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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XETP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

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 **05/02/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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 :
Sheryl Reed, HFE NE II 05/02/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/21/2014 (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
04/01/1978
(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
04/09/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5221

On 04/09/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, was determined that the facility had not achieved substantial compliance pursuant to the 01/31/14 standard survey. In addition, CMS surveyors conducted a Federal Monitoring Survey (FMS) on 04/09/14.

On 05/02/14, a second Post Certification Revisit (PCR) was completed by the Department of Health. Based on the second PCR, it has been determined that the facility has achieved substantial compliance pursuant to the 01/31/14 standard survey and the FMS completed on 04/09/14, effective 04/28/14. Refer to the CMS 2567B forms for health and FMS.

Effective 04/28/14, the facility is certified for 96 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CMS Certification Number (CCN): 24-5221

May 21, 2014

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

Dear Ms. Jensen:

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

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

Effective April 28, 2014, the above facility is certified for:

96 - Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 96 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status. Please note, it is your responsibility to share the information contained in this letter and the results of this PCR with the President of your facility's Governing Body.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination. Please contact me if you have any questions.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically Delivered: May 21, 2014

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

RE: Project Number S5221024 and S5221025

Dear Ms. Jensen:

On April 24, 2014, we informed you that the following enforcement remedy was being imposed:

- State Monitoring effective May 1, 2014. (42 CFR 488.422)

On February 26, 2014, the Centers for Medicare and Medicaid Services (CMS) forwarded the results of the Federal Monitoring Survey (FMS) and informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective May 1, 2014. (42 CFR 488.417 (b))

This was based on the deficiencies cited by this Department for a standard survey completed on January 31, 2014, and a FMS completed February 14, 2014. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), whereby corrections were required.

On April 9, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 31, 2014 and the FMS completed on February 14, 2014. The deficiency not corrected was as follows:

- **F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals**

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the revisit findings, your facility is not in substantial compliance. The category 1 remedy of State Monitoring will remain in effect. (State Monitoring effective May 1, 2014. (42 CFR 488.422))

In addition, this Department recommended the following remedy to CMS Region V Office; they concurred and imposed the following remedy and authorized this Department to notify you of the imposition of Mandatory

Denial of payment for new Medicare and Medicaid admissions effective May 1, 2014 remain in effect. (42 CFR 488.417 (b))

In our letter of April 24, 2014, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 1, 2014, due to denial of payment for new admissions.

On May 2, 2014, 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 the Health PCR and FMS PCR completed on April 9, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of April 28, 2014. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR and FMS, completed on April 9, 2014, as of April 28, 2014. As a result of the revisit findings, the Department is discontinuing the Category 1 remedy of state monitoring effective April 29, 2014.

In addition, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of April 24, 2014. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 1, 2014, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective May 1, 2014, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 1, 2014, is to be rescinded.

In our letter of April 28, 2014, we advised you that, 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 was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 1, 2014, due to denial of payment for new admissions. Since your facility attained substantial compliance on April 28, 2014, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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 about this electronic notice.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: anne.kleppe@state.mn.us
Telephone: (651) 201-4124 Fax: (651) 215-9697

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245221	A. Building B. Wing	5/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**04/28/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** SR/AK	**Date:** 05/21/2014	**Signature of Surveyor:** 22581	**Date:** 05/02/2014
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 1/31/2014		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**		**YES** **NO**

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245221	A. Building B. Wing	5/2/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	**04/28/2014**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	05/21/2014	30922	05/02/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2014			

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XETP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

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 **04/09/2014** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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 :
Mary Heim, HPR-Social Worker Specialist 04/24/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Anne Kleppe, Enforcement Specialist 05/14/2014 (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
04/01/1978
(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
04/09/2014
(L33)

DETERMINATION APPROVAL

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

CCN: 24-5221

On 04/09/14, a Post Certification Revisit (PCR) was completed by the Department of Health. Based on the PCR, it has been determined that the facility has not achieved substantial compliance pursuant to the 01/31/14 standard survey. Refer to the CMS forms 2567 and 2567B for survey findings.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered: April 24, 2014

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

RE: Project Number S5221024

Dear Ms. Jensen:

On February 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 31, 2014. This survey found the most serious deficiencies to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

Subsequently, a survey team representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility on February 14, 2014. As the survey team informed you during the exit conference, the FMS has revealed that your facility continues to not be in substantial compliance. The FMS found deficiencies, with the most serious being at S/S level F.

On February 26, 2014 CMS forwarded the results of the FMS to you and informed you that the following enforcement remedy was being imposed:

- **Mandatory Denial of payment for new Medicare and Medicaid admissions effective May 1, 2014. (42 CFR 488.417 (b))**

However, as CMS notified you in its letter of February 26, 2014, 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 May 1, 2014.

On April 9, 2014, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on January 31, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 25, 2014. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on January 31, 2014 and the FMS completed on February

14, 2014. The deficiency not corrected is as follows:

- **F0431 -- S/S: D -- 483.60(b), (d), (e) -- Drug Records, Label/store Drugs & Biologicals**

The most serious deficiencies in your facility were found to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567, whereby corrections are required.

As a result of the standard survey and FMS survey findings, your facility is not in substantial compliance, this Department is imposing the following category 1 remedy:

• State Monitoring effective April 29, 2014. (42 CFR 488.422)

In addition, Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. In addition, this Department recommended the following remedy to CMS Region V Office; they concur and are 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 May 1, 2014 remain in effect. (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 May 1, 2014. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective May 1, 2014. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(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 a denial of payment. Therefore, Good Samaritan Society - Maplewood is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective May 1, 2014. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, 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.

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.

APPEAL RIGHTS

If you disagree with this determination, 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 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.

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:

Susanne Reuss, Supervisor
Metro A Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Email: susanne.reuss@state.mn.us

Phone: (651) 201-3793
Fax: (651) 201-3790

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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for 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 allegation of compliance and/or 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 second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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 July 31, 2014 (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
Division of Compliance Monitoring
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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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

Feel free to contact me if you have questions about this letter.

Sincerely,

Anne Kleppe

Anne Kleppe, Enforcement Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4124 Fax: (651) 215-9697
Email: anne.kleppe@state.mn.us

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245221	A. Building B. Wing	4/9/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **03/10/2014**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **03/10/2014**	ID Prefix **F0244** Reg. # **483.15(c)(6)** LSC	Correction Completed **03/10/2014**
ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **03/10/2014**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	Correction Completed **03/10/2014**	ID Prefix **F0315** Reg. # **483.25(d)** LSC	Correction Completed **03/10/2014**
ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **03/10/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/10/2014**	ID Prefix **F0428** Reg. # **483.60(c)** LSC	Correction Completed **03/10/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/10/2014**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	04/24/2014	30922	04/09/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/31/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	R 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

(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 An onsite resurvey was conducted on April 8, 9, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on February 14, 2014.	{F 000}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	{F 431}		4/28/14

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

Electronically Signed | 4/25/2014

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
	245221	A. BUILDING _____ B. WING _____	R 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

(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 431}	Continued From page 1 be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to discard expired medications for 1 of 5 insulin vials. In addition, an expired medication was given to 1 of 3 residents (R9) whose medication vial was observed for medication storage on the first floor south. Findings include: The medication storage area was observed on 4/7/14, at 2:05 p.m. with licensed practical nurse (LPN)-A, in the first floor south. One medication stored in the cart was an opened insulin vial, dated 3/1/14 and undated with expiration date. The insulin vial was R9's Lantus (medication for diabetes II) LPN-A verified the medication was opened and dated 3/1/14. In addition, LPN-A stated, an expired medication (Lantus) needed to be removed from the storage area after 28 days when opened. LPN-A further stated, "Is expired 3/29/2014." Review of R9's electronic medication administration record (eMAR) for March 2014 and April 2014, specifically 3/30/2014 - 4/6/2014, revealed the expired medication (Lantus insulin) was administered to R9, every bedtime. Blood sugar levels, read, 217 on 3/31/14, 167 on 4/2/14, 167 on 4/4/14 and 169 on 4/7/14. Audit forms for 1st south station directed "Check medication carts and medication rooms" Review of the forms for 3/31/14 and 4/7/14 revealed,	{F 431}	Plan of Correction General Disclaimer 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 facility is not in substantial compliance with Federal requirements of participation, this response and plan of correction constitutes the facility□s allegation of compliance in accordance with section 7305 of the State Operations Manual. F 431 483.60(b)(d)(e) Drug Records, Labels/Store Drugs & Biologicals: Corrective Action for resident R9 R9 Insulin vial was removed immediately and properly discarded. A system for properly dating medications when opened, and removal of expired medications is in place. How to identify other residents with the same issue All resident□s medication labels have been reviewed for open dates and expiration dates. A system for properly dating medications when opened, and removal of expired medications is in	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	R 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

(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 431}	Continued From page 2 "Are there "Date open" dates marked on every open medication?" "Yes" was checked as the answer. The audit forms further revealed "Are there medications that have expired that have not been discarded and removed from cart?" "No" was checked as the answer. On 4/9/14, at 9:29 a.m. registered nurse (RN-B), stated her expectation was staff should date all multiple dose medication bottles when they opened them with date open and expiration date. RN-A further stated, " That is what nurses are trained on and is in our training package." Policy and procedure titled: Medication Administration General Guidelines dated 12/12, reads, "8. Check expiration date on packages/container. No expired medication will be administered to a resident. b. The nurse shall place a 'date opened' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. c. Certain products or packages types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating, once opened, to ensure medication purity and potency. " The Pharmerica Value Trust Performance, dated 2/28/14, indicated, to discard Insulin 28 days after opened. Product information from, "Epocrates," a drug and disease reference site regarding Lantus insulin indicated after opening the vial it should be used or discarded after 28 days.	{F 431}	place. An Insulin Open Date along with Expiration Date Log was put into place immediately on 4-9-14. Medications with Special Expiration Date Requirements is posted at each nursing unit. A system is in place for nurses and TMAs to check expiration dates on each medication before giving medications. Recurrence will be prevented by All nurses and TMAs have received re-education on the system for medication open dating, expiration dates, discarding expired medications, and filling out the Insulin Open Date along with Expiration Date Log. Audits will be completed on a schedule as below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers, and appointed nurses will conduct audits of medication labels as specified in the system mentioned above. The audits will be completed weekly for four weeks, monthly for one quarter, and quarterly thereafter. Audit results will be brought to the quality assurance committee for further review as needed.	

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245221	A. Building B. Wing	4/9/2014

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0312** Reg. # **483.25(a)(3)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0329** Reg. # **483.25(l)** LSC	Correction Completed **03/25/2014**	ID Prefix **F0356** Reg. # **483.30(e)** LSC	Correction Completed **03/25/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **03/25/2014**	ID Prefix **F0465** Reg. # **483.70(h)** LSC	Correction Completed **03/25/2014**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	SR/AK	04/24/2014	30922	04/09/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
2/14/2014			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	R 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

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{F 000}	INITIAL COMMENTS An onsite resurvey was conducted on April 7, 8, 9, 2014, to determine compliance with Federal deficiencies issued during a recertification survey exited on January 31, 2014.	{F 000}		
{F 431} SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can	{F 431}		4/28/14

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

Electronically Signed | 4/25/2014

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
	245221	A. BUILDING _____ B. WING _____	R 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	R 04/09/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

(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 431}	Continued From page 2 medication rooms." Review of the audit forms dated on 3/31/14 and 4/7/14 revealed, "Are there "Date open" dates marked on every open medication?" "Yes" was checked as the answer. The forms further noted "Are there medications that have expired that have not been discarded and removed from cart?" "No" was checked as the answer. During the interview on 4/9/14, at 9:29 a.m. registered nurse (RN-B), stated her expectation was staff should date all multiple dose medication bottles when they were opened with the date opened and expiration date. RN-A further stated, " That is what nurses are trained on and is in our training package." Policy and procedure titled: Medication Administration General Guidelines dated 12/12, reads, "8. Check expiration date on packages/container. No expired medication will be administered to a resident. b. The nurse shall place a ' date opened ' sticker on the medication if one is not provided by the dispensing pharmacy and enter the date opened. c. Certain products or packages types such as multi-dose vials and ophthalmic drops have specified shortened end-of-use dating, once opened, to ensure medication purity and potency." The Pharmerica Value Trust Performance, dated 2/28/14, indicated, to discard Insulin 28 days after opened. Product information from, "Epocrates," a drug and disease reference site regarding Lantus insulin indicated after opening the vial it should be used or discarded after 28 days.	{F 431}	place. An Insulin Open Date along with Expiration Date Log was put into place immediately on 4-9-14. Medications with Special Expiration Date Requirements is posted at each nursing unit. A system is in place for nurses and TMAs to check expiration dates on each medication before giving medications. Recurrence will be prevented by All nurses and TMAs have received re-education on the system for medication open dating, expiration dates, discarding expired medications, and filling out the Insulin Open Date along with Expiration Date Log. Audits will be completed on a schedule as below. These issues will be monitored in the following manner The Director of Nursing, Nurse Managers, and appointed nurses will conduct audits of medication labels as specified in the system mentioned above. The audits will be completed weekly for four weeks, monthly for one quarter, and quarterly thereafter. Audit results will be brought to the quality assurance committee for further review as needed.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: XETP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/31/2014** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **96** (L18)

13.Total Certified Beds **96** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	96			
(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 :
Vidya Tomar, HFE, NE II 03/11/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kate JohnsTon, Enforcement Specialist 04/07/2014 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
04/01/1978
(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

Page 2
Provider Number: 24-5221
Item 16 Continuation for CMS-1539

At the time of the standard survey completed 1/31/14, the facility was not in substantial compliance and the most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E) whereby corrections were required as evidenced by the attached CMS-2567. The facility has been given an opportunity to correct before remedies are imposed. Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered
February 18, 2014

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

RE: Project Number S5221024

Dear Ms. Jensen:

On January 31, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

<u>Potential Consequences</u> - the consequences of not attaining substantial compliance 3 and 6

months after the survey date; and
Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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

DEPARTMENT CONTACT

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

Susanne Reuss, Supervisor
Metro A Survey Team
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
susanne.reuss@state.mn.us

Phone: (651) 201-3793
Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 12, 2014, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 12, 2014 the following remedy will be imposed:

- Per instance civil money penalties. (42 CFR 488.430 through 488.444)

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,

- Include electronic acknowledgement signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by May 1, 2014 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of

this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by July 31, 2014 (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
Division of Compliance Monitoring
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 electronic 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. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
pat.sheehan@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0541

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
Division of Compliance Monitoring
Minnesota Department of Health
mark.meath@state.mn.us

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

Enclosure

cc: Licensing and Certification File 5221s14.rtf

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS THE FACILITY PLAN OF CORRECTION (POC) WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION.	F 000		
F 164 SS=E	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law.	F 164		3/10/14

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

Electronically Signed | 02/27/2014

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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F 164	Continued From page 1 The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to safeguard and securely store old medical records and other files from 2004 to 2011. This potentially could have affected residents whose files were stored in the garage. Findings include: During the environmental tour on 1/30/14 at 11:39 a.m. the head of maintenance (M)-A was asked about the stand alone garage adjacent to the nursing home. The garage was approximately 40 yards from the nursing home which was located in a residential neighborhood. The back of the garage, separated by a wall from the main part of the garage was used as a storage area for medical records. During observation, over 100 covered card board boxes of medical record files dated from 2004 to 2011 were observed. There were boxes of payroll information and death records as well. There was no sprinkler system observed and the building was filled with cobwebs. The boxes were stored off the floor, on wooden shelves 2-3 boxes deep and about 5 shelves high. A window was located in the garage and although the door to the garage could be locked, it was not a dead bolt lock.	F 164	-CORRECTIVE ACTION - This REQUIREMENT will be met by removing all medical records/financial documents from 2004 to 2011 retained in cardboard boxes in the garage storage area and will be transferred in to the facility in the medical records department or the business office where they will be taken out of the cardboard boxes and placed in file cabinets and locked in the department storage area. This will provide a safe and secure environment to protect the physical integrity of the record, prevent loss, destruction and unauthorized access. This area is sprinkled which will also prevent destruction and offer protection. File cabinets have been purchased and the transferring of these records will be completed by March 10, 2014. -OTHER RESIDENTS IDENTIFIED- To prevent this from happening again the garage storage area adjacent to the facility will no longer be used for medical record and/or financial document storage. The area inside of the Medical Records Department will be a permanent place for	

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F 164	Continued From page 2 The policy and procedure titled, Security of the Medical Records and HIM Department, Storage System Options, dated 9/2013 was reviewed. The policy indicated storage systems will be secure to protect the physical integrity of the record, prevent loss, destruction, and unauthorized access. The policy indicated if storage boxes are utilized they must be below sprinkler heads and if storage sheds are used the medical record must be secure, protected from loss or destruction and protected from moisture and rodents. Interview on 1/30/14 at 1:00 p.m,. with health information (HIM)-A, revealed that only two staff persons had keys (maintenance and HIM). HIM-A agreed the records should be in file cabinets under lock and key. She indicated the boxes have been stored in the garage for years and that section of the garage had been built for storage, however there was no sprinkler system and the building had only one single lock.	F 164	medical record storage. The financial documents will be locked in the business office area. -MEASURES PUT IN PLACE TO ENSURE DEFECIENT PRACTICE WILL NOT RECUR- All discharged residents paper medical records/ financial documents will be placed in files within the facility as to ensure a safe and protected environment. -MONITOR THIS ACTION TO ENSURE THIS CORRECTION IS SUSTAINED- The employees in the Health Information Management Department and/or business office will monitor this correction to ensure the safety of paper medical records/financial documents.	
F 241 SS=E	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 provide a dignified personal care experience for 4 of 4 residents (R11, R46, R50, and R105) observed dependent on others for activities of daily living. The facility	F 241	F 241 483.15(a)Dignity and Respect of Individuality: Corrective Action for residents R11, R46, R50 and R105 regarding personal care	3/10/14

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F 241	Continued From page 3 also failed to provide a dignified dining experience for 3 of 8 residents (R3, R46 and R73) observed in the dining room. Findings include: R11 did not receive an ongoing explanation of cares throughout the care process while cares were being performed by staff at 4:30 p.m. on 1/27/14. During observation on 1/27/14, at 4:30 p.m., R 11 was sitting on the commode calling out for help. Nursing assistant (NA)-F said to R11, "You are on the commode, go ahead and push it." R11 was complaining, "It hurts so bad sitting on this." NA-F and NA-H were present but did not acknowledge R11's complaints of discomfort nor did they attempt to reposition R11 on the commode. Without informing R11 that they were going to take her off of the commode, the NA's raised the mechanical lift and pulled up the incontinence brief and resident slacks without comment. Then, to position R11 into the wheel chair, NA-F used the waistband of R11's slacks to pull R11 back into the wheel chair. During observation on 1/29/14, at 7:00 a.m. R11 was partially dressed and lying in bed. NA-B and NA-D came into the room with the mechanical stand and proceeded to set R11 up on the side of the bed without introduction or conversation. The NA's attached the mechanical sling and proceeded to lift R11 out of the bed without informing R11 when the mechanics of the mechanical lift were taking place in raising her out of the bed and again in lowering the lift onto the commode. R11 stated, "I am cold, I need a jacket. Don't dump me, I am scared." R11 continued to complain of "My butt is sticking out, I can't go like this." R11 continued complaints of hurting while sitting on the commode. The nursing assistants failed to inform the resident of each	F 241	experience: Staff caring for these residents will be re-educated in providing dignified ADL care, including introducing themselves, explanation of cares throughout the care process prior to providing each care, communicating to residents, repositioning and obtaining the nurse when residents experience pain during cares, using the proper equipment such as a transfer belt, staff to avoid any complaining about their own pain or discomfort, and following the care plan for specifics such as cues, reassurance, loving support and allowing resident to freely verbalize feeling/concerns. Re-education will also include checking with the resident to make sure all ADL needs are met prior to moving the resident out of their room. (Examples include combing hair, helping with oral care and shaving.) Audits will be completed for these residents and then will be part of audits as outlined below. Corrective Action for residents R3, R46, and R73 regarding dignified dining: Staff caring for these residents were re-educated in providing dignified dining, including introducing themselves, offering conversation, informing residents what was being offered or fed throughout the meal, encouragement to eat and participate in the eating process and explanations of position changes during and after meals prior to making these changes. Follow the care plan for information such as using communication techniques which enhance interaction, provide encouragement to maintain as	

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F 241	Continued From page 4 step in the process to alleviate anxiety with positioning on the commode and did not inform the nurse to evaluate R11's positioning on the commode. R11 was raised off the commode and brief and slacks were pulled up without direction. NA-B used R11's slacks waistband to pull R11 into position in the wheel chair. Questioned NA-B as to why the waistband of the slacks was used and he stated, "That is how we position them in the chair." When asked about friction and shearing, NA-B and NA-D shrugged shoulders and NA-B stated, "That is how we do it." When interviewed on 1/29/14, at 7:50 a.m. R11 verified she did not like the staff pulling on the waistband of her slacks to position her in the chair. The principal diagnosis from the plan of care lists vascular dementia and generalized pain. R11's Brief Interview for Mental Status (BIMS) dated 11/11/13, was a 3 out of a 15 possible which indicates cognitive skills are impaired, rarely/never able to make self understood. R11's plan of care dated 2/4/13 directs staff to provide resident with necessary cues, present just one thought, idea, question or command at a time and to redirect, reassure as needed. R46 was not informed in a dignified manner of cares that were being performed and did not receive dignified assistance with eating on 1/27/14, at 5:30 p.m. and 1/29/14, at 9:00 a.m. and 11:45 a.m. During dining observation on 1/27/14, at 5:30 p.m. NA-D and NA-F used the waistband of R46's slacks to pull her up into a better sitting position for eating in the Broda chair. The nursing	F 241	much independence as possible, and allow resident time to talk and express feelings. Audits for theses residents will be completed and then will be part of audits as outlined below. How to identify other residents with the same issue All residents have the right to dignified dining and dignified ADL care. Social Service Director will in-form residents at the next Resident Council meeting of their right to dignified care and dignified dining, and will ask residents if they are experiencing any problems with this. Audits will be conducted during dining and during ADL cares to identify any other residents who may be experiencing care or dining that is not dignified. Recurrence will be prevented by A Procedural Guide for Dignified ADL Care was developed, and will be used for educating all nursing staff. A Procedural Guide for Dignified Dining was developed and will be used for educating all nursing and dietary staff. Dining room and ADL care audits will be completed to prevent recurrence. These issues will be monitored in the following manner The Director of Nursing and Nurse Managers will complete audits to ensure dignified dining and ADL care weekly for one month, then monthly for one quarter, and then quarterly. Audit results will be brought to the quality assureance committee for further review as needed.	

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	245221	A. BUILDING _____ B. WING _____	01/31/2014

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F 241	Continued From page 5 assistants failed to inform the resident of each step in the process. R46 had a mechanical sling under her in the chair. NA-F was observed feeding R46 and did not offer conversation or inform R46 what was being fed to her or offered throughout the meal. During an observation on 1/29/14, at 9:00 a.m. NA-B tipped back R46's Broda chair without informing her of the mechanical change. R46 had a startled look on her face as NA-B wheeled the chair over to the piano/television area of the dining room. On 1/29/14, at 11:45 a.m., NA-A and NA-B did not explain to R46 who they were or what they were going to do for cares or for using the mechanical lift. NA-A lifted R46's legs off the chair and began to move the lift into position. During the transfer, the nursing assistants did not inform R46 when the mechanics of the mechanical lift were taking place to alleviate anxiety. R46 let out a verbal groan when the lift started to go up. The principal diagnosis from the plan of care lists Alzheimer's disease, anxiety state and generalized pain. R46's BIMS dated 1/14/14, indicated resident cognitive pattern is rarely/never understood. R46's plan of care dated dated 12/23/13, directed staff "Resident needs total assistance with all decision making. Resident has a communication problem R/T [related to] Advanced Alzheimer's Dementia inability to verbally communicate needs to staff.	F 241	Residents will be asked at the Resident Council meetings each month for one quarter, and addressed as needed. Concerns will be brought to the quality assurance committee for further review as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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F 241	Continued From page 6 R50 did not receive an ongoing explanation of cares throughout the care process while they were being performed by staff on 1/29/14, at 8:40 a.m. During an observation on 1/29/14, at 8:40 a.m. NA-D did not inform R50 of each step in the process to alleviate anxiety with morning cares. NA-D set R50 up on the side of the bed as R50 stated, "What about my right foot?", as NA-D used the waistband of R50's slacks to move her into the wheel chair. R50 was taken to the BR by wheelchair and again moved to the toilet using the waistband of her slacks to stand up. NA-D said "Grab here." directing R50 to use the grab bar in the BR. After voiding on the toilet, NA-D handed R50 a wet wash cloth to which R50 stated, "What are you doing, dressing me up." NA-D stated, "Yup." NA-D took the brush and brushed R50's hair without encouraging R50 to assist. NA-D walked away from R50 and said, "Now you can go out." R50, in an interview on 1/28/14, at 10:38 a.m. stated, "They think I can do more for myself than I can. I cannot move in the bed. I have to have help with everything. One of the aides says she can't help me too much because her back is sore, well I can't do anything about it, then I feel terrible because she has such a terrible time getting me over to a chair." R50 expressed wishing the staff were more informative in a tone of voice she could hear to explain her cares. The principal diagnosis from the plan of care lists hypertension and peripheral vascular disease. R50's BIMS dated 11/1/13, is a 7 out of a possible 15 which indicates impaired cognition.	F 241		

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R50's plan of care dated 8/7/13 directed staff to provide one to one attention, reassurance, loving support, allow to freely verbalize feelings/concerns.

R73 did not receive dignified assistance with eating on 1/27/14, at 12:38 p.m. and 5:30 p.m.

During an observation on 1/27/14 at 12:38 p.m. NA-E was sitting with R73 but was not having any conversation with R73. NA-E would say, "Open your mouth." every now and then, but did not explain to R73 the foods and fluids that were being fed. At one time R73 reached out for the glass of milk and NA-E moved her hand away and proceeded to feed the milk. There was no encouragement for R73 to hold the glass of milk or to hold any utensil. NA-E did not engage in conversation with R73 other than to say open your mouth every once in a while.

During another observation on 1/27/14, at 5:30 p.m. NA-D was sitting next to R73 in the dining room and was feeding the resident foods and fluids without an explanation as to what the food and fluid items were. NA-D did not engage in conversation with R73.

The principal diagnosis from the plan of care for R73 lists senile dementia with delirium, anorexia, and episodic mood disorder.

R73's BIMS was a 3 out of 15 which indicated resident cognitive pattern is rarely/never understood.

Review of the care plan dated 11/6/12 directed staff to, "Use communication techniques which

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enhance interaction.: ask yes/no questions if appropriate, use simple brief, consistent words/cues. Anticipate /meet all of resident's basic needs for her. Provide encouragement /assistance/support to maintain as much independence as possible and Allow resident time to talk. Encourage resident to express feelings."

R105 did not receive an ongoing explanation of cares throughout the care process while they were being performed by staff on 1/29/14, at 7:45 a.m.
During continued observation on 1/29/14, at 7:45 a.m., R105 was in bed when nursing assistant NA-D lowered the head of the bed without informing R105 what was going to happen. NA-D put R105's legs into the slacks, donned stockings and shoes without informing R105 what she was doing. NA-D told R105, "Come this way." Without conversation, NA-D rolled R105 to a sitting position on the side of the bed. NA-D applied the mechanical stand sling and raised R105 to a squatting position and applied an incontinence brief, pulled up slacks and used the waistband of the slacks to position R105 into the wheelchair. NA-D instructed R105 to do her teeth and she would be back. R105 took dentures out of the water at the bedside and put them in her mouth and attempted to comb her hair but was unable to reach the back, which was flattened from being in bed. NA-D came back to get R105 and without saying anything audible, moved R105 to the dining room.
When interviewed on 1/29/14, at 9:30 a.m., R105 indicated she is used to the staff not telling her what steps they are performing before, during and after cares and stated, " You just adjust and tell yourself this is how it is. " R105 became teary

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F 241	Continued From page 9 eyed and stated " You just learn to adjust. I wish the staff would be more communicative but this is how it is." Asked R105 why didn't she tell staff about her facial hair that bothers her and she said, "Oh that is ok my daughter will be in soon, she's been sick a few days, they [staff] aren't that helpful with my teeth so I know it is best to just have my daughter take care of my whiskers." Asked R105 how she felt about staff using the waistband of her pants to position her in the chair and R105 indicated she did not like it but did not want to complain about it and restated, " You just adjust and tell yourself this is how it is. " The principal diagnosis for R105 from the plan of care lists multiple sclerosis, osteoporosis and unspecified pain. R105's BIMS, dated 11/6/13, was a 9 out of a possible 15 which indicates Cognitive skills are impaired and has difficulty making decisions. R105's plan of care dated 1/25/13, read; Cue, reorient and supervise as needed. Communicate with resident/family regarding resident's capabilities and needs. When interviewed on 1/31/14, at 9:30 a.m., registered nurse RN-B verified R3, R11, R46, R50, R73 and R105 were to have cares explained by staff. RN-B indicated the staff training for open communication is to inform the resident what you are going to do before you do it. If a resident is upset, to remove them from the situation and take the time to sit down with them and see what the concerns are. Make sure customer service makes them [residents] feel secure. Training to talk with residents and dementia training to approach people from the front, touch hand gently, not being quick or fast with actions, positive and presenting yourself in a way that is non-threatening or intimidating. When it comes to doing anything for the resident they	F 241		

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are to tell them before they do any cares.

RN-B further indicated facial hair is to be checked every day and if appropriate removed. Staff should make the offer to shave facial hair every day as a dignity issue for women.

All trained medication aides, nurses and nursing assistants have a transfer belt provided by the facility which is to be used for positioning. Resident waistbands are not a positioning device and are not to be used. The transfer belt is for positioning and transferring residents.

The facility did not have a specific policy addressing the actual feeding of the residents and engaging in conversation, nor was there a policy specifically that addressed informing the residents regarding cares. The education training for Alzheimer's dementia was requested but not received, which according to RN-B would cover these topics in training.

On 1/27/14 at 5:50 p.m. and 1/28/14 at 12:15 p.m. the meal and dining experience in the North dining room was observed. R3 sat at a large round table with 2 - 3 other residents that required assistance with feeding. Licensed practical nurse (LPN)-B began feeding R3, explained to the resident what food was on the plate and spoke to the resident during the meal. At 5:50 p.m. nursing assistant (NA)-H took over the feeding from LPN-B. NA-H did not explain to the resident what was happening except to tell the resident to open mouth when food was put near the resident's mouth. There was no other communication with the resident during the meal.

On 1/28/14 during meal observation at 12:15

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p.m., the food was delivered to R3's table at 12:35 p.m. NA-D began to feed R3 and beyond telling R3 to "open mouth", never explained what food was on the plate or provided any other conversation.

Review of the quarterly minimum data set (MDS) dated 10/29/13 revealed R3 had total cognitive impairment and the brief interview for mental status (BIMS) was not marked, as resident could not complete it.

The care plan dated 12/23/13 indicated impaired cognitive function, and directed staff to anticipate all of the residents needs, provide consistency and resident was total care.

On 1/30/14 at 11:30 a.m., family member (FM)-E, was interviewed regarding their experience of the dining experience when visiting R3. FM-E said that during meal times staff have been observed not explaining or talking to the residents during the meal.

On 1/31/14 at 8:25 a.m., during interview, NA-D indicated when feeding we are to talk to the residents even if confused and explain what we are giving them. When asked about the meal on 1/28/14, when NA-D was feeding the residents and not talking to them, NA-D indicated she thought she was talking to the residents.

On 1/31/14 at 9:30 a.m., during interview, registered nurse (RN)-B the inservice director revealed all staff are trained to inform and explain to the resident, even if confused, what you are going to do and always talk to the resident, to "treat people like you want to be treated" and to make sure residents can hear you without raising

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F 241	Continued From page 12 your voice. Use gentle touch, and carry on a conversation.	F 241		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow-up on the resident council recommendations to provide dignified dining experience for 4 of 15 (R9, R61, R92, R104) residents observed during meals on 1st floor south dining room. Findings include: Although timely meal service had been brought up at resident council meetings on several occasions, observations of R9, R61, R92, R104's lunch meals were served late on 01/28/14 and 01/29/14. Review of resident council minutes for November, December and January 2014 indicated the following: November 15, 2013, read, "A concern was made regarding the late start for meals. This happens on both north and 1st and it happens with all meals. Often times meals start at least 15	F 244	Plan of Correction F244-483.15 (c) (6) Listen/act on group grievance/recommendation Corrective Action 1. An updated procedure has been written for serving meals in all units that will ensure residents R9, R61, R92 and R104 will be served on time. 2. Meals will start at posted times in all units. 3. Those seated are served first and service will continue to other residents as they come into the dining room. 4. Dietary and nursing staffs will be educated on new procedure for serving in the dining rooms 5. Through completed audits R9, R61, R92 and R104 are being served on time.	3/10/14

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F 244	Continued From page 13 minutes late and residents are not in the dining room on time. Will inform nursing. Resident's said this seems to be improving." December 13, 2013, read, "A concern was made regarding the late start for meals. This happens on both north and 1st and it happens with all meals. Often times meals start at least 15 minutes late and residents are not in the dining room on time. Will inform nursing. Resident's said this seems to be improving." January 15, 2014, read, "A concern was made regarding the late start for meals. This happens on both north and 1st and it happens with all meals. Often times meals start at least 15 minutes late and residents are not in the dining room on time. RESOLVED." Althought the resident council minute notes for January 2014 stated this issue had been resolved, the resident council committe member indicated there had been no follow-up on this concern. The meal times for 1st south dining room were listed as: breakfast at 8:00 a.m., lunch at 12:00 noon and supper at 5:15 p.m. On 1/28/14 at 12:00 noon, during the lunch meal observation in 1st south dining room on 1/28/2014, 15 residents were observed waiting in the dining room for their meals. Dietary assistant (DA)-A was passing fluids and the steam table in the kitchenette held the food for the meal. Although the fluids were served by 12 noon, the meal was not served until 12:19 p.m., a 19 minute delay. R9 stated in a loud voice, "they don't give us our meal on time and we have to wait for it for a long time, and we come in the dining room	F 244	Other Residents 1. By following the updated procedure for serving the meals in the dining room 2. Education of dietary and nursing staff. Reoccurrence 1. Periodic audits will be completed to ensure that meals are starting at posted times. 2. Education of dietary and nursing staff. Monitored 1. Periodic audits will be completed 4 times per week for one month in random dining rooms and at random meal times for one month and then randomly to ensure compliance. Audits will be completed by the Director of Dietary Services, the Registered Dietitian or the Cook Supervisor. 2. Audits will be brought to the Quality Assurance Committee for further review as needed. Completed: 1. March 10, 2014	

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F 244	Continued From page 14 first." During interview with R9 on 1/28/14, at 12:25 p.m., R9 expressed their meals are late all of the time, typically the meal is served 15 minutes late. During an interview with R61 on 1/28/14, at 12:26 p.m. stated, "It does not matter because I am not hungry normally." During an interview with R92 on 1/28/14, at 12:27 p.m. stated, "We wait for more than 20 minutes depending on when you come into the diningroom." During an interview with R104 on 1/28/14, at 12:29 p.m. stated, "We wait at least 15 minutes every meal." During an interview with dietary aide (DA)-A on 1/28/2014 at 12:35 p.m. stated, "I start serving the fluids as residents come and start serving food when the nursing assistant comes in to the dining room." During the lunch meal on 01/29/14 at 11:45 a.m. observed 15 residents entering 1st south dining room. The staff did not start serving the meals until 12:16 p.m., however, the serving time for the meal was at 12:00 p.m. There was a 16 minute delay in the residents recieving their meals, again. During an interview with registered nurse (RN)-B on 1/31/2014, at 8:50 a.m., RN-B stated, there was no nurse manager on the first floor and the floor nurse needed to make sure the meals were served on time.	F 244	Plan of Correctiplan on F244-483.15 (c) (6) Listen/act on group grievance/recommendation Corrective Action a. As concerns are brought forth during the Resident Council meeting a concern form (GSS 213) will be filled out. b. Each concern will be numbered and documented on a Resident Council Concern Tracking sheet. c. Concerns forms will be given to Social Service Director, who will review and pass on to the appropriate department for follow up. d. After completion of investigation Social Service Director will return a copy of the completed concern form to Resident Council for follow up review at the monthly meeting. e. The above plan of correction was reviewed with R9, R61, R92 and R104, and they have agreed to the plan. R44 has since deceased. Other Residents a. Will address resident concerns, brought forward at the Resident Council meeting, and document on concern form with follow up at monthly Resident Council meeting. Reoccurrence a. As concerns are brought forth during	

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F 244	Continued From page 15 During an interview with license practical nurse (LPN)-A on 1/31/2014, at 8:52 a.m. stated, "The nursing assistants serve food trays, the dietary assistant has to wait until the nursing staff are present in the dining room to serve the meals." During an interview with nursing assistant (NA)-G on 1/31/2014, at 8:59 a.m., NA-G stated, one of the nursing assistants had to be in the dining room before the dietary staff served the food. She further explained they try to be there on time but it depended on what they were doing such as helping other residents and if none of the NAs were able to be in the dining room, then the nurse needed to help. During an interview with R44 on 1/31/2014, at 9:01 a.m. stated, sometimes the dietary staff have to serve the meal because nursing assistants were busy getting the residents up and transporting them into the dining room. R44 further explained, the food is normally served late in the dining room and if DA-A was in the dining room, she would ask the residents of their food preferences. R44 indicated they had brought up this issue during their resident council meetings, however, no follow-up had been done. During an interview with dietary director (DM) on 1/31/2014 at 3:41 p.m., DM explained, the food is normally in the dining room ready to be served, however, they have to wait for the nursing assistants to be in the dining room before dishing up the food so that the nursing assistants could serve the hot food to the residents. The policy and procedure, issued, 2/13, titled, "Guidelines MEAL SERVICES/DINING	F 244	the Resident Council meeting a concern form (GSS 213) will be filled out. b. Each concern will be numbered and documented on a Resident Council Concern Tracking sheet. c. Concerns forms will be given to Social Service Director, who will review and pass on to the appropriate department for follow up. d. After completion of investigation Social Service Director will return a copy of the completed concern form to Resident Council for follow up review at the monthly meeting. Monitored a. Audit the return of concern forms and resolutions prior to the monthly resident council meeting by using the Resident Council Tracking sheet. b. Audit will be brought to the Quality Assurance committee for further review as needed. Completion Date Completed by March 10, 2014	

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F 244	Continued From page 16 RESTAURANT-STYLE DINING", indicated, "4. Minimum Staffing. There will be adequate staff to complete meal service timely. The goal should be to serve each resident in 20 minutes or less depending on census and complexity of any special requests from the individual." Interview with family member (FM)-F was completed on 1/27/14 at 6:15 p.m. When asked about the meals and dining service, FM-F revealed that with certain meals the dietary staff come to the dining room and pour all the liquids first, which puts the start of the meal behind. FM-F stated the food sits in the steam table for 15-20 minutes and that the food is less tasteful when it sits for that long. FM-F indicated this has been a concern for some time and we thought it was resolved but it is not. FM-F further revealed the nursing assistants sometime stand around waiting for the server to complete pouring the liquids before serving of the meal begins and was wondering if something different could be done so that the meal could start on time.	F 244		
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 follow the care plan for	F 282	F282 483.20 (k)(3)(ii) Services By Qualified Persons/Per Care Plans:	3/10/14

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F 282	Continued From page 17 2 of 3 residents (R46, R101) observed for repositioning and toilet/incontinence needs. Findings include: R46 did not receive assistance with repositioning and incontinence care every 2 hours according to the plan of care. R46's care plan dated 12/11/13, directed staff, that R56 has a potential for pressure ulcer development and to, "Reposition with use of total-lift (Large repositioning sling) and assist of 2, q (every) 2 h (hour) in w/c (wheel chair), q 2-3 h in bed and PRN (whenever necessary)." The care plan also directed staff to, "Check for incontinence q2h and cleanse/change PRN." The nursing assistant assignment sheet directed staff to, "Resident is totally dependent on staff for toilet use. Is incontinent [sic] of B&B (bowel & bladder) with no awareness-check for incontinence q2h and cleanse/change PRN. Continuous observation of R46 on 1/29/14, from 8:00 a.m. until 11:50 a.m. (3 hours and 50 minutes) with no repositioning or incontinence care. When interviewed on 1/29/14, at 11:43 a.m. licensed practical nurse (LPN)-A verified R46 was to have a position change every two hours and incontinence check and care every two hours. When interviewed on 1/29/14, at 11:50 a.m. nursing assistant (NA)-B verified R46 was to have a position change every two hours and incontinence check and care every two hours and validated the care did not occur since 8:00 a.m. R101 did not receive assistance with	F 282	Corrective Action for residents R46 and R101 Re-education will be provided to specific staff members involved regarding following the care plan for repositioning, toileting and incontinence care. Audits for these two residents will be completed and then will be part of audits as outlined below. How to identify other residents with the same issue Weekly observational audits will be completed to ensure that residents are receiving cares as per care plan and that nursing assistants are providing toileting, repositioning and incontinence care interventions as per care plan with immediate re-education given as needed. Audits will continue as outlined below. Recurrence will be prevented by Re-education will be given to all nursing staff. Observational audits will continue as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse managers, and nurses will audit toileting, and repositioning cares provided by nursing assistants for accurately implementing care plan interventions weekly for one month, then monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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F 282	Continued From page 18 repositioning or toileting (incontinence care every two hours and when necessary according to the plan of care. R101's plan of care dated 12/20/13, directed staff, "Resident has potential for pressure ulcer development R/T (related to) compression fx. (fracture) of thoracic spine w/ (with) potential for pain and decreased mobility. Frequent repositioning. Check for incontinence q2h and cleanse/change PRN." Continuous observation of R101 on 1/29/14, from 7:00 a.m. until 12:00 p.m. (5 hours) there were no offers or attempts to reposition or provide incontinence care for R101. When interviewed on 1/29/14, at 11:43 a.m. licensed practical nurse (LPN)-A verified R101 was to have a position change every two hours and incontinence check and care every two hours. When interviewed on 1/29/14, at 11:50 a.m. nursing assistant (NA)-B verified R101 was to have a position change every two hours and incontinence check and care every two hours and validated the care did not occur since 7:00 a.m.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.	F 314		3/10/14

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F 314	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to prevent the development of additional pressure ulcers for 1 of 3 residents (R11) reviewed for pressure ulcers and failed to provide repositioning every two hours for 2 of 3 residents R46 & R101 observed who were at risk for developing pressure ulcers. Findings include: R11 did not receive care and services to prevent a re-occurrence of a pressure ulcer on the coccyx. R11's Minimum Data Set (MDS) skin assessment from 2/11/13 addresses the coccyx area on the admission MDS as scar tissue over a bony prominence. R11's Brief Interview for Mental Status (BIMS) dated 11/11/13, indicated a score of 3 out of a possible 15 (cognitive skills are impaired, rarely/never able to make self understood). The form titled Braden Scale for Predicting Pressure Sore Risk and dated 11/11/13, indicated mild risk currently for developing pressure ulcers. R11's medical record progress notes identified a coccyx open area on 2/14/13 and healed 3/31/13. Re-occurrence of an opened coccyx area on 5/23/13 and healed 7/14/13. Currently open area to coccyx noted 1/27/14 at 5:45 p.m. as verified by nursing assistants (NA)-F and NA-H. The open area was not addressed by licensed practical nurse (LPN)-A or registered nurse (RN)-A until 1/29/14, at 11:00 a.m.	F 314	F314 483.25(c)Treatment/SVCS to Prevent/Heal Pressure Sores: Corrective Action for resident R11 A comprehensive skin assessment of the open area will be completed. Preventive measures will be in place to prevent any further skin issues. Care plan will be reviewed and updated. Nursing assistants and LPNs caring for this resident will be re-educated on commode placement and making sure resident is comfortable. Resident has received a new commode which is more comfortable. Corrective Action for residents R46 and R101 Re-education will be provided to specific staff members involved regarding following the care plan for repositioning, toileting and incontinence care. Audits for these two residents will be completed and then will be part of audits as outlined below. How to identify other residents with the same issue All residents will receive a comprehensive skin assessment with their quarterly MDS to determine risks and interventions to prevent pressure ulcer development. Weekly observational audits will be completed to ensure that residents are receiving cares for toileting, repositioning and incontinence care interventions as	

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F 314	Continued From page 20 R11's plan of care dated 3/22/13 read, "Resident has potential for pressure ulcer development R/T (related to) CVA (cerebral vascular accident) with weakness and immobility, Protein Calorie Malnutrition, Dementia w/ (with) potential for poor nutrition/wt.loss and overall decline as condition progresses, Anemia, Edema of L/E (lower extremity) Incontinence of B&B (bowel and Bladder)" Interventions include to "Assist to reposition at least every 2 hours and PRN (whenever necessary), per resident request. Reposition with 1-2 assist. Avoid positioning resident on coccyx due to previous ulcer; use body pillow for positioning." Progress notes address on 2/14/13, at 12:59 p.m. contacted daughter regarding open area on coccyx and informed of treatment order. Progress notes on 2/23/13 read "Tx (treatment) o/a (open area) on coccyx and Butt [sic] paste q (every) shift and p (after) incontinence. Progress notes 3/31/13, o/a to coccyx has remained healed since 3/31/13. Progress notes on 5/23/13 read, "Weekly wound rounds; res (resident) has had reoccurrence of o/a to coccyx; 1x0.2 cm,(centimeter) superficial. Dtr (daughter) provides butt paste that she/res prefer to use as tx (treatment) RNP (registered nurse practitioner) updated via voice mail. Care plan updated. Progress notes on 7/14/13, @ 4:00 p.m. read, "Area on coccyx remains but is superficial with scar tissue present; receive Buttpaste to area as ordered." Progress notes dated 1/29/14 at 1:59 indicated, Recurrent open area to coccyx this a.m. Had previously healed in July 2013. Area is superficial 0.8 x 0.2 with surrounding white, macerated skin 2 x 1.5 centimeter. Will continue with buttpaste four times a day and whenever	F 314	per care plan with immediate re-education given to staff as needed. Audits will continue as outlined below. Recurrence will be prevented by Re-education will be given to all nursing staff. Observational audits will continue as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse managers, and nurses will audit toileting, incontinence care, and repositioning provided by nursing assistants for accurately implementing care plan interventions weekly for one month, then monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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necessary. Will encourage side lying in bed on pressure redistribution mattress and body pillow. Cushion in wheel chair, nutritional dietary supplement 2 oz ounces everyday.

The principal diagnosis from the form titled Admission Record dated 2/4/13, lists vascular dementia and generalized pain.

R11's plan of care dated 2/4/13 direced staff to provide resident with necessary cues, present just one thought, idea, question or command at a time and to redirect, reassure as needed.

During observation on 1/27/14, at 5:45 p.m. R11 was sitting on the commode in her bedroom calling out for help. Nursing assistant (NA)-F said to R11, "You are on the commode, go ahead and push it." R11 was complaining, "It hurts so bad sitting on this." NA-F and NA-H were present but did not acknowledge R11's complaints of pain nor did they attempt to reposition R11 on the commode. NA-H stated, "She doesn't like the commode." After washing the coccyx area, and as R11 was lifted with the mechanical stand, an open area to coccyx was visualized on the gluteal crease. NA-F stated, "The wound is getting better than it had been, the nurse will have to put on the Butt paste, that helps, they know about this."
During observation on 1/29/14, at 7:00 a.m. R11 was transported by mechanical lift to the commode by NA-B and NA-D. R11 was complaining of pain sitting on the commode. R11 stated, "It really hurts." Referring to coccyx area but unable to describe the pain. At 7:40 a.m. NA-B turned on the call light for the nurse to come and treat the coccyx area. Licensed practical nurse (LPN)-A came into the room to

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apply Butt paste. The nurse was informed R11 is complaining of pain and LPN-A stated, "She always does." Prior to the nurse treating the coccyx area, surveyor asked her to take a closer look at the coccyx area to determine if it was open. LPN-A revealed the resident would need to lay down so she could get a better look at the coccyx area after breakfast. R11 revealed the area on her bottom had, "Cooled down now." and validated it felt better after the treatment.
NA-B used R11's slacks waistband to pull her into position in the wheel chair. Questioned NA-B as to why the waistband of the slacks was used and he stated, "That is how we position them in the chair." When asked about friction and shearing, NA-B and NA-D shrugged shoulders and NA-B stated, "This is how we do it."
Observation on 1/29/14, at 11:00 a.m. of LPN-A and registered nurse (RN)-A measuring the open area on R11's coccyx and treating with Buttpaste. Interview with LPN-A and RN-A verified the area to the coccyx had re-opened.

R46 was at risk for skin breakdown and did not receive assistance to reposition every two hours on 1/29/14, from 8:00 a.m. until 11:50 a.m. (3 hours and 50 minutes).

R46's principal diagnosis from the form dated 4/14/05, titled "Admission Record" lists Alzheimer's disease, anxiety state and generalized pain.

R46's BIMS dated 1/14/14, indicated a score of 3 out of a possible 15 (cognitive pattern is rarely/never understood). The form titled Braden Scale for Predicting Pressure Sore Risk and dated 1/14/14, indicated moderate risk currently for developing pressure ulcers.

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R46's care plan dated 12/11/13, directed staff, that R46 has a potential for pressure ulcer development and to, "Reposition with use of total-lift (Large repositioning sling) and assist of 2, q (every) 2 h (hour) in w/c (wheel chair), q 2-3 h in bed and PRN (whenever necessary)." The care plan also directed staff to, "Check for incontinence q2h and cleanse/change PRN." The nursing assistant assignment sheet directed staff to that R46 was totally dependent on staff for toilet use. Is incontinent bowel & bladder with no awareness-check for incontinence every two hours and cleanse/change as needed.

During continuous observation on 1/29/14, from 8:00 a.m. until 9:10 a.m. R46 was seated in the Broda chair with a pressure relieving cushion and was fed 100% of breakfast food and fluids. At 9:10 a.m. R46 was moved in the chair to the piano/television area of the dining room. At 9:40 a.m. NA-A moved R46 from the piano/television area of the dining room and was taking her down the hallway when an activity person asked if she could take R46 to the first floor chapel area for an activity. There was no offer to re-position R46. From 9:45 a.m. until 10:45 a.m. R46 attended music/piano, chapel service. At 10:50 a.m. R46 was returned from the activity, taken to bedroom and set in front of television from 10:55 a.m. until surveyor informed LPN-A at 10:43 a.m. R46 has not had a position change since prior to 8:00 a.m. At 11:50 a.m. NA-A and LPN-A using the mechanical lift were able to lay R46 in bed by 12:00 p.m. R46 was incontinent of urine and stooling. NA-A verified the incontinence brief was from the night shift as it was the blue nighttime brief. LPN-A and NA-A verified R46 had deep craters and crevices to her buttocks and thighs

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F 314	Continued From page 24 from sitting up and from the pressure of the incontinence brief. When interviewed on 1/29/14, at 11:43 a.m. licensed practical nurse (LPN)-A verified R46 was to have a position change every two hours and incontinence check and care every two hours. When interviewed on 1/29/14, at 11:50 a.m. nursing assistant (NA)-B verified R46 was to have a position change every two hours and incontinence check and care every two hours and validated the care did not occur since getting up just before 8:00 a.m. R101 was at risk for skin breakdown and did not receive assistance to reposition every two hours on 1/29/14, from 7:00 a.m. until 12:00 p.m. (5 hours). R101's principal diagnosis from the form dated 9/7/12, titled "Admission Record" lists Alzheimer's disease, peripheral neuropathy, osteoporosis and osteoarthrosis of lower leg. R101's BIMS dated 12/19/13, indicated a score of 3 out of a possible 15 (cognitive pattern is rarely/never understood). The form titled Braden Scale for Predicting Pressure Sore Risk and dated 12/19/13, indicated moderate risk currently for developing pressure ulcers. R101's plan of care dated 12/20/13, directed staff, "Resident has potential for pressure ulcer development R/T (related to) compression fx. (fracture) of thoracic spine w/ (with) potential for pain and decreased mobility. Frequent repositioning. Check for incontinence q2h and cleanse/change PRN."	F 314		

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During continuous observation of R101 on 1/29/14, at 7:00 a.m. until 8:00 a.m. sat in a specialty wheelchair with cushion at the dining room table until 8:00 a.m., when beverages were served by the dietary aide. At 8:25 a.m. R101 received breakfast and at 9:00 a.m,. R101 was moved to the piano/television area of the dining room and remained in this area until 9:40 a.m., when taken to the first floor chapel area for a music/piano service. R101 remained seated in the specialty chair with no offer to change position. At 10:45 a.m. R101 was taken to her bedroom and set in front of the bed. At 11:30 a.m. NA-A took R101 to the dining room. At 11:40 a.m. surveyor informed LPN-A there had been no position change for R101 since getting up at 7:00 a.m. At 12:05 p.m. R101 was laid in bed with the use of the mechanical lift by NA-A and NA-B. R101 was incontinent of urine and bowel. The skin surrounding the buttocks and thighs had deep craters and crevices. R101 did not complain of pain.

When interviewed on 1/29/14, at 11:43 a.m. licensed practical nurse (LPN)-A verified R101 was to have a position change every two hours and incontinence check and care every two hours. When interviewed on 1/29/14, at 11:50 a.m. nursing assistant (NA)-B verified R101 was to have a position change every two hours and incontinence check and care every two hours. Interviews on 1/29/14, at 12:15 p.m. with NA-A, NA-B and NA-D verified R101 did not have a position change since prior to 7:00 a.m.

The facility policy and procedure titled Pressure Ulcer Skin Assessment and Prevention dated September 2012, read Residents who are unable to reposition themselves independently should be

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F 314	Continued From page 26 repositioned as often as directed the the care plan approaches.	F 314		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to check/change or offer toileting every two hours for 2 of 3 residents (R46, R101) observed who were dependent on others for incontinence care. Findings include: R46 was at risk for incontinence and assessed to be totally dependent on staff to check and change every two hours. R46 was observed on 1/29/14, from 8:00 a.m. until 11:50 a.m. (3 hours and 50 minutes) without being checked/changed. R46's principal diagnosis from the form dated 4/14/05, titled "Admission Record" lists Alzheimer's disease, anxiety state and generalized pain.	F 315	F315 483.25(d) Prevent UTI Corrective Action for residents R46 and R101 Re-education will be provided to specific staff members involved regarding following the care plan for repositioning, toileting and incontinence care. Audits for these two residents will be completed and then will be part of audits as outlined below. How to identify other residents with the same issue Weekly observational audits will be completed to ensure that residents are receiving cares as per care plan and that nursing assistants are providing toileting, repositioning and incontinence care	3/10/14

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F 315	Continued From page 27 R46's BIMS dated 1/14/14, indicated a score of 3 out of a possible 15 (cognitive pattern is rarely/never understood). R46's care plan dated 12/11/13, directed staff to, "Check for incontinence q2h and cleanse/change PRN." The nursing assistant assignment sheet directed staff to, "Resident is totally dependent on staff for toilet use. Is incontinent of B&B (bowel & bladder) with no awareness-check for incontinence q2h and cleanse/change PRN. During continuous observations on 1/29/14, from 8:00 a.m. until 9:10 a.m. R46 was seated in the Broda chair and was fed 100% of breakfast foods and fluids. At 9:10 a.m. R46 was wheeled in the chair to the piano/television area of the dining room. At 9:40 a.m. NA-A wheeled R46 from the piano/television area of the dining room and was taken down the hallway, when an activity person asked if she could take R46 to the first floor chapel area for an activity. There was no offer to check/change R46 for incontinence. From 9:45 a.m. until 10:45 a.m. R46 attended music/piano chapel service. At 10:50 a.m. R46 was returned from the activity, taken to her bedroom and set in front of the television from 10:55 a.m. until surveyor informed LPN-A at 10:43 a.m. R46 has not been checked/changed for incontinence prior to 8:00 a.m. At 11:50 a.m. NA-A and LPN-A using the mechanical lift were able to lay R46 in bed by 12:00 p.m. R 46 was incontinent of urine and loose bowel movement. NA-A verified the incontinence brief was from the night shift as it was the blue nighttime brief. LPN-A and NA-A verified R46 had deep red craters and crevices to her buttocks and thighs from sitting up and from the pressure of the incontinence brief.	F 315	interventions as per care plan with immediate re-education given as needed. Audits will continue as outlined below. Recurrence will be prevented by Re-education will be given to all nursing staff. Observational audits will continue as outlined below. These issues will be monitored in the following manner The Director of Nursing, Nurse managers, and nurses will audit toileting, and repositioning cares provided by nursing assistants for accurately implementing care plan interventions weekly for one month, then monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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The quarterly Minimum Data Set (QMDS) dated 10/22/13, indicated R46 required total lift and extensive assistance of two staff for incontinence and to be on a check and change every two hours schedule.

When interviewed on 1/29/14, at 11:43 a.m. licensed practical nurse (LPN)-A verified R46 was to have a incontinence check/change every two hours.

When interviewed on 1/29/14, at 11:50 a.m. nursing assistant (NA)-B verified R46 was to have a incontinence check and care every two hours and validated the care did not occur since getting up just before 8:00 a.m.

101's principal diagnosis from the form dated 9/7/12, titled "Admission Record" lists Alzheimer's disease, peripheral neuropathy, osteoporosis and osteoarthrosis of lower leg.

R101's BIMS dated 12/19/13, indicated a score of 3 out of a possible 15 (cognitive pattern is rarely/never understood).

R101's plan of care dated 12/20/13, directed staff, "Resident has potential for pressure ulcer development R/T (related to) compression fx. (fracture) of thoracic spine w/ (with) potential for pain and decreased mobility. Check for incontinence q2h and cleanse/change PRN."

During continuous observation of R101 on 1/29/14, at 7:00 a.m. until 8:00 a.m., R101 sat in a specialty wheelchair and cushion at the dining room table until 8:00 a.m. when beverages were served by the dietary aide. At 8:25 a.m. R101

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F 315	Continued From page 29 received breakfast mealand at 9:00 a.m. R101 was moved to the piano/television area of the dining room and remained in this area until 9:40 a.m., when taken to the first floor chapel area for a music/piano service. R101 remained seated in the specialty chair with no offer to change position. At 10:45 a.m. R101 was taken to her bedroom and set in front of the bed. At 11:30 a.m. NA-A took R101 to the dining room. At 11:40 a.m. surveyor informed LPN-A there had been no position change for R101 since getting up at 7:00 a.m. At 12:05 p.m. R101 was laid in bed with the use of the mechanical lift by NA-A and NA-B. R101 was incontinent of urine and bowel. The skin surrounding the buttocks and thighs had deep craters and crevices. R101 did not complain of pain. When interviewed on 1/29/14, at 11:43 a.m. licensed practical nurse (LPN)-A verified R101 was to have a position change every two hours and incontinence check and care every two hours. When interviewed on 1/29/14, at 11:50 a.m. nursing assistant (NA)-B verified R101 was to have a incontinence check and care every two hours. Interviews on 1/29/14, at 12:15 p.m. with NA-A, NA-B and NA-D verified R101 did not have a position change since prior to 7:00 a.m. The facility document dated September 2012, and titled "Bladder Assessment" indicated an individualized toileting plan would be developed for each resident and the care plan would be developed for interventions for elimination.	F 315		
F 323 SS=D	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident	F 323		3/10/14

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F 323	Continued From page 30 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 interview and document review, the facility failed to effectively analyze the risk associated with falling and to monitor the effectiveness of fall interventions for 1 of 3 residents (R101) reviewed for accidents. Findings include: Review of the admission record for R101 revealed that the resident had been admitted to the facility with diagnoses that included, but were not limited to: Alzheimers, osteoarthrosis of the lower legs and peripheral neuropathy. Review of the Minimum Data Set (MDS) dated 9/19/13, revealed that R101 had 2 falls during the quarter and the Brief Interview for Mental Status (BIMS) dated 12/19/13, was a 3 out of a possible 15 indicating severe cognitive impairment and never/rarely was able to make self understood. Review of plan of care for R101 regarding fall risk read,"*Resident at risk for falls d/t (due to)weakness and cognitive impairment." and the intervention read, "Sensor alarm placed on bed and TABS alarm in chair and bed for safety d/t restlessness, confusion and safety concerns-check alarm function and placement q (every) shift. Dycem in w/c (wheel chair) to keep	F 323	F323 483.25(h) Free of Accident Hazards/Supervision/Devices Corrective Action for residents R101 R101 will receive a thorough analysis of the risk for falls, including a fall risk assessment and an interdisciplinary review of past falls. Care plan has been reviewed and updated. Staff will monitor the effectiveness of fall interventions with the use of an audit to make sure that interventions are in place and effective to help prevent falls. How to identify other residents with the same issue All residents will have a fall risk assessment completed upon admission, quarterly and each time there is a fall. The care plan will have fall interventions in place, which will be updated as needed. An Interdisciplinary Review of Falls will be completed after each fall so that a thorough analysis of each fall, including precipitating events and potential interventions aimed at prevention of future falls will take place. Recurrence will be prevented by	

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F 323	Continued From page 31 resident from slipping." Revision on 12/13/13. Review of the fall incidents from 7/4/13 to 1/9/14, revealed the following incidents: On 7/4/13, at 11:38 a.m. R101 according to the Incident Description read, " Found pt (patient) sitting on floor, next to the bed, shoes on, facing head of bed." R101 was unable to give any explanation and no injuries observed. On 7/7/13, at 11:48 a.m. R101 according to the Incident Description read, "NA R (nursing assistant, registered) went to get resident for lunch and found her sitting on her buttocks next to bed, legs out in front of her, one shoe on one off. Resident states she was reaching over to put her paper in her drawer and then down she went out of the chair on to the floor. Also stated she didn't get hurt or hit her head." The 7/4/13 and 7/7/13 incidents were combined in the Fall Risk Evaluation report and read, "Resident continues to be high risk for falls d/t (due to) immobility and significant cognitive impairment, with very poor judgement, little to no safety awareness and agitation noted-she has had 2 falls in the past 7 days with no injuries noted. Resident now has TABS alarm present when in w/c (wheel chair) and bed, to alert staff to any movement or self transfer attempts." The third fall in 6 months was documented 1/9/14, at 6:46 a.m. and read, "Writer entered resident's room and resident was kneeling by her bed side facing the door, head and hands on bed. When writer asked resident what was going on, resident stated she was saying her morning prayers. Resident then asked writer to give her a	F 323	Re-education will be given to all nursing staff. Audits will continue as outlined below. These issues will be monitored in the following manner The Director of Nursing, and Nurse Managers will complete audits regarding thorough analysis of the fall risk assessment completion, interdisciplinary fall review, care plan interventions, and effectiveness of these interventions weekly for one month, then monthly for one quarter, and then quarterly. The Quality Improvement team will continue to use the point click care system to look for trends in fall location, time, date, risk factor management and potential root cause. Audit results will be brought to the quality assurance committee for further review as needed.	

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few minutes to finish her prayers. Writer then stepped out for a few minutes." The Fall Risk Evaluation read, "Resident was found on the floor, kneeling by the side of her bed-she reported to staff that she was "praying" {sic} and asked that they leave her alone until she was finished. Resident really doesn't have the cognitive awareness to know what she's doing, and most likely became restless/agitated, climbed or fell out of bed, and this is the reason she gave staff for being on the floor, when questioned. Nurse that was taking care of resident was one that is unfamiliar with this resident nd her significant cognitive impairment. Resident requires use of total-lift and 2 assist for all transfers, 1 assist for all w/c mobility. POC (plan of care) already in place to address resident's risk for falls/impaired mobility-POC reviewed and remains appropriate to resident s needs/status at this time-will continue with POC."

When interviewed on 1/30/14, at 12:07 p.m. the director of nursing (DON) verified the three falls for R101 did not address precipitating events to help prevent falls in the future by addressing the activity of R101 prior to the fall. Information was not available regarding prevention with precipitating factors associated with the resident toileting, positioning, pain medication use and observation of anxiety level prior to the three falls. There was not an assessment of the Sensor alarm or the TABS alarms at the time of the 1/9/14 fall. The DON stated, "There was a glitch in the Point Click Care computer system in gathering the information and assessing each fall individually and the nurse doing the assessments knew the residents very well but did not transfer her knowledge of the resident to the resident assessment."

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F 323	Continued From page 33 The facility policy titled, Prevention and Management of Falls and dated September 2012, under Risk Evaluation read, "Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current standards of practice." The Falls Committee section read, "The interdisciplinary Team should perform an analysis of the precipitating events for individual resident falls and evaluate potential interventions aimed at prevention of future falls. In addition, this team should perform ongoing systemic evaluation to determine the efectiveness of the Falls Prevention Program." And the Quality Improvement section from the Prevention and Management of Falls read, "The Quality Improvement team should utilize the tools available within PCC (Point Click Care) to look for trends in Falls location, time and date, risk factor management and potential root cause."	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug	F 329		3/10/14

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F 329	Continued From page 34 therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to adequately identify, assess, and monitor clinical indications for continued use of medications for 2 of 5 residents (R32, R28) in the sample who received psychopharmacological medications. Findings include: R32 was reviewed for unnecessary medications and the following concerns were identified. The registered nurse practitioner (RNP) notes dated 1/21/14 revealed R32 was being started on Abilify 5 mg daily (an antipsychotic) as an adjunct to the Effexor ER 300 mg (antidepressant) which the resident was receiving daily since 9/18/12. There was no indication another antidepressant had been tried or non pharmacological interventions were tried. R32 was receiving Prochlorperazine (Compazine) 10 mg everyday (qd) for nausea and vomiting since 4/10/13 with no indication there had been any problems with nausea and vomiting. Trazodone 50 mg for sleep had been started on 12/26/13 with no indication that a sleep study had been performed prior or any other non	F 329	F329 483.25(l) Drug Regimen Review Is Free From unnecessary Drugs: Corrective Action for residents R32, R28 Administrator and Director of Nursing met with Medical Director on 2-26-14. Physician visit and psychoactive medication review was completed for R32 Nurse Practitioner visit and psychoactive medication review was completed for R28. Care plan was reviewed and updated and plan is in place to adequately identify, assess and monitor clinical indications for use of psychoactive medications for R32 and R28. Sleep assessment was completed for R32. Clinical monitoring for the continued use of psychoactive medications and side effects per facility policy will be ongoing. How to identify other residents with the same issue All residents who use psychoactive medications will have an interdisciplinary assessment to identify, assess, and	

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F 329	Continued From page 35 pharmacological interventions had been tried. R32 was admitted to the facility 1/19/09 with diagnoses of Parkinson's Disease, Dementia, and depression. During observation on 1/27/14 at 5:45 p.m. R32 was observed at meals and was observed with hand tremors. During interview on 1/27/14 at 6:15 p.m. with family member (FM)-F present R32 indicated she had tremors from her Parkinson's and sometimes they are worse as the day progresses. She denied any problems with nausea or vomiting. R32 was on Prochlorperazine (Compazine) 10 mg qd (everyday) for nausea and vomiting and had been receiving the medication since 4/2013. The medical record did not indicate the resident had any problems with nausea and vomiting. The Nursing Drug Handbook 2005, indicated use with caution in patients with Parkinson's Disease as it may cause extrapyramidal reactions (abnormal movements) and may aggravate Parkinsonian symptoms. The drug handbook also indicated the drug should be used only when vomiting cannot be controlled by other measures, or when only a few doses are needed. The registered nurse practitioner (RNP) notes dated 9/18/13, 10/22/13, 12/26/13 and 1/21/14 did not identify the continued need for the medication. The nurses notes dated 10/7/13 through 1/29/14 indicated no nausea or vomiting. R32 had recently (1/22/14) started on Abilify (an antipsychotic) 10 mg daily as a adjunct for the 300 mg of Venlafaxine (Effexor ER) as patient had major depressive disorder. R32 had been on Seroquel 12.5 mg qd which was discontinued on 8/22/13. The nurses notes dated 10/7/13 through 1/29/14 indicated no behavior problems, no	F 329	monitor clinical indications for continued use of psychoactive medications along with side effect monitoring upon admission, quarterly, and with change of condition. Medications will be reviewed quarterly, and with change of condition for reduction. Recurrence will be prevented by Re-education to nurses and social service will be provided. Administrator and Director of Nursing met with the consultant pharmacist to review deficiencies and pharmacy expectations for monthly reviews on 2-25-14. Consultant pharmacist and interdisciplinary team will meet monthly for gradual dose reduction. These issues will be monitored in the following manner Director of Nursing, Social Service and designees will complete quarterly audits to review residents who use psychoactive medications to monitor that there are ongoing assessments to adequately identify, assess, and monitor clinical indications as well as side effects for continued use of medications. Audits will be brought to the quality assurance committee for further review and recommendation.	

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problems with depression.

The most recent quarterly minimum data set (MDS) dated 11/13/13 indicated the resident had a score of 2 on mood score. She had slight problem with sleeping and concentration from 2-6 days. The Brief Interview for Mental Status (BIMS) dated 11/13/13 indicated R32 scored a 6 on a scale of 0-15, which indicated cognitive issues. There was no identified behavior issues. The plan of care (POC) dated 11/13 indicated R32 had impaired cognition, behavioral disturbances, anxiety, depression, mood problem, anger, sad/worried expressions, negative statements and insomnia. The POC directed staff to monitor, document, redirect, reassure. Keep resident's routine consistent. Administer medications, allow resident to talk and express feelings. The POC does not address the issue of nausea/vomiting.

Seen by Psychiatrist 1/28/14 however the notes from the RNP visit on 1/21/14 regarding the Abilify had not been given to the psychiatrist. The psychiatrist suggested a switch from the Effexor ER to Remeron to improve sleep and he suggested light therapy to improve mood and manage insomnia. He suggested to discontinue the Trazodone.

1/30/14 at 3:50 p.m., RN-E was interviewed and indicated there was nothing in the medical record about the resident having problems with nausea and vomiting. She also indicated if there was any nonpharmacological interventions tried prior to the starting of the medications, Abilify and Trazodone, they would be documented in the nurses notes. She was unable to find anything. RN-E also indicated a sleep study should have

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been completed to assess the resident for possible non pharmacological interventions, however, no sleep study could be located.
The Medical Director (MD)-B was interviewed on 1/30/14 at 4:50 p.m., MD-B also happened to be the physician for R32 and indicated the continued need for Compazine had been assessed but was unsure if there was any documentation to provide for the continued need for the medication. MD-B indicated the Abilify was started as an adjunct to the Effexor and the Trazodone was started for insomnia, but was unsure whether there was any non pharmacological interventions prior to the starting of the Abilify and the Trazodone. She agreed that non pharmacological interventions should be tried prior to starting resident on medications.
On 1/31/14 at 3:00 p.m. the pharmacist (P)-D was interviewed and indicated Abilify is being used more frequently as adjunctive therapy but usually only after resident had been on two different medications and failed to respond to therapy. He was thinking the Compazine was PRN (as needed). He agreed that Compazine had side effects that could aggravate the Parkinson's and cause abnormal movements. If the resident was not having nausea and vomiting the continued use of Compazine should be assessed. He also said the number one choice would always be to use nonpharmacological interventions.

Documentation was lacking in the record for R28 related to consistent side effect monitoring for the use of the antipsychotic medication, Seroquel and antidepressant, Remeron.

R28 was admitted to the facility on 06/19/2013 and had diagnoses that included: depressive

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disorder, delusional disorder, dizziness and giddiness, muscle weakness, congestive heart failure, stroke, diabetes and chronic kidney disease. R28's medication regimen included the medications: remeron 15 milligrams (mg) tablet daily; Seroquel 12.5 mg daily; 25 mg daily at bedtime; Seroquel 25 mg every 24 hours as needed.

Documentation in a nurse practitioner progress note on 11/22/13, listed R28 assessment/plan as: vascular dementia with paranoia and delusions, "failed trial dose reduction to the Seroquel increase back to 25 mg bid due to recent issues with hallucinations".

On 01/29/14 at 11:00 a.m. R28 verbalized she was experiencing sudden jerky movements intermittently and upset stomach. R28 felt the jerky movements and upset stomach was due to her multiple medications. R28 stated the nurses were told about these issues and she did not know if there was anything being done about her concerns.

On 01/30/14 at 12:00 p.m. Licensed Social Worker (LSW)-A reviewed R28's computerized medical record and stated R28 was stared on Seroquel 25 mg twice daily on 11/10/12. An attempt to decrease the dose to 25 mg daily and 12.5 mg every evening was conducted on 09/27/12; however, the resident stared hallucinating bugs crawling on her and accused staff of taking her belongings. Therefore, Seroquel was increased to 25 mg twice daily. Another gradual dose reduction was attempted on 01/09/14 to 25 mg daily and 12.5 mg every evening, stated LSW-A.

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On 01/30/14 at 12:15 p.m. Licensed Practical Nurse (LPN)-A indicated they document side effects of medications for the resident only if they observe any changes to the residents normal pattern. LPN-A indicated she knew the residents on the unit and R28 had not exhibited any changes in her health conditions. LPN-A stated they documented by exception and if there were any changes observed in a resident's health status that would be documented in weekly nursing notes in the computer. Further, LPN-A added she was not aware of R28's concerns regarding upset stomach or the jerky movements.

On 01/30/14 at 5:00 p.m. LSW-A indicated there were no documentation in the progress notes of R28's medication side effect monitoring. LSW-A indicated the nurses document only if they observe if there were any changes in a resident's health status.

On 01/31/14 at 8:45 a.m. Registered Nurse, Director of Nursing (DON) stated the new computerized system did not have a specific form for the medication side-effect monitoring like their old paper system did. DON stated this gets missed and it was difficult to know if the nurses were documenting on medication side-effect monitoring. In addition, DON stated the staff was learning the computer system and may need additional training on where to document medication side effects.

On 01/31/14 at 2:35 p.m. consulting pharmacist (P)-D indicated R28 just recently had a gradual dose reduction and an Abnormal Involuntary Movement Scale (AIMS) was done on 12/20/13 which indicated R28 did not exhibit any spontaneous movements. P-D indicated he was

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F 329	Continued From page 40 not aware of R28 voicing concerns regarding jerky movements or upset stomach and the staff needed to monitor and document medication side-effects consistently. The facility policy/procedures, revised 01/2014, titled, "Administration of Medication," directed staff to be familiar with action and adverse reactions of medications by utilizing a Drug Handbook. In addition, it directed staff to observe and document any adverse reactions.	F 329		
F 428 SS=D	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure the consultant pharmacist identified irregularities related to lack of clinical indications and monitoring for continued use of medications for 2 of 5 residents (R32, R28) whose medications were reviewed. Findings include: The facility's consulting pharmacist lacked	F 428	F428 483.60(c) Drug Regimen Review.. Corrective Action for residents R32 R28 The facility□s Administrator and Director of Nursing will met with the pharmacist on 2-25-14 to discuss identifying irregularities related to lack of clinical indications and monitoring for continued use of medications for R32 and R28. Pharmacist will review R32 and R28 with next Drug	3/10/14

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F 428	Continued From page 41 documentation on monitoring of medications for R32 who was receiving Prochlorperazine (Compazine) 10 mg everyday (qd) for nausea and vomiting since 4/10/13 with no indication there had been any problems with nausea and vomiting. R32 was admitted to the facility 1/19/09 with diagnoses of Parkinson's Disease, Dementia, and depression. During observation on 1/27/14 at 5:45 p.m. R32 was observed at meals and was observed with hand tremors. During interview on 1/27/14 at 6:15 p.m. with her husband present she indicated she had tremors from her Parkinson's and sometimes they are worse as the day progresses. She denied any problems with nausea or vomiting. R32 was on Prochlorperazine (Compazine) 10 mg qd (everyday) for nausea and vomiting and had been receiving the medication since 4/2013. The medical record did not indicate the resident had any problems with nausea and vomiting. The Nursing Drug Handbook 2005, indicated use with caution in patients with Parkinson's Disease as it may cause extrapyramidal reactions (abnormal movements) and may aggravate Parkinsonian symptoms. The drug handbook also indicated the drug should be used only when vomiting cannot be controlled by other measures, or when only a few doses are needed. The registered nurse practitioner (RNP) notes dated 9/18/13, 10/22/13, 12/26/13 and 1/21/14 do not identify the continued need for the medication. The nurses notes dated 10/7/13 through 1/29/14 indicated no nausea or vomiting. The pharmacy notes dated from 6/3/13 through 1/16/14 do not assess the use of the Compazine	F 428	Regimen Review. Clinical monitoring for the continued use of psychoactive medications and side effects will be ongoing. R32 and R28 have been assessed for mood and behaviors and care plan has been updated. Sleep assessment was completed for R32. Administrator and Director of Nursing met with Medical Director on 2-26-14. Physician visit and psychoactive medication review was completed for R32 Nurse Practitioner visit and psychoactive medication review was completed for R28. Care plan was reviewed and updated and plan is in place to adequately identify, assess and monitor clinical indications for use of psychoactive medications for R32 and R28. How to identify other residents with the same issue All residents will be assessed for mood and behaviors and addressed on care plan as indicated. All residents in the facility will have mood and behaviors monitored per facility policy. Residents with psychotropic medications will be monitored for side effects per facility policy. The pharmacist will review monthly the drug regimen of each resident, and report these to the physician and director of nursing. The facility will monitor that these are acted upon. Gradual dose reductions will be completed per policy and per orders for all residents as indicated. Recurrence will be prevented by Re-education to nurses and health	

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F 428	Continued From page 42 or any problems with nausea and vomiting. 1/30/14 at 3:50 per RN-E was interviewed and she indicated there was nothing in the medical record about the resident having problems with nausea and vomiting. On 1/31/14 at 3:00 p.m. the pharmacist (P)-D was interviewed. He was thinking the Compazine was PRN (as needed). He agreed that Compazine had side effects that could aggravate the Parkinson's and cause abnormal movements. If the resident was not having nausea and vomiting the continued use of Compazine should be assessed. He also said the number one choice would always be to use nonpharmacological interventions. Documentation was lacking in the record for R28 related to consistent side effect monitoring for the use of the antipsychotic medication, Seroquel and antidepressant, Remeron. R28 was admitted to the facility on 06/19/2013 and had diagnoses that included: depressive disorder, delusional disorder, dizziness and giddiness, muscle weakness, congestive heart failure, stroke, diabetes and chronic kidney disease. R28's medication regimen included the medications: remeron 15 milligrams (mg) tablet daily; Seroquel 12.5 mg daily; 25 mg daily at bedtime; Seroquel 25 mg every 24 hours as needed. Documentation in a nurse practitioner progress note on 11/22/13, listed R28 assessment/plan as: vascular dementia with paranoia and delusions, "failed trial dose reduction to the Seroquel	F 428	information staff as to the above procedure will be provided. Consultant pharmacist and interdisciplinary team will meet monthly for gradual dose reduction. Administrator and Director of Nurses met with the consultant Pharmacist on 2-25-14 to review deficiencies and pharmacy expectations for monthly reviews These issues will be monitored in the following manner Health Information Director will complete monthly audits to review the recommendations made by the pharmacist to check whether the above procedure is being followed and appropriate documentation has been obtained by physician. Director of Nursing and Nurse Managers will conduct audits regarding mood, behavior, and psychopharmacological medications. Audit results will be brought to the quality assurance committee for further review as needed.	

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F 428	Continued From page 43	F 428		

increase back to 25 mg bid due to recent issues with hallucinations".

On 01/29/14 at 11:00 a.m. R28 verbalized she was experiencing sudden jerky movements intermittently and upset stomach. R28 felt the jerky movements and upset stomach was due to her multiple medications. R28 stated the nurses were told about these issues and she did not know if there was anything being done about her concerns.

On 01/30/14 at 12:00 p.m. Licensed Social Worker (LSW)-A reviewed R28's computerized medical record and stated R28 was stared on Seroquel 25 mg twice daily on 11/10/12. An attempt to decrease the dose to 25 mg daily and 12.5 mg every evening was conducted on 09/27/12; however, the resident stared hallucinating bugs crawling on her and accused staff of taking her belongings. Therefore, Seroquel was increased to 25 mg twice daily. Another gradual dose reduction was attempted on 01/09/14 to 25 mg daily and 12.5 mg every evening, stated LSW-A.

On 01/30/14 at 12:15 p.m. Licensed Practical Nurse (LPN)-A indicated they document side effects of medications for the resident only if they observe any changes to the residents normal pattern. LPN-A indicated she knew the residents on the unit and R28 had not exhibited any changes in her health conditions. LPN-A stated they documented by exception and if there were any changes observed in a resident's health status that would be documented in weekly nursing notes in the computer. Further, LPN-A added she was not aware of R28's concerns regarding upset stomach or the jerky movements.

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F 428	Continued From page 44 On 01/30/14 at 5:00 p.m. LSW-A indicated there were no documentation in the progress notes of R28's medication side effect monitoring. LSW-A indicated the nurses document only if they observe if there were any changes in a resident's health status. On 01/31/14 at 8:45 a.m. Registered Nurse, Director of Nursing (DON) stated the new computerized system did not have a specific form for the medication side-effect monitoring like their old paper system did. DON stated this gets missed and it was difficult to know if the nurses were documenting on medication side-effect monitoring. In addition, DON stated the staff was learning the computer system and may need additional training on where to document medication side effects. On 01/31/14 at 2:35 p.m. consulting pharmacist (CP)-D indicated R28 just recently had a gradual dose reduction and an Abnormal Involuntary Movement Scale (AIMS) was done on 12/20/13 which indicated R28 did not exhibit any spontaneous movements. CP-D indicated he was not aware of R28 voicing concerns regarding jerky movements or upset stomach and the staff needed to monitor and document medication side-effects consistently. The facility policy/procedures, revised 01/2014, titled, "Administration of Medication," directed staff to be familiar with action and adverse reactions of medications by utilizing a Drug Handbook. In addition, it directed staff to observe and document any adverse reactions.	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		3/10/14

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F 431 SS=D	Continued From page 45 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record	F 431	F 431 483.60(b)(d)(e) Drug Records,	

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F 431	Continued From page 46 review, the facility failed to discard 10 of 24 culture tubes, from the transitional care unit storage room, that had expired and failed to date an insulin vial after opening for 1 of 4 residents (R44) who recieved insulin and for 1 resident (R28) who had an outdated nitroglycerin medication bottle, during tour of the medication storage rooms and medication carts on the first floor. Findings include: On 1/27/14 at 12:00 p.m. the initial tour, observations of the medication storage rooms and medication carts on first floor were completed. The following medications were open and not dated: R44 had a vial of Lantus insulin from pharmacy dated 10/14/13 which was almost empty. The vial was not dated as to when it was opened. R44 received Lantus insulin 15 units every night (qhs). R28 had a open nitrostat (nitroglycerin, a medication given for chest pain) with a pharmacy date of 6/19/12. The bottle had been opened however there was no date as to when it was opened. Medication records from November 2013 through January 2014 indicated R28 had not received the medication. Licensed practical nurse (LPN)-A on 1/27/14 at 12:45 p.m, indicated, medications are to be dated when opened. She further indicated all nurses are responsible for labeling medications when opened and removing medications when expired. The transitional care unit (TCU) was toured on 1/27/14 at 12:30 p.m. and there were 10 of 24 culture tubes that expired 12/13 and 1 that expired 5/13. On 1/27/14 at 12:45 p.m. RN-B was interviewed and indicated all medications need to be labeled	F 431	Labels/Store Drugs & Biologicals: Corrective Action for residents R44, R28 R44 Insulin vial has been properly discarded. R28 Nitroglycerin has been properly discarded. The 10 expired culture tubes have been properly discarded. A system for properly dating medications when opened, and removal of expired medications will be in place. How to identify other residents with the same issue All resident□s medication labels have been reviewed for open dates and expiration dates. A system for properly dating medications when opened, and removal of expired medications will be in place. Medications with Special Expiration Date Requirements is posted in each medication room. Recurrence will be prevented by All nurses will receive re-education on the system for medication open dating, expiration and discarding medications. Audits will be completed on a schedule as below. These issues will be monitored in the following manner The Director of Nursing and Nurse Managers will conduct audits of medication labels as specified in the system mentioned above. The audits will be completed weekly for four weeks, monthly for one quarter, and quarterly thereafter. Audit results will be brought to	

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F 431	Continued From page 47 and removed when expired. Culture tubes, which were utilized in the TCU, should be discarded when expired. It is the responsibility of all nurses to be checking the medications for labeling and outdates. Document review of the policy and procedure titled, Medications with Special Expiration Date Requirements, dated 12/12 revealed that nitroglycerin should be discarded 12 months after opening. Lantus insulin should be discarded after 28 days. Product information from, "Epocrates," a drug and disease reference site regarding Lantus insulin indicated after opening the vial it should be used or discarded after 28 days.	F 431	the quality assurance committee for further review as needed.	
F 441 SS=E	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 prevent the spread of infection, the facility must	F 441		3/10/14

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F 441	Continued From page 48 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 use standard infection control practice during wound care for 1 of 3 residents (R11) observed for wound care. The facility failed to implement proper handwashing and/or glove use when providing care for 2 of 2 residents (R11, R105). The facility failed to sanitize the mechanical stand between resident use for 2 of 3 residents (R11, R105) observed for mechanical lift use. The facility failed to remove Individual care equipment that was observed on the floor in shared bathrooms for 4 of 6 residents (R16, R73, R41, and R120) and the facility failed to implement procedures to prevent the spread of infection during blood glucose monitoring for 1 of 3 residents (R202) observed who required blood glucose monitoring. Finding include:	F 441	F441 483.65, Infection Control Corrective Action for residents R11, R105, R16, R73, R41,R120, R202 Nurse who was providing wound care for R11 will be retrained in proper infection control practices regarding wound care. Observational audits of wound care will be conducted. Nursing Assistants caring for R11 and R105 will receive re-education in hand washing, glove use, sanitizing the mechanical lift between uses and sanitizing commode. Stained commodes were removed and new commodes were purchased and given to residents. Observational audits will be conducted. Individual care equipment was removed from the bathrooms of R16, R41 R73, and R120 and will be stored in their own	

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F 441	Continued From page 49 R11 was observed during wound care for on 1/29/14, at 11:00 a.m. Licensed practical nurse (LPN)-A and registered nurse (RN)-A were working together to cleanse the coccyx area and measure a wound that had re-opened. LPN-A washed the Buttpaste (physician ordered treatment) from the coccyx area and without changing gloves or washing hands reached over to the chair where LPN-A had set an otoscope to use for better lighting, to visualize the wound. RN-A measured the wound and wearing the same gloves took the baggie with the Buttpaste, removed the Buttpaste and wearing the same gloves applied the Buttpaste to the coccyx wound. RN-A removed gloves, washed hands, picked up the otoscope and the baggie with the Buttpaste and left the room returning them to the treatment area without sanitizing. LPN-A removed gloves, picked up the small bag of linen from washing the coccyx area and left the room without sanitizing hands. During an interview on 1/31/14 at 9:40 a.m. with the infection control nurse RN-B verified the facility procedure is to prevent cross contamination and the nurses should have disinfected the otoscope, baggie with the Buttpaste and LPN-A should have changed gloves and washed hands after cleansing the coccy area and donned new gloves to complete positioning and cares for R11. Furthermore, RN-B verified LPN-A should have washed hands after removing her gloves and cares were completed before leaving the resident room.. R11 was observed during cares on 1/27/14, at 5:45 p.m. Nursing assistant NA-F and NA-H were assisting R11 off the commode in the bedroom using a mechanical stand. NA-F was opening and	F 441	private space in their own rooms. Re-education will be provided to the nursing assistants caring for these residents. Nurse that was caring for R202 was retrained immediately on cleaning the glucose monitor. Glucose monitor is being cleaned with bleach wipes. Observational audits will be conducted. How to identify other residents with the same issue Weekly observational audits will be completed to ensure that nursing staff are providing cares using proper infection control practices, and that residents are receiving care that will prevent the spread infection. Re-education will be given ongoing as needed. Audits will continue as outlined below. Recurrence will be prevented by Re-education will be given to all nursing staff in infection control practices, and audits will continue as outlined below. These issues will be monitored in the following manner The Director of Nursing, and Nurse Managers, will complete infection control audits weekly for one month, then monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

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closing the bathroom door getting supplies, basin, wash cloths, brief, wearing the gloves used to remove the resident brief and provide perineal cleansing after voiding on the commode. R11 was settled into her wheelchair with the use of the mechanical stand. NA-F was using contaminated gloves from providing perineal cleansing to remove the sling and work the mechanics of the mechanical lift. NA-H took the mechanical lift out of the bedroom and set it into the hallway without sanitizing the handles that R11 held on to. NA-F emptied the urine from the commode, rinsed the commode bucket with water from the bathroom sink, then put the highly stained commode bucket back into the commode, closed the lid and moved the commode to the other side of the bedroom without sanitizing the commode after use. Then removed contaminated gloves, washed hands and left the room.

R105 was observed during cares on 1/28/14, at 11:24 a.m. (NA)-C donned gloves to assist R105 to the commode in the bedroom using a mechanical stand for the transfer. NA-C moved the commode from across the bedroom, opened the lid on the commode then, using the same gloves picked up the remote on the mechanical stand to mechanically lift R105. NA-C removed gloves, washed hands and donned a new pair of gloves and proceded to raise the mechanical lift and provide perineal cleansing to R105. NA-C pulled up the brief and slacks of R105, grabbed the remote control using the gloves that provided perineal cleansing and worked the mechanics of the lift. NA-C removed the mechanical lift sling with contaminated gloves, emptied the urine from the commode, rinsed the commode bucket with water, returned the bucket to the commode,closed the commode lid and moved

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the mechanical stand out of the way so the commode could be moved back to the other side of the room without sanitizing the commode or bucket. NA-C acknowledged there was a "strong urine smell" to the commode. NA-C moved the mechanical lift out into the hallway without sanitizing the handles that R105 was holding on to. NA-C removed gloves in the bathroom, washed hands and left the room.

During interview with R105 on 1/28/14, at 11:09 a.m. she complained about the stained commode in the bedroom and asked, "Can you smell that commode? I think it smells, it has been like that and no one brings a new one, they can't smell it."

R105 was observed during cares again on 1/29/14, at 7:45 a.m. R105 was being assisted by NA-D who brought the mechanical stand directly from providing care to R11 without sanitizing the handles that R11 held on to. NA-D, while wearing gloves, dressed R105 and put on shoes and stockings. NA-B came into the room and donned a pair of gloves without washing hands. NA-D used the mechanics of the lift to raise R105 and position her on to the commode. The commode was highly stained with strong urine odor. Surveyor asked NA-B and NA-D if they noticed the odor and both said they did not. NA-B touched the cover of the commode, adjusted the slings on the mechanical lift, removed the straps from the mechanical lift and tossed the mechanical lift sling into the bedding. NA-D emptied the commode in the bathroom toilet, rinsed the bucket but did not sanitize the bucket. NA-D adjusted bed linens still wearing the contaminated gloves. NA-D removed the gloves and did not wash hands. NA-D moved the mechanical stand out into the hallway without

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	245221	A. BUILDING _____ B. WING _____	01/31/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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sanitizing the handles.

When interviewed on 1/30/14, at 8:00 a.m. housekeeper (H)-A and H-B verified that nursing is responsible for washing and changing the commode buckets in the resident rooms. When interviewed on 1/30/14, at 8:10 a.m. NA-E said nursing rinses out the commode bucket but housekeeping is responsible for cleaning the bucket and commode. Interview with licensed practical nurse (LPN)-B on 1/30/14 at 8:14 a.m. was not sure who was responsible to clean the commode and bucket but thought maybe nursing was but again not sure, would need to find out.

A review of the undated facility policy titled, "Infection Control Disinfecting of Commodes" read, "All commodes are to be disinfected by nursing assistant and cleaned with Virex II 256 between each resident/patient use. Commode is to be disinfected weekly on bath day. Commode is to be disinfected throughout the week as needed by the nursing assistant.

A review of the Hand Hygiene and Handwashing procedure dated June 2012 read, "Wash hands immediately after gloves are removed, between resident contact and when otherwise indicated to avoid transfer of microorganisms to other residents or environments Gloves will be removed promptly after use, before touching non-contaminated items and environment surfaces and before going to another resident. Hands will be washed immediately after removal of gloves to avoid transfer of microorganisms to other residents or environments."

The policy titled, "Standard Precautions dated September 2012 addresses Resident Care

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	245221	A. BUILDING _____ B. WING _____	01/31/2014

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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Equipment and read, "Reusable equipment will not be used for the care of another resident until it has been appropriately cleaned and reprocesed."

During an interview on 1/31/14, at 9:40 a.m. with the infection control nurse RN-B verified the sanitizing wipes are easily accessible to the staff and each mechanical lift is to be sanitized in between the resident use, especially the handlebar areas where the resident grabs and holds unto during the transfer.

During resident environment observations and resident interviews on 1/27/14, 1/28/14 and 1/29/14 on the North West unit there were observed resident care equipment on the floor of the bathrooms. R73 and R16 share a bathroom and had a wash basin and measuring graduate on the floor all three days. R41 and R120 share a bathroom and had a washbasin and emesis basin on the floor all three days.

During an interview on 1/31/14, at 9:40 a.m. with the infection control nurse RN-B verified the facility procedure is to prevent cross contamination and the resident care items are not to be on the contaminated floor.

The RN failed to properly disinfect the machine, after the multi patient use glucometer machine was used to check the blood sugar for R202.

R202 had her blood sugar checked on 1/29/14 at 12:00 p.m. by registered nurse (RN)-D. After performing the blood sugar, RN-D cleaned the glucometer with alcohol. When asked if that was how she was to clean it, she indicated it was. She wiped it off for approximately one minute and then put the machine away in the drawer.

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F 441	Continued From page 54 1/30/14 at 9:15 a.m. interview with RN-B (the education director) indicated all staff are aware of how to clean a glucometer and are taught to use the bleach sani wipes provided. RN-B indicated the nurse did not do it correctly. The infection control policy and procedure, titled Cleaning and Disinfecting Blood Glucose Meters, dated 6/12 directed staff to use the bleach wipe packets and allow to air dry for 3 minutes. RN-B indicated the air drying allows the bleach to work. 1/31/14 8:15 a.m. information from the "Assure" company regarding their glucometer product, directed staff to disinfect the glucometer with bleach.	F 441		

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

F522023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2014**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117**

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K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Maplewood Good Samaritan Center is a 2-story building with no basement. The building was constructed at three different times. In 1965 the nursing home was built and was determined to be of Type II(111) construction. In 1967 an addition was constructed to the south of the main building, that was determined to be of Type II(111) construction. In 1998 an addition was constructed to the south and west of the 1967 building that was determined to be of Type II(000) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The sleeping rooms in the 1997 addition have single smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota	K 000		

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

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

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**01/29/2014**

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K 000	Continued From page 1 State Fire Code. The facility has a capacity of 102 beds and had a census of 81 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		