m. indicated R23's motion sensor was sounding. Upon entering R23's room, R23 was found sitting on the floor next to her bed. No injuries. R23 was assisted back into bed. R23's Falls Tool dated 10/20/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, difficulty seeing objects, impaired balance, weight bearing	2 830		

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2 830	Continued From page 26 changes, and took high risk medications. The tool further identified R23 had cognitive risk factors which included, confusion, poor memory, difficulty following instructions and forgot to use the call light and assistive devices. The Action Plan section indicated R23 would be referred to therapy. This was not a new interventions as R23 was currently receiving therapy services. R23's Investigation form dated 10/20/16, at 3:20 p.m. indicated R23 was found on the floor next to her bed. The report indicated R23 did not call for help, and attempted to transfer herself, lost her balance, and her walker tipped over. The report further indicated this was a repeat incident with previous injuries or circumstances over the last 31-180 days. The report identified R23 had difficulties seeing objects, had no injuries, and personal alarms were working. Fall interventions included neuro checks and R23 was re-educated on using call light for help, and reminded R23 she needed assistance for transfers. The continence area of the report was left blank. R23 had received narcotic and diuretic medication within eight hours of the fall. Both the administrator and DON signed this form 10/27/16. R23's FSHW dated 10/20/16, at 5:30 p.m. indicated R23 was found on floor in own room after attempting a self transfer. R23 has difficulty seeing objects, lost balance, walker tipped over and fall alarms were working. A description of the scene was drawn. R23 was alert and oriented to person, place and time, was forgetful prior to and after the fall. meds administered identified. No injury. Neuro checks initiated.	2 830		

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2 830	Continued From page 27 5. R23's Investigation form dated 10/27/16, at 8:10 a.m. indicated R23 was seated in the wheelchair and witnessed to reach towards her shoe or the floor (unknown) and fell in the dining room. The report further indicated this was a repeat incident with previous injuries or circumstances over the last 30 days. The report identified R23's hand was a little sore. The vision and continence areas of the report was left blank. Fall interventions were R23 was re-educated on calling or asking for assistance, self-releasing seat belt was added to her wheelchair and R23 educated on use and R23 was able to release seat belt. R23 had received diuretic medication within eight hours of the fall. Although the report indicated a seat belt was installed on R23's wheelchair, it was later revealed the seat belt was not applied until she returned from the hospital on 10/31/16, because the facility had to order a belt in which it had finally been delivered. This form was signed by the DON on 11/2/16, and the administrator on 11/3/16. R23's FSHW dated 10/27/16, at 8:10 a.m. indicated R23 was in the dining room, reaching, and was lowered to the floor. No injuries. The scene of the incident was drawn on the form. R23 was alert and oriented to person, place and time prior to and after the fall. Medication used identified. R23 complained hand was a little sore, "hurts a little." Staff to monitor mobility. R23's PN dated 10/27/16, at 9:49 a.m. by physical therapy indicated R23 had fallen out of her wheelchair in the dining room. R23 had been reaching and leaned too far forward. R23 reported right hand pain at 4 of 10 on a 0-10 scale (10 worst pain). Pain was noted most	2 830		

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2 830	Continued From page 28 increased over the 2nd metacarpal area and tender to touch. R23's right knee also continues to have pain. This was reported to nursing. R23 to be seen on physician rounds. Pain created limitations to R23's therapy session. A subsequent PN written by OT at 11:34 a.m. indicated R23 had fallen earlier. R23 was noted to have guarded use of her right thumb and right lower extremity. Wheelchair mobility decreased due to R23 declining to use right hand and foot to propel the wheelchair. 6. R23's PN dated 10/30/16, at 8:30 a.m. indicated R23 was found sitting on the floor of the 100-hallway on her buttocks. R23 was assisted back into the wheelchair via a mechanical lift. R23 was noted to be holding her right shoulder and had a large hematoma to her forehead. R23 denied pain but Tylenol had been previously given at 7:00 a.m. R23 was sent the emergency department (ED) for evaluation. A subsequent PN at 11:39 a.m. indicated R23 returned from the ED with no new orders. R23 had a CT of the head which showed no acute intracranial pathology and a CT of the spine which was also negative. The ED recommended facility staff continue to monitor R23's neurological status and frontal hematoma for skin breakdown and for R23 to follow up with the ED on 10/31/16, as R23 received an X-factor A inhibitor (anticoagulant medication). R23's Investigation form dated 10/30/16, indicated at 9:30 a.m. R23 was found on the floor in the hallway after she had slipped or tripped and she attempted to transfer herself or ambulate. The report indicated this was a repeat incident with previous injuries or circumstances over the	2 830		

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2 830	Continued From page 29 last 30 days. The report further identified R23 had no injuries, and R23's wheelchair brakes were not locked. The vision and continence areas of the report was left blank, and did not identify R23's personal alarms were working. Fall interventions included R23 was re-educated on the importance of asking for help, and was re-educated that she needed assistance with all transfers. R23 had received diuretic, cardiovascular and narcotic medications, and a laxative within eight hours of the fall. Both the DON and administrator signed the form 10/31/16. R23's FSHW dated 10/30/16, at 9:50 a.m. indicated R23 was found on the floor in the hallway and had slit or fell out of wheelchair. R23 had slipped and wheelchair brakes were unlocked. A diagram of the scene was drawn. R23 was alert to person and forgetful. Medications administered within previous eight hours identified. No injury. The Comments section indicated R23 does not ask for help and attempted to ambulate and transfer self. A second Investigation form dated 10/30/16, at 5:00 p.m. indicated R23 was leaning too far forward in her chair and fell. R23 was to have a self releasing seat belt installed and R23 was to be reeducated. The Results of Investigation section indicated R23 was reeducated to not lean so far forward and to ask for assistance. Seat belt added to wheelchair. Demonstrated and educated R23 on use. R23 demonstrated understanding by releasing seat belt per self. Staff will continue to monitor weekly. The DON signed the form on 11/2/16, and the administrator on 11/3/16. Although the form indicated a seat belt was added to R23's wheelchair, further	2 830		

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2 830	Continued From page 30 investigation revealed a seat belt had been ordered and had not been delivered to the facility and applied to R23's wheelchair until 10/31/16. 7. R23's PN dated 10/30/16, at 5:15 p.m. indicated R23 was found on the floor in the dining room lying on her right side with a heavy bloody nose from both nostrils. R23 denied pain. R23 was assisted into a dining room chair via a mechanical lift. However, R23's nose continued to bleed. R23 was removed from the dining area. A subsequent PN titled "Late Entry" at 6:30 p.m. indicated R23 fell at 4:45 p.m. and sustained a bloody nose. R23 was assisted into a dining chair however continued to "head bob" and bleed through her nose. R23 was returned to her room and assisted into bed. R23 was given an antianxiety medication to "settle" her. At this time, R23 was found in her bed with with large amounts of blood on her pillow and her nose clotted with blood. R23's blood pressure was 87/54. The on call physician was notified and R23 was taken back to the ED for evaluation. A subsequent note indicated R23 was admitted to the hospital for observation of a head injury and possible urinary tract infection. R23's bleeding had ceased and she was receiving fluids. An earlier CT revealed a hematoma but no hemorrhaging on the brain. R23's FSHW dated 10/30/16, at 6:00 p.m. indicated R23 slid or fell from wheelchair and was found on the floor in the dining room. R23's wheelchair brakes were unlocked. A diagram of the scene was drawn. R23 was alert but forgetful. Medications used within last eight hours were indicated. R23 had a bloody nose. The Comments sections indicated therapy to reevaluate R23's wheelchair for a possible	2 830		

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2 830	Continued From page 31 smaller one. R23's Falls Tool dated 10/30/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, impaired balance, and took high risk medications. The tool further identified R23 had cognitive risk factors which included, poor memory, impulsive, difficulty following instructions, forgot to use the call light or assistive devices, and received high risk medications. The Action Plan listed was to refer R23 to therapy, however, R23 was currently receiving therapy services. R23's Falls Tool dated 10/31/16, indicated R23 was at low risk (despite being identified as high risk previously) for falls due to recent falls, and took high risk medications. The tool further identified R23 forgot to use the call light or assistive devices, and was incontinent. The Fall Action plan was to refer R23 to therapy. R23's PN dated 10/31/16, at 11:58 a.m. by physical therapy indicated R23 was admitted to the hospital for observation after having two falls with closed head injury and significant bloody nose. R23's PN dated 10/31/16, at 3:38 p.m. indicated R23 had a fall the day prior and sustained a bloody nose and did hit her head. R23 had a large lump on her forehead and was seen in the ED/hospitalized. The physician evaluated R23's medications and discontinued a few. R23 is currently resting in bed. Nose is still bleeding lightly. Gauze provided and call light within R23's	2 830		

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2 830	Continued From page 32 reach. 8. R23's Falls Tool dated 11/7/16, indicated R23 was at medium risk for falls due to recent falls, mobility and transfer problems, difficulty seeing objects, not wearing her glasses, impaired balance, and took high risk medications. The tool further indicated R23 had cognitive risk factors which included poor memory, impulsiveness, and was unsafe to use equipment. The Action Plan was to refer R23 to therapy. R23's Investigation form dated 11/7/16, at 8:15 a.m. indicated R23 was found on the floor in her bathroom in front of the toilet and sink. The report indicated R23 did not call for assistance, and transferred herself. The report further indicated this was a repeat incident with previous injuries or circumstances over the last 30 days. The report identified R23 was not wearing her glasses, did not identify if R23's personal alarms were sounding and the continence area of the report was left blank. The report indicated R23 had no injuries, and fall intervention was to re-educate R23. R23 had diuretic medication within eight hours of the fall. The Results of Investigation section was blank. The signature section of the form was also blank. R23's record lacked documentation of a fall investigation in order to determine causal factors and interventions to be implemented. R23's PN dated 11/7/16, at 10:13 a.m. by physical therapy indicated R23 had a fall in the bathroom with self transferring. She was found on the bathroom floor. R23 stated she had pain in her right knee rated a 5 out of 10. R23's hands	2 830		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

(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) COMPLETE DATE
2 830	Continued From page 33 appear sore as well as R23 keeps rubbing them together. R23 was agreeable to therapy. R23 was educated on importance of asking for assistance when going to the bathroom. R23 was unaware of poor safety. R23's PN dated 11/7/16, at 12:27 p.m. written by OT indicated OT and nursing both responded to R23's wheelchair alarm and found R23 attempting to self transfer from the wheelchair to the bed. Nursing informed OT of R23's fall that morning. R23's FSHW dated 11/7/16, at 3:30 p.m. indicated R23 was found on the bathroom floor, had attempted self transfer, was not wearing glasses and had slipped. A diagram of the scene was drawn. R23 was alert to person and place and was forgetful. Medication given within previous eight hours identified. No injury and no pain. The Comments section indicated R23 did not use call light and self transferred. No further information identified. On 11/7/16, at 5:31 p.m. R23 was observed in the dining room, seated in her wheelchair. The brakes were off while at the table and R23 had a self-releasing seat belt fastened around her with the alarm unit attached to the left side of the wheelchair. R23 had a large purple bruise over her right eye which extended down the right side of her nose. R23 also had a large purple goose egg on her right forehead. On 11/8/16, at 10:14 a.m. R23 was observed in bed, asleep. She had only one body pillow	2 830		

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2 830	Continued From page 34 positioned behind her. R23's room was dark, her bedroom door was 3/4 closed, bilateral grab bars were noted on the bed frame, bed was in lowest position, a four wedge mattress was on her bed, the audio alarm was on, her wheelchair was next to the bed, and walker was in the corner of the room across from her bed. On 11/08/16, at 1:33 p.m. R23 was observed in bed, asleep. One body pillow laid vertically above her head. R23 had no body pillows on either side of her. R23's bedroom door was 3/4 closed, her bed was in lowest position, had bilateral grab bars, four wedge bed mattress, sensor alarm was on, wheelchair was next to bed, and walker in the corner of the room across from her bed. During this observation, R23's audio alarm sounded. The human resources and quality assurance coordinator (HR/QA) walked into R23's room, and immediately walked out to the nurses station and turned R23's audio alarm off. -At 2:07 p.m. R23's sensor alarm sounded, health information management (HIM) was observed to go into R23's room, immediately walk out and went directly to the nurses station and turned R23's alarm off. -At 2:25 p.m. R23's sensor alarm sounded. Nursing assistant (NA)-H was observed to enter R23's room and immediately exit walking directly to the nurses station. On NA-H's way to the nurses station, resident assistant (RA)-A was heard to call out from outside the nurses station to NA-H, "Did she roll over?" NA-H stated, "Yes," and walked over and turned R23's alarm off. -At 2:56 p.m. R23's sensor alarm was sounding. Registered nurse (RN)-B came out of her office	2 830		

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2 830	Continued From page 35 which was next to the nurses station. RN-B had witnessed the surveyor exit R23's room and immediately turned the alarm off at the nurses station. RN-B did not go to R23's to check on her. -At 3:31 p.m. R23's sensor alarm sounded. Licensed practical nurse (LPN)-B entered R23's room and turned on R23's call light and immediately walked out of R23's room towards the nurses station and loudly stated to RA-A, "can you help her? RA-A replied, "Yes," LPN-B proceeded to turn off R23's alarm. RA-A entered R23's room and closed the door. On 11/09/16, at 7:30 a.m. R23's motion alarm sounded. R23 was observed in bed on her left side, pulling up covers. One body pillow was noted on the floor, her bed was in lowest position, four wedge mattress on bed, bilateral grab bars, walker in corner of room across from her bed, and her wheelchair was by her bed. -At 7:33 a.m. R23 was observed seated on the edge of her bed, in her night gown. R23's wheelchair was near with the brakes on. LPN-B applied R23's rubber soled slippers, applied a gait belt. R23 slowly rocked back slightly, paused for a second, and pushed herself slowly up with both of her hands while LPN-B lifted her up with gait belt and assisted R23 into her wheelchair. R23 kept both of her knees bent during the transfer, was hunched/leaned over and leaned forward, was unsteady and did not stand up straight. R23 favored her left leg during the transfer. Once in the chair, LPN-B pointed to R23's left brake handle and R23 pulled the long handle and released it. R23 sat with her head down while LPN-B released her right wheelchair brake. R23 slowly scooted herself back twice in her	2 830		

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2 830	Continued From page 36 wheelchair, and pulled the right half of her self-releasing seat belt around her right side while LPN-B pulled the left side strap of her seatbelt Velcro the belt straps together. R23's failed to identify the use of the self releasing seat belt. -At 7:39 a.m. NA-H was observed to enter R23's bedroom and LPN-B exited. R23 was assisted into the bathroom. -At 7:48 R23 was observed standing up in front of the toilet while facing the doorway. R23 had both hands on the wheelchair handles and was stretched over the wheelchair seat. R23's legs were bent at her knees. NA-H held on to R23's gait belt and applied a clean brief and then assisted her into the wheelchair. R23 was unsteady and required NA-H to hold onto her and guide her into the wheelchair during the transfer. Following the observation, NA-H verified R23 was at a high risk for falls and required staff assistance with all ADLs. NA-H stated he was not sure what R23's cognition was because R23 was unable to speak and that got in the way. NA-H stated R23 transferred pretty well, however, staff have had to stop her from self-transferring. R23 moved quickly and did not wait for staff. He stated R23 unfortunately always thought about sleep and was also confused sometimes as to why her seatbelt was on. He stated R23's fall interventions were her seat belt and wall alarm. He stated he did not know of any other interventions to prevent R23 from falling. NA-H stated the last time R23 self transferred was on 11/7/16, in which R23 must have fallen when she got off the toilet because there was stool in the	2 830		

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2 830	Continued From page 37 toilet bowl and the water was running in the bathroom. He stated he found her on the floor in her bathroom that morning at about 8:00 a.m. with her back against the wall under the towel rack and her legs were out by the toilet and no alarms were sounding. NA-H stated he called the nurse in because he was worried about the bump on her head and he did not know if that fall had caused the bump or another fall had. NA-H pulled R23's small white communication board from a bag in the back of R23's wheelchair and wrote time to eat on it for R23 to read. -At 7:58 a.m. R23 was observed self propelling her wheelchair slowly down the hallway towards the dining room. R23's self releasing seat belt on and fastened correctly. R23 used both arms, and her left leg and foot to propel herself. R23 grabbed the right side hallway rail and pulled herself along until the railing ended and she found her seat at the dining room table. R23 was not supervised by staff as she self propelled from her room to the dining room. On 11/09/16, at 8:53 a.m. physical therapist (PT) was observed to ambulate with R23 in the hallway outside of R23's room. PT applied a gait belt and lifted/assisted R23 to stand up. R23 was stooped over and both legs remained bent at the knee. R23 took small, slow steps. and appeared to favor her left leg. PT held on to R23's gait belt with her left hand, and pushed R23's wheelchair with her right hand. PT stated R23 liked to get ahead of her walker, and her right side tended to buckle. R23 walked stooped over, legs bent and was not standing straight up. R23's eyes looked down to the floor or her feet and R23 did not look ahead. R23 walked like this for approximately 30	2 830		

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2 830	Continued From page 38 feet before she slowed way down, and PT assisted her with gait belt into her wheelchair. Once in the wheelchair, R23 grimaced and rubbed her right leg. PT confirmed R23's signs of pain, and stated she asked R23 before she walked if she had any pain, and R23 had told her no. PT asked R23 if she wanted some pain medication from the nurse, however, R23 was unable to communicate with PT regarding her pain or desire for pain medication. PT stated she did not know what R23's cognition was, and stated communication was a determining barrier and felt R23 had some degree of impairment related to dementia. She stated R23's fall interventions were to educate her to call for help, and walk inside her walker, but R23 just did not follow through. She stated she was not sure if R23 did not follow through after being educated because of her cognition or if it was her choice not to. PT stated R23 did not hold her walker close to her body for safety when using it rather, held it way out. PT also stated R23 was unable to account for improved walking ability when her walker was closer to her. She stated R23 also favored her left leg more because R23 sustained a right hip fracture in March of 2016, and again in August 2016, and had pain. Pt confirmed R23 was at high risk for falls related to unsafe self transfers and R23 not wanting to wait for staff assistance. PT confirmed R23 continued to self transfer unsafely and without staff assistance and because of R23's impaired ambulation and gait she definitely required staff assistance. She stated she thought the last time R23 self transferred was 11/7/16, at which time, R23 had fallen. PT stated she thought R23 took herself to the bathroom. She stated staff had hoped she would get better and go back to assisted living, but stated she did not feel it was possible now.	2 830		

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2 830	Continued From page 39 On 11/09/16, at 11:00 a.m. the PT stated R23's fall interventions included a room sensor to help alert staff when she was trying to self transfer when R23 did not use her call light, staff also added a self-releasing seat belt because R23 had been leaning too far forward in her wheelchair and had fallen out. PT stated despite adding the seat belt, R23 had fallen two more times from her wheelchair. PT stated R23 sustained a head injury after she fell out of her wheelchair and went to the hospital. R23 always attempted to self transfer, always looked down at her feet, and had a history of falls including two hip fractures in March and August of 2106. PT stated R23 had a history of being developmentally delayed and had previously sustained a traumatic injury/skull fracture in a car accident. She stated on 11/7/16, R23 had been put on the toilet by staff and R23 was supposed to use her call light to let staff know when she was done but had not and self transferred from the toilet and fell before staff got back to her room. She stated a restorative nursing program, and staff assistance were recommended approaches to prevent further falls for R23. PT did not identify R23's reacher, body pillows, grab bars, or bed position and raised mattress as additional fall interventions. On 11/09/16, at 12:25 p.m. PT confirmed R23 had many barriers to safe ambulation and transfers. She stated R23 was non-weight bearing (NWB) for a long time because R23 was unable to participate in NWB training. PT stated they tried to communicate with R23 and tried written cues, visual demonstration, and manual cues and were unsuccessful. PT stated when R23 was admitted she was not able to bear weight on her right leg related to a repeat right hip	2 830		

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2 830	Continued From page 40 fracture, surgical pain, weakness, and impaired cognition and communication. PT stated R23 had slowly improved and would be discharged from therapy on 11/11/16. She stated she was afraid R23 would not be able to return to assisted living because she had poor safety recall and continued falls. She stated R23 had to be cued to put her wheelchair brakes on, and required one staff person to assist her with all transfers and ambulation. On 11/9/16, at 3:00 p.m. R23's sensor alarm sounded. R23 was observed in bed with a wedged raised mattress, bilateral grab bars in place, no body pillows in place, bed in lowest position, wheelchair by her bed, and her walker in the corner of the room across from her bed. On 11/10/16, at 7:30 a.m. R23 was observed in bed, asleep. There were no body pillows in place as directed by the care plan. R23's room was dark, her bedroom door was 3/4 closed, her bed was in lowest position, bilateral grab bars in place, a raised edge mattress on her bed, her sensor alarm was on her wheelchair by her bed, and her walker in the corner of the room across from her bed. On 11/10/16, at 9:02 a.m. R23's sensor alarm was sounding. R23 was observed in bed with no body pillows in place. LPN-B confirmed R23 did not have any body pillows in bed with her. LPN-B located one body pillow on top of R23's dresser and also looked in several other locations in R23's room and confirmed she couldn't find the second body pillow and stated she would check with laundry.	2 830		

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2 830	Continued From page 41 On 11/09/16, at 12:58 p.m. the DON stated R23 was admitted from assisted living facility after she had sustained her 3rd fall and broken hip this year. She stated R23's physician was afraid R23 would fall again, get injured, and may never walk again. She stated R23 was deaf and had mild cognitive impairment, and required staff assistance with all ADLs. The DON stated R23 was so impulsive that staff tried to have someone with her at all times. She stated when R23 was admitted they checked on her more frequently, and educated R23 on the use of her call light and she started falling. At 1:34 p.m. R23's aforementioned falls including incident reports, investigation reports and interventions implemented were reviewed with the DON who stated the following: -9/3/16, the DON verified the fall information and stated she did not think R23 used her call light and felt that was why R23 had so many falls. The DON stated every time after R23 fell, the staff re-educated R23 on the fact that she couldn't get up or walk on her own. She stated staff had initiated neuro checks and added the sensor alarm to her bed and updated her care plan. -9/6/16, 4:00 a.m. the DON verified the fall information and stated she thought anxiety caused R23 to self-transfer and fall out of bed. She confirmed neuro checks were initiated, and the new fall intervention was to keep bed in low position when R23 was in bed. -9/11/16, 8:00 a.m. the DON verified the fall information and stated neuro checks were initiated and fall interventions included two body	2 830		

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2 830	Continued From page 42 pillows along side the resident when in bed and staff education. -9/13/16, 4:10 p.m. the DON verified the fall information and stated R23 was inconsistent with call light use. Staff reeducated R23 on call light use. The DON stated fall interventions implemented were neuro checks, resident/employee/family education and the addition of a raised edged mattress to R23's bed. -10/20/16, 3:30 p.m. fall incident not discussed at this time due to the fall information was not available for review yet. The information was provided on 11/10/16. -10/27/16, 8:10 a.m. the DON confirmed the fall information and stated R23 was reeducated on calling/asking for help. The DON stated a self releasing seat belt was added to R23's wheelchair and R23 was educated on the use. -10/30/16, 9:30 a.m. the DON confirmed the fall information and stated the fall intervention implemented was for R23 to be reeducated on the importance of asking for help and that she needed assistance with all transfers. -10/30/16, at 5:00 p.m. the DON confirmed the fall information and subsequent hospitalization. -11/7/16, 8:15 a.m. the DON confirmed the fall information and stated R23 never, never used her call light and verified an investigation was not completed nor were new interventions implemented except for re-educating R23 and reminding her to use the call light to ask for help. The DON stated she had not had a chance to complete the fall investigation report yet. The DON stated she did not know what else to do to	2 830		

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2 830	Continued From page 43 minimize R23's continued falls. On 11/9/16, at 2:50 p.m. trained medication administration (TMA) stated R23 set off her sensor alarm by her bed all the time. She stated R23 also had a seat belt alarm on her wheelchair now. She stated R23 played with the alarm belt, and continued to transferred herself. She stated staff just kept an eye on her. In addition, after meals R23 wanted to go right back to her room. On 11/9/16, at 3:04 p.m. NA-J stated any movement in R23's room would set off the sensor alarm by R23's bed. She stated R23 could sit up in bed by herself and could also read her white communication board. She stated R23 should have two body pillows in bed with her at all times, and confirmed R23 did not currently have two body pillows in bed and was not sure where they were at. She stated R23 had a seat belt and can remove it on her own and liked to grab at the velcro strap on her shoes, but if she did not wear her velcro shoes, she did not reach for her feet. NA-J stated she had been on duty when R23 had fallen and stated R23 usually fell out of her wheel chair. She stated R23 did not fall in her room, but fell in the dining room, and in the hallway. She stated when there were changes to resident care the other NA's would discuss it, and there was also a Kardex in the charting room for staff to review if they needed to. She stated she did not check the Kardex when she was working, but if there was something strange going on with a resident she might. On 11/10/16, at 7:40 a.m. LPN-B stated R23 was able to be left alone in the bathroom and was	2 830		

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2 830	Continued From page 44 pretty good at using her call light. She stated staff usually did not go far when R23 was in her bathroom by herself. On 11/10/16, at 8:11 NA-L stated she would not leave R23 alone in her bathroom because she would fall. NA-L stated she may just step outside the bathroom when R23 was on the toilet, but did not leave R23's bedroom. On 11/10/16, at 8:44 a.m. NA-H stated R23 could remove her seat belt, and fiddled with it when she wheeled herself from the dining room and had seen her take it off a couple times. He stated it was not ok for staff to leave R23 unattended on the toilet by herself. NA-H stated he did not leave R23 alone in her bathroom because R23 was impulsive and would self transferred. He stated he wasn't sure if R23 was left alone on the toilet on 11/7/16, and stated it was possible because no alarms were going off when he found her on the floor in her bathroom. He also stated R23 hated to waste water and when he found her water faucet on he wasn't sure if a staff person turned the water on for her and left, or if R23 had turned the water on. On 11/10/16, at 12:43 p.m. the DON and administrator were interviewed. The DON confirmed R23 also fell on 10/20/16, at 3:20 p.m. and stated R23 was found on the floor next to her bed after she self transferred and her walker tipped over. She stated R23 had no injury, R23 did not call for help and attempted to self transfer. Fall interventions included were to re-educate R23 on using her call light for help, and reminded R23 she needed assistance for transfers. Neuro	2 830		

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2 830	Continued From page 45 checks were also initiated. There was no documentation of whether R23 was incontinent or not. The DON stated she had not had time to investigate R23's fall on 11/7/16, at 8:15 a.m. because she had been working on the medication cart. The DON stated she thought R23 had been put on the toilet after breakfast, was left alone, self transferred, and fell. The DON stated because R23's alarms were turned off, a staff person must have left her alone on the toilet. The DON and administrator confirmed this incident should have been investigated to determine causal factors and interventions to be implemented. The Administrator stated she hadn't completed the investigation for the fall on 11/7/16, because she felt it needed to be a team effort and stated she could have completed the investigation, but did not. She stated staff typically reviewed falls during their morning huddle meeting and because of the survey, they had not held their morning meetings this week. Additionally, the DON admitted R23's alarming seat belt was ordered on 10/27/16, and did not arrive at the facility until 10/31/16, therefore was not affixed to R23's wheelchair until 10/31/16. The DON stated the next intervention they would try for R23 was to add a sensor alarm in R23's bathroom because R23's current sensor did not reach into the bathroom and other than the bathroom alarm she had no idea what else to do to prevent R23's falls. The DON stated they would order an alarm for R23's bathroom. Lastly, the DON confirmed R23 understood directions but did not have the ability to remember to follow directions. The DON was asked if the facility had completed a comprehensive fall assessment and the DON stated she did not know if they had, but staff had had fall assessment discussions regarding other residents. The DON confirmed the facility had not completed a overall	2 830		

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2 830	Continued From page 46 comprehensive fall assessment. During a facility monitoring visit on 11/11/16, at approximately 12:30 p.m. the OT confirmed R23 had impaired cognition, had impaired safety awareness and no instruction/safety measure recall after cued/instructed. She R23 would be discharge from therapy today. The OT stated R23's fall in the bathroom resulted from LPN-B assisting R23 onto the toilet and leaving her unattended. The OT stated R23 did not remember to use the call light to alert staff assistance was needed and would usually turn on the call light only to shut if off herself, shortly thereafter. On 11/11/16, at 12:45 p.m. LPN-B confirmed she had assisted R23 onto the toilet and had left her unattended, however, was not sure if it was Monday 11/7/16, or a previous Monday. LPN-B also confirmed R23 did not always use the call light to request assistance when on the toilet. The Fall Prevention and Management policy dated 5/2016, indicated the facility was accountable for fall prevention and management. The policy indicated after a fall, a resident may experience impaired function, decreased mobility, loss of independence, sustain injuries or be the cause of their death. Fall risk factors were identified as: vision problems, mobility and transfer problems, cognitive problems, sleep problems, equipment and assistive device problems, environmental problems, medical problems and continence problems. The policy defined an "avoidable" accident (fall) meant that an accident occurred because the facility failed to: identify environmental hazards and individual	2 830		

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2 830	Continued From page 47	2 830		

resident risks of having an accident, evaluate or analyze the hazards and risks, implement interventions, including adequate supervision that was consistent with the residents needs, goals, plan of care and current standards of practice, or monitor the effectiveness of the interventions in order to reduce the risk of an accident. The policy also indicated the facility would take a proactive approach to fall prevention which included identifying a potential risk and taking steps to mitigate the risk before actual harm occurred, and they would predict what might cause a resident to fall and what action can be taken to prevent it.

The immediate jeopardy which started on 11/10/16, at 4:00 p.m. was removed on 11/15/16, at 3:27 p.m. after the facility completed the following interventions as part of their removal plan:

-R23 was comprehensively assessed for falls
-R23's care plan was updated to reflect R23's assessed risks for falls and fall prevention interventions
-Staff were educated on R23's fall interventions
-On 11/15/16 from 3:03 p.m. to 3:19 P.M. direct care staff, including licensed nursing staff were interviewed regarding R23's safety risks. All of the interviewed staff were aware of R23's risk for falls, and fall prevention interventions to ensure R23's safety.

SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could review and/or revise policies and procedures related to assessment and implementation of interventions following a fall. Education could be provided to the staff. The quality assurance committee could

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2 830	Continued From page 48 develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	2 830		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control.	21390		12/26/16

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21390	Continued From page 49 This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure contact isolation precautions were implemented during the provision of direct resident contact for 1 of 1 resident (R26) observed during personal care and was in contact precautions. Findings include: R26's quarterly Minimum Data Set (MDS) dated 8/10/16, indicated R26 had mild cognitive impairment and required extensive assistance of one staff for bed mobility. On 11/7/16, at 3:00 p.m. during the initial tour, an isolation cart (plastic container with personal protective equipment) was observed outside of R26's room. The cart contained a sign which indicated the individual in the room required contact precautions (precautions used during care of patients known or suspected to have a serious illness easily transmitted by direct patient contact or by indirect contact with items in the patient's environment) . Licensed practical nurse (LPN)-A stated R26 had tested positive for methicillin-resistant staphylococcus aureus (MRSA) at his suprapubic catheter (urinary catheter inserted into the bladder from the belly) site. On 11/8/16, at 1:50 p.m. R26 was observed to call for assistance. At 1:53 p.m. nursing assistant (NA)-M entered R26's room, apply gloves and proceeded to empty R26's suprapubic catheter	21390	Corrected 12/26/16	

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21390	Continued From page 50	21390		

drainage bag. NA-M removed her gloves and washed her hands. Without gloved hands, NA-M proceeded to make R26's bed touching multiple areas of the bed including the covers, bed rails and pillows. When completed the task, NA-M talked to R26 while touching his wheelchair and his body then exited the room. NA-M was not observed to wash her hands or use sanitizer as she left the room and walked into another residents room (R5). NA-M was about to touch R5 when the State Agency staff asked to speak to her.

On 11/8/16, at 2:00 p.m. NA-M verified she had not washed her hands prior to leaving R26's room. She confirmed R26 currently required contact precautions related to MRSA and stated she should have washed her hands when she exited the room.

On 11/8/16, at 2:10 p.m. registered nurse (RN)-B confirmed R26 had MRSA at the suprapubic catheter cite and the linens on his bed were considered contaminated. She confirmed the nursing assistants were to be washing their hands after caring for R26.

On 11/10/16, at 8:40 a.m. the director of nurses(DON) verified R26 required contact precautions for MRSA at his suprapubic catheter site. The DON confirmed NA-M should have washed her hands in an attempt to minimize contamination from R26's prior to leaving the room.

A policy related to infection control/hand hygiene

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21390	Continued From page 51 was requested and none was provided. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or their designee, could develop and implement policies/procedures and staff training related to infection control practices. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	21390		
21805	MN St. Statute 144.651 Subd. 5 Patients & Residents of HC Fac.Bill of Rights Subd. 5. Courteous treatment. Patients and residents have the right to be treated with courtesy and respect for their individuality by employees of or persons providing service in a health care facility. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure residents seated at the same dining table were served at the same time as their tablemates during 2 of 3 meals observed for 1 of 1 resident (R41) who was observed seated without being served the meal while tablemates had been served and were eating. Findings include:	21805	Corrected 12/26/16	12/26/16

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21805	Continued From page 52 R41's quarterly Minimum Data Set (MDS) dated 10/14/16, indicated R41 was diagnosed with nutritional deficiency, had intact cognition, had severely impaired vision, and required assist of one staff for eating for encouragement and cueing. R14's care plan dated 10/24/16, indicated R41 had a performance deficit related eating due to blindness. The plan directed staff to provide set up with meal tray, assist with meals and to encourage intake. The plan indicated R41 was able to feed self but needed to be told what food items were and where they were located. On 11/9/16, at 7:35 a.m. Nursing assistant (NA)-J was observed to assist R41 to the dining room via her wheelchair and positioned her at her dining room table. Once at the table, NA-J left the dining room. -At 7:38 a.m. dietary aide (DA)-A served R41 water and grape juice. -At 7:43 a.m. R41 was observed drinking her water while a tablemate had been served and was eating the meal. -At 7:59 a.m. licensed practical nurse (LPN)-B was observed to provide R41 with her medications. R41 took her medications and LPN-B returned to her medication cart. -At 8:17 a.m. R41's tablemate had finished her breakfast and left the table. Nursing staff were observed to bring other residents into the dining room and serve them their breakfasts. R41 had not been served her meal yet. -At 8:27 a.m. NA-J was observed to enter the dining room and observe R41 seated at her table.	21805		

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21805	Continued From page 53 NA-J obtained a breakfast meal of hot cereal and toast for R41. NA-J applied peanut butter and jelly to the toast and added sugar to the cereal then exited the dining room. R41 sat at the dining room table a total of 52 minutes without being served or assisted with her breakfast meal. On 11/9/16, at 11:43 a.m. NA-J assisted R41 to the dining room and positioned at her table. Other residents have been observed arriving to the dining room and seated at other tables and provided meals. -At 11:53 a.m. R41's tablemate was served her lunch meal and began eating. -At 12:03 a.m. NA-K provided R41 with her lunch meal and sat down next to her. R41 sat at her dining table a total of 20 minutes without being served or assisted with her lunch meal after her tablemate had been served. On 11/9/16, at 8:54 a.m. R41 stated most of the time, she had to wait long periods of time for her meals and did not know why it took so long. R41 stated she knew there were a lot of other people to help, but thought staff could take turns so she would not have to wait so long all the time. On 11/9/16, at 9:07 a.m. NA-J verified R41 was not served her breakfast until she returned to the dining room after assisting other residents. NA-J stated, R41 should not have to wait that long to eat. On 11/09/2016, at 12:19 p.m. dietary supervisor stated R41 should not wait that long to be served and she expected all residents at the same table	21805		

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21805	Continued From page 54 to be served before going to another table. The supervisor stated R41 should not have to wait that long for her meal. On 11/09/2016, at 3:36 p.m. the director of nursing (DON) verfied R41 should have been served her meal timely and stated R41 should not have to wait over 45 minutes to be served, even the 20 minute wait at lunch time was absolutely unacceptable. The DON stated her expectation was for staff to ensure all residents were served timely and did not have to wait to be served meals. The Residents Dignity policy dated 2/2013, directed staff to provide care in a manner that enhanced resident dignity regarding dietary aspects and to serve all residents at the table at the same time, so residents could their meals eat together. SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could implement policies and procedures dignified dining expereience. The quality assessment and assurance committee could perform random audits to ensure compliance. TIME PERIOD FOR CORRECTION: Twenty (21) days.	21805		
21980	MN St. Statute 626.557 Subd. 3 Reporting - Maltreatment of Vulnerable Adults Subd. 3. Timing of report. (a) A mandated	21980		12/26/16

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21980	Continued From page 55	21980		

reporter who has reason to believe that a vulnerable adult is being or has been maltreated, or who has knowledge that a vulnerable adult has sustained a physical injury which is not reasonably explained shall immediately report the information to the common entry point. If an individual is a vulnerable adult solely because the individual is admitted to a facility, a mandated reporter is not required to report suspected maltreatment of the individual that occurred prior to admission, unless:

(1) the individual was admitted to the facility from another facility and the reporter has reason to believe the vulnerable adult was maltreated in the previous facility; or

(2) the reporter knows or has reason to believe that the individual is a vulnerable adult as defined in section 626.5572, subdivision 21, clause (4).

(b) A person not required to report under the provisions of this section may voluntarily report as described above.

(c) Nothing in this section requires a report of known or suspected maltreatment, if the reporter knows or has reason to know that a report has been made to the common entry point.

(d) Nothing in this section shall preclude a reporter from also reporting to a law enforcement agency.

(e) A mandated reporter who knows or has reason to believe that an error under section 626.5572, subdivision 17, paragraph (c), clause (5), occurred must make a report under this subdivision. If the reporter or a facility, at any time believes that an investigation by a lead agency will determine or should determine that the reported error was not neglect according to the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5), the reporter or

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21980	Continued From page 56 facility may provide to the common entry point or directly to the lead agency information explaining how the event meets the criteria under section 626.5572, subdivision 17, paragraph (c), clause (5). The lead agency shall consider this information when making an initial disposition of the report under subdivision 9c. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to immediately report to the State agency (SA), and/or thoroughly investigate incidents of potential mistreatment related to significant injuries and bruises of unknown origin for possible mistreatment and neglect of care for 1 of 1 resident (R23) who had unwitnessed falls with serious injury and had bruises of unknown origin. In addition, the facility failed to timely report to the SA incidents of missing money for 1 of 1 resident (R12) who reported money missing. Lastly, the facility failed to ensure 1 of 5 agency staff members (LPN-A) had a criminal background screening completed. Findings include: R23 sustained bruises of unknown origin and had two unwitnessed falls with significant injury which were not reported to the SA. R23's admission Minimum Data Set (MDS) dated 9/2/16, indicated R23 had severe cognitive impairment, was rarely or never understood, required extensive assistance with activities of daily living (ADLs), had a history of falls with	21980	Corrected 12/26/16	

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21980	Continued From page 57 fractures, and received anti-anxiety and diuretic medications which could increase fall risk. R23's Diagnosis Report dated 11/9/16, indicated R23 was admitted to the facility in August 2016, following surgical repair of a fractured femur and diagnoses which included interoperable hemorrhage and hematoma (bleed or bruise) of the musculoskeletal structure, Alzheimer's disease, anxiety, anemia, pain, osteoarthritis, hearing loss and weakness. R23's Care Area Assessment (CAA) dated 9/2/16, identified R23 had Alzheimer's disease, cognitive impairment and anxiety. CAA indicated R23 had a functional limitation in range of motion, pain and an inability to perform ADLs without significant physical assistance, was deaf and non-verbal. The CAA further identified R23 had vision problems, restricted mobility, balance problems during transitions, and difficulty sitting due to recent hip fracture and surgery. The CAA further identified R23 had urinary urgency related to diuretic medication use and received anti-anxiety medication (sedative) which increased R23's risk for falls. An incident report noted in R23's medical record revealed on 10/10/16, at 6:07 p.m. indicated R23 was noted to have bruises on lower legs and upper back (in the spine area). The report did not identify the size/coloring of the bruises. The bruises were identified as being of an unknown origin. The facility did not report the bruises of unknown origin to the SA. The facility completed an investigation on 10/14/16, in which they determined the bruises to the lower legs may	21980		

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21980	Continued From page 58	21980		

have been from the wheelchair legs, however, the origin for the bruise to the spine was not identified.

On 11/10/16, at 10:30 a.m. the administrator confirmed the bruises identified on 10/10/16, were of an unknown origin and they were not reported to the SA, nor were they investigated to determine the cause of the bruising.

R23's progress note (PN) dated 10/30/16, indicated R23 was found on her buttocks on the 100-hallway floor at 8:30 a.m. R23 was assessed by nursing and assisted back into the wheelchair via a mechanical lift. R23 was noted to be holding her right shoulder and had a large hematoma to her forehead. R23 denied pain and had been previously administered Tylenol with codeine at 7:28 a.m. that morning. R23 was sent to emergency department (ED) for evaluation. R23 returned from the ED at 11:39 a.m. The note indicated R23 had a Cat Scan with no acute pathology noted. The ED recommended staff continue to monitor R23's neurological status and frontal hematoma for skin breakdown and for R23 to follow up with the clinic on 10/31/16.

R23's PN dated 10/30/16, indicated at 5:15 p.m. the nurse was informed R23 was found on the dining room floor, lying on her right side with a heavy bloody nose from both nostrils. R23 was assessed and R23 denied pain. R23 was assisted into a dining room chair via a mechanical lift. R23's nose continued to bleed so R23 was removed from the dining area. A follow up noted at 6:30 p.m. indicated the above fall occurred at 4:45 p.m. and while seated in the dining room

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GOOD SAMARITAN SOCIETY - WARREN	410 SOUTH MCKINLEY STREET WARREN, MN 56762

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21980	Continued From page 59	21980		

chair, R23 continued to "head bob" and bleed through the nose, therefore she was assisted to her room and in to bed. An antianxiety medication was given to "settle her." Once settled into bed, a nurse entered R23's room, and observed large amounts of blood on R23's pillow and her nose clotted with blood. R23's blood pressure was 87/54. The on call physician was notified and R23 was taken to the ED.

-A follow up noted at 11:30 p.m. indicated R23 was admitted to the hospital for observation of head injury and possible urinary tract infection. The bleeding had ceased and R23 was receiving fluids. The hospital would continue to monitor R23 and hopefully she would return to the facilty the next day.

R23's PN dated 11/7/16, at 2:26 p.m. indicated R23 was found on the floor in her bathroom, next to the sink. No injuries were sustained. R23 was assisted into the wheelchair via a mechanical lift. Although no injuries were sustained, R23's medical record lack documentation of an investigation as to the root cause of the fall and to determine if neglect of care had occurred.

Review of the facility vulnerable adult (VA) reports lacked documentation in which the SA had been notified of R23's unwitnessed falls with significant injury.

On 11/09/16, at 1:34 p.m. the director of nursing (DON) stated she didn't know if R23's injuries sustained on 10/30/16, should have been reported to the SA or not, however, felt R23's injuries somewhat met the criteria for reporting to the SA. The DON confirmed R23 had sustained

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21980	Continued From page 60 a right frontal hematoma, nose bleed, and was hospitalized after the second fall on 10/30/16. The DON stated she didn't previously know why R23 was hospitalized and was unaware until now that R23 had sustained a right frontal scalp hematoma. She stated no one had told her R23 had sustained a hematoma as she had just thought R23 had a bump on her head. She stated R23's hematoma should have been reported to the SA. On 11/10/16, at 12:43 p.m. The DON and administrator were interviewed. Both confirmed R23's injuries sustained on 10/30/16, were not reported to the SA because they were not aware of how serious R23's injuries actually were, and confirmed the incidents should have been reported to the SA, immediately. The DON and administrator verified they were both notified immediately via text message after both R23's falls on 10/30/16. In addition, the administrator stated she hadn't completed a root cause investigation for R23's fall on 11/7/16, because she felt it needed to be a team effort investigation, and stated she could have completed the investigation but didn't. She stated the staff typically reviewed falls during their morning huddle meeting, and stated because of the survey, they did not hold their morning meetings this week. Due to lack of investigation, it was unknown if R23's care plan was followed/neglect of care occurred. During a facility monitoring visit on 11/11/16, at approximately 12:30 p.m. the occupational therapist (OT) confirmed R23's cognition was limited, she had impaired safety awareness and	21980		

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21980	Continued From page 61 no instruction/safety measure recall after cued/instructed. The OT stated R23's fall in the bathroom was due to licensed practical nurse (LPN)-B assisting R23 onto the toilet and leaving her unattended. The OT stated R23 does not remember to use the call light to alert staff assistance was needed and would usually turn on the call light only to shut if off herself, shortly thereafter. On 11/11/16, at 12:45 p.m. LPN-B confirmed she had assisted R23 onto the toilet and had left her unattended, however, wasn't sure if it was Monday 11/7/16, or a previous Monday. LPN-B also confirmed R23 did not always use the call light to request assistance when on the toilet. On 11/14/16, at 11:34 a.m. LPN-B stated she was on the scene for both of R23's falls on 10/30/16. LPN-B stated the facility policy directed them to report major injuries if a resident's care plan wasn't followed. She stated she determined R23's care plan was followed for both R23's falls on 10/30/16, and stated that's why she didn't report R23's major injuries. On 11/15/16, at 10:42 a.m. the DON and administrator were interviewed again. both stated they had completed R23's fall investigation from 11/7/16, and had determined R23 had taken herself to the bathroom after breakfast. The adminstrator stated R23's falls with serious injuries were not reported to the SA because the falls were investigated, the care plan was followed, there was no evidence of maltreatment, and R23 had been seen by a physician. However, both the administrator and the DON	21980		

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21980	Continued From page 62 stated they were not aware what the facility policy directed staff to do when incidents of unwitnessed falls with injury occurred. The Minnesota Reporting of Maltreatment of Vulnerable Adults dated, 9/15 indicated if the facility had knowledge that a vulnerable adult had sustained a physical injury which was not reasonably explained, the facility was required to report the incident to the SA. The policy further indicated if the facility had reason to believe an "error," resulting in harm or injury occurred must make a report to the SA. The facility Abuse and Neglect policy dated 2/2013, directed staff to report alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin to be reported immediately to the facility administrator and the State agency. R12's report of missing money was not reported to the SA timely. Review of the VA reports from 6/2016 - 11/2016, included a report dated 8/14/16, in which R12 had reported she was missing one twenty dollar bill, one ten dollar bill, five five dollar bills and three one dollar bills (for a total of $58.00) from her purse. R12 reported the concern to the facility via a suggestion or concern form dated 8/14/16. The facility did not report the concern to the SA until 8/15/16. On 11/10/16, at 12:30 the administrator confirmed	21980		

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21980	Continued From page 63 R12 had reported the concern on Sunday, 8/14/16, and the SA was not notified until the next day, Monday, 8/15/16. The administrator stated the facility was to report concerns of misappropriation of resident property to the SA immediately. The Abuse Definitions policy dated 2/2013, identified misappropriation of resident property as abuse and directed the staff to report misappropriation of resident property to the administrator and SA immediately. Background Checks: On 11/8/16, at 10:28 a.m. the administrator confirmed licensed practical nurse (LPN)-A had been contracted and worked at the facility from 5/2/16, through 11/2/16. The administrator stated LPN-A had worked on the nursing units providing direct resident care and as the minimum data set (MDS) coordinator. On 11/9/16, at 11:13 a.m. administrator confirmed the facility had not conducted a back ground check on LPN-A. Background Investigations - Minnesota policy dated 8/15, indicated the facility would follow state specific procedures for obtaining employee back ground checks. SUGGESTED METHOD OF CORRECTION: The administrator or designee could review and / or revise the policies and procedures for reporting and investigating, educate the staff on what is reportable and to immediately report to the	21980		

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21980	Continued From page 64 administrator and the state agency. The administrator of designee could develop a system to monitor the effectiveness of the plan. TIME PERIOD OF CORRECTION: Twenty-one (21) Days.	21980		
22000	MN St. Statute 626.557 Subd. 14 (a)-(c) Reporting - Maltreatment of Vulnerable Adults Subd. 14. Abuse prevention plans. (a) Each facility, except home health agencies and personal care attendant services providers, shall establish and enforce an ongoing written abuse prevention plan. The plan shall contain an assessment of the physical plant, its environment, and its population identifying factors which may encourage or permit abuse, and a statement of specific measures to be taken to minimize the risk of abuse. The plan shall comply with any rules governing the plan promulgated by the licensing agency. (b) Each facility, including a home health care agency and personal care attendant services providers, shall develop an individual abuse prevention plan for each vulnerable adult residing there or receiving services from them. The plan shall contain an individualized assessment of: (1) the person's susceptibility to abuse by other individuals, including other vulnerable adults; (2) the person's risk of abusing other vulnerable adults; and (3) statements of the specific measures to be taken to minimize the risk of abuse to that person and other vulnerable adults. For the purposes of this paragraph, the term "abuse" includes self-abuse.	22000		12/26/16

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22000	Continued From page 65 (c) If the facility, except home health agencies and personal care attendant services providers, knows that the vulnerable adult has committed a violent crime or an act of physical aggression toward others, the individual abuse prevention plan must detail the measures to be taken to minimize the risk that the vulnerable adult might reasonably be expected to pose to visitors to the facility and persons outside the facility, if unsupervised. Under this section, a facility knows of a vulnerable adult's history of criminal misconduct or physical aggression if it receives such information from a law enforcement authority or through a medical record prepared by another facility, another health care provider, or the facility's ongoing assessments of the vulnerable adult. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to implement their abuse policy as directed related to the immediate reporting to the State agency of injures of unknown origin for 1 of 1 resident (R23) identified with bruising of unknown origin; failed to immediately report and thoroughly investigate falls with significant injury for possible mistreatment and neglect of care for 1 of 1 resident who sustained significant injures during unwitnessed falls. The facility failed to report missing money to the State agency for 1 of 1 resident (R12) who had reported missing money and failed to conduct background checks for 1 of 5 agency staff members licensed practical nurse (LPN)-A) who lacked a criminal	22000	Corrected 12/26/16	

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22000	Continued From page 66 background check. Findings include: The Abuse and Neglect policy dated 2/2013, directed the staff to report alleged or suspected violations involving any mistreatment, neglect, or abuse including injuries of unknown origin to be report immediately to the facility administrator and the State Agency (SA). The Abuse Definitions policy dated 2/2013, identified misappropriation of resident property as abuse and directed the staff to report misappropriation of resident property to the administrator and SA immediately. Background Investigations - Minnesota policy dated 8/15, indicated the facility would follow state specific procedures for obtaining employee back ground checks. Findings include: R23 sustained bruises of unknown origin and had two unwitnessed falls with significant injury which were not reported to the SA. During record review for R23, an incident report dated 10/10/16, at 6:07 p.m. indicated R23 was noted to have bruises on lower legs and upper back in the spine area (the report did not indicate the size of the bruises.) The bruises were	22000		

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22000	Continued From page 67 identified as being of an unknown origin. The facility completed an investigation on 10/14/16, in which they determined the bruises to the lower legs may have been from the wheelchair legs, however, the origin for the bruise to the spine was not identified. The facility did not report the bruises of unknown origin to the State Agency. The administrator signed the report on 10/14/16. On 11/10/16, at 10:30 a.m. the administrator confirmed the bruises identified on 10/10/16, were of an unknown origin and they were not reported to the SA timely nor were they investigated to determine if abuse had occurred. During record review for R23, an entry in the Progress Note (PN)dated 10/30/16, at 8:30 a.m. R23 was found seated on the floor in the hallway with a large hematomoa on her right forehead. The fall was unwitnessed. R23 was sent to the emergency room for an evaluation which included a CT of her head. A PN dated 10/30/16, at 5:17 p.m. R23 was found on the floor of the dining room. R23 had sustained a bloody nose. At 6:18 p.m. R23's blood pressure dropped to 87/54, she was then transferred to the hospital to rule out head injury from the falls. R23's PN dated 11/7/16, at 2:26 p.m. indicated R23 was found on the floor in her bathroom, next to the sink. No injuries were sustained. R23 was assisted into the wheelchair via a mechanical lift. Although no injuries were sustained, R23's medical record lack documentation of an	22000		

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22000	Continued From page 68 investigation as to the root cause of the fall and to determine if neglect of care had occurred. Review of the VA reports lacked documentation in which the SA had been notified of R23's falls with significant injury or an investigation to determine causal factors of unwitnessed fall to determine if neglect of care had occurred. On 11/10/16, at 1:05 p.m. the administrator confirmed R23 had sustained significant injury from unwitnessed falls. The incidents had not been reported to the SA immediately as directed by the policy. R12's report of missing money was not reported to the SA timely. Review of the VA reports from 6/2016 - 11/2016, included a report dated 8/14/16, in which R12 had reported she was missing one twenty dollar bill, one ten dollar bill, five five dollar bills and three one dollar bills (for a total of $58.00) from her purse. R12 reported the concern to the facility via a suggestion or concern form dated 8/14/16. The facility did not report the concern to the SA until 8/15/16. On 11/10/16, at 12:30 the administrator confirmed R12 had reported the concern on Sunday, 8/14/16, and the SA was not notified until the next day, Monday, 8/15/16. The administrator stated the facility was to report concerns of misappropriation of resident property to the SA immediately.	22000		

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22000	Continued From page 69 Background Checks: The facility failed to ensure background checks had been completed on 1 of 5 agency staff, licensed practical nurse (LPN)-A. On 11/8/16, at 10:28 a.m. the administrator confirmed licensed practical nurse (LPN)-A had been contracted and worked at the facility from 5/2/16, through 11/2/16. The administrator stated LPN-A had worked on the nursing units providing direct resident care and as the minimum data set (MDS) coordinator. On 11/9/16, at 11:13 a.m. administrator confirmed the facility had not conducted a back ground check on LPN-A. SUGGESTED METHOD OF CORRECTION: The administrator could in-service all staff on the need to immediately report and investigate suspected abuse/neglect to the designated state agency/common entry point according to the facility's policy. The director of nurses' could monitor incident reports for implementation of this requirement. TIME PERIOD FOR CORRECTION: Twenty One (21) days.	22000		