DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered
January 23, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: CCN: 245221
Cycle Start Date: December 18, 2023

Dear Administrator:

On January 17, 2024, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 23, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: Reinspection Results
Event ID: Y7X512

Dear Administrator:

On January 17, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 18, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

***Revised letter due to new enforcement cycle start date.
Please disregard previous letters recieved on 12/29/23 and 1/2/24.***

Electronically delivered
January 4, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: CCN: 245221
Cycle Start Date: December 18, 2023

Dear Administrator:

On December 18, 2023, a survey was completed at your facility by the Minnesota Department of Health 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 isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

Within **ten (10) calendar days** after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

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

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

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

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend

to the CMS Region V Office that one or more of the following remedies be imposed:

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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 the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

If substantial compliance with the regulations is not verified by March 18, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by June 18, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 4, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: State Nursing Home Licensing Orders
Event ID: Y7X511

Dear Administrator:

The above facility was surveyed on December 14, 2023 through December 18, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Golden Rule Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

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

Protecting, Maintaining and Improving the Health of All Minnesotans

Revised Letter to replace letter sent on 12/29/2023

Electronically delivered

January 2, 2024

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: CCN: 245221
Cycle Start Date: September 28, 2023

Dear Administrator:

On October 12, 2023, we informed you that we may impose enforcement remedies.

On December 18, 2023, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Mandatory Denial of Payment for new Mediare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 28, 2023

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 28, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 28, 2023.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 28, 2023, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Maplewood will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 28, 2023. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being

corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Freeman Building
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 28, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42

CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

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

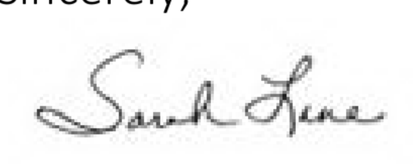
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NH-Dispute-Resolution

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 29, 2023

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: CCN: 245221
Cycle Start Date: September 28, 2023

Dear Administrator:

On October 12, 2023, we informed you that we may impose enforcement remedies.

On December 18, 2023, the Minnesota Department(s) of Health completed a survey and it has been determined that your facility is not in substantial compliance. The most serious deficiencies in your facility were found to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically attached CMS-2567, whereby corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 13, 2024.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 13, 2024. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 13, 2024.

You should notify all Medicare/Medicaid residents admitted on, or after, this date of the restriction. The remedy must remain in effect until your facility has been determined to be in substantial compliance or your provider agreement is terminated. Please note that the denial of payment for new admissions includes Medicare/Medicaid beneficiaries enrolled in managed care plans. It is your obligation to inform managed care plans contracting with your facility of this denial of payment for new admissions.

This Department is also recommending that CMS impose a civil money penalty. You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

- Civil money penalty. (42 CFR 488.430 through 488.444)

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,995, has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 13, 2024, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Maplewood will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 13, 2024. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
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- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.

- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Freeman Building
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 28, 2024 (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 § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Steven.Delich@cms.hhs.gov

Requests for a hearing submitted by U.S. mail or commercial carrier are no longer accepted as of October 1, 2014, unless you do not have access to a computer or internet service. In those circumstances you may call the Civil Remedies Division to request a waiver from e-filing and provide an explanation as to why you cannot file electronically or you may mail a written request for a waiver along with your written request for a hearing. A written request for a hearing must be filed no later than sixty (60) days after receiving this letter, by mailing to the following address:

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
202-795-7490

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Steven Delich, Program Representative at (312) 886-5216. Information may also be emailed to Steven.Delich@cms.hhs.gov.

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

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

Nursing Home Informal Dispute Process

Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

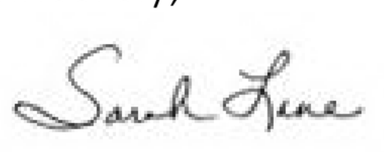
This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: https://forms.web.health.state.mn.us/form/NH-Dispute-Resolution

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

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

Feel free to contact me if you have questions.

Sincerely,



Sarah Lane, Compliance Analyst
Federal Enforcement | Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, MN 55164-0900
Telephone: 651-201-4308 Fax: 651-215-9697
Email: sarah.lane@state.mn.us

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 29, 2023

Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Re: State Nursing Home Licensing Orders
Event ID: Y7X511

Dear Administrator:

The above facility was surveyed on December 14, 2023 through December 18, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

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

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

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

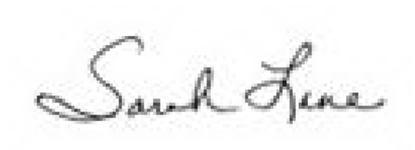
Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting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

Annette Winters, Rapid Response Unit Supervisor
Metro 1, Freeman Building
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: annette.m.winters@state.mn.us
Mobile: (651) 558-7558

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

Please feel free to call me with any questions.

Sincerely,



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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 _____	C 12/18/2023

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

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F 000	INITIAL COMMENTS On 12/14/23 - 12/18/23, a standard abbreviated survey was conducted at your facility. Your facility was NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were reviewed. H52217864C (MN98457) The following complaints were reviewed. H52217706C (MN98977) with a deficiency issued at F578, F609, F610, F656, F842, F880. And Deficient practice was identified related to incidental finding at F583 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 578 SS=G	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		1/12/24

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

Electronically Signed | 01/08/2024

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

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F 578	Continued From page 1 §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to comply with resident rights to	F 578	F578 The Right to request, refuse, and/or discontinue treatment.	

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F 578	Continued From page 2 refuse treatment for 1 of 4 residents (R1) reviewed when staff proceeded with a urinary straight catheterization while R1 verbally and physically refused the procedure. R1 has had increased anxiety since the straight catheterization procedure. Findings include: R1's Minimal Data Set (MDS) dated 11/5/23 indicated R1 admitted to the facility on 10/30/23. R1's pertinent primary medical conditions indicated on the MDS included anxiety disorder, morbid obesity, metastatic breast cancer, pathological fracture of the left tibia (shin bone) and generalized muscle weakness. R1 had no cognitive deficits. R1 was dependent upon staff with toileting and lower body dressing and transfers. R1 required maximum assistance from staff with upper body dressing and bathing. R1's treatment administration record (TAR) with a start date 10/30/23 at 3:00 p.m., end date 10/31/23 at 4:01 p.m. indicated postvoid residuals (PVRs) (a scan of the bladder to determine the amount of residual urine after voiding) every shift for urine residual greater than 350 cubic centimeters (cc) to use a straight catheter (a soft, thin flexible tube is inserted into the urethra, until urine flows out, the catheter is then removed and discarded) three times. If straight catheterizations were greater than three times, reinsert an indwelling urinary catheter (an indwelling tube that stays in the urethra and bladder for urine voiding). - 10/30/23 evening shift R1 had a PVR of 550 cc's. - 10/30/23 to 10/31/23 night shift R1 had a PVR	F 578	Corrective Action for resident R1 Resident R1 discharged from the facility on 11/30/2023 How to identify other residents with the same issue All residents with urinary catheters have the potential to be affected by the deficient practice. They have been reviewed to ensure that the resident or the resident representative have been educated on the right to refuse treatment and have given acknowledgement for use. To ensure systematic changes are sustained Re-education for all nursing facility staff was completed on Good Samaritan Society□s Policy Resident□s Right to refuse treatment. Re-education will completed by 1/12/2024 These issues will be monitored in the following manner Director of Nursing and Nurse managers will conduct audits to ensure appropriate documentation of resident□s consent or refusal of treatment in the medical record. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 578	Continued From page 3 of 35 cc's. - 10/31/23 day shift R1 had a PVR of 1000 cc's. R1's progress notes from 10/30/23 to 11/30/23 indicated: - 10/30/23 at 12:28 p.m. R1 admitted to the facility from the hospital for skilled services following surgical repair of R1's left tibia. - 10/31/23 at 1:02 p.m. a summary of R1's skilled services indicated R1 was to receive skilled nursing services, physical therapy, and occupational therapy. R1 had anxiety, edema, urinary retention, incisional dressing, and pain was monitored. R1 was sensitive to touch and cares, anxious about what would happen next. Scheduled antianxiety medications helps with R1 conditions. R1 had urinary retention in the hospital. Had PVR orders. R1 attempted to void this morning but was unable, a PVR scan was completed that showed 1000 cc of urine in the bladder. R1 and R1's family member (FM)-A requested an indwelling urinary catheter be placed. Next catheterization, including the hospital straight catheterizations, would be the fourth time. The indwelling urinary catheter procedure was tolerated by R1, returning 1200 cc of clear yellow urine. R1 was comfortable and less anxious. - 10/31/23 to 11/13/23 monitoring of the indwelling catheter was performed with no concerns from R1. - 11/14/23 at 4:25 p.m. R1 complained of pain and burning from the indwelling urinary catheter. An order was obtained for removal. R1's catheter was removed. - 11/30/23 at 3:26 p.m. R1 discharged from the facility. R1's physician order dated 11/1/23 at 9:31 a.m.	F 578		

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F 578	Continued From page 4 indicated indwelling urinary catheter, 16 French with 15 cc's in 30 cc balloon, to dependent drainage. Change catheter as needed if dislodged or plugged and unable to clear with irrigation. R1's physician order dated 11/14/23 at 7:00 a.m. indicated okay to remove indwelling urinary catheter if R1 wants. PVR every shift for 72 hours. Straight catheter if residual urine is 350 cc or greater. If straight catheter needed three times reinsert indwelling urinary catheter. Upon interview on 12/15/23 at 8:46 a.m. R1 stated she left the facility after one month due to how she was treated. She stated she has been in pain ever since the staff "forced catheterization" on her. She was sobbing during interview, having to stop between sentences, saying "I'm sorry, I'm sorry, I hurt physically and emotionally." She stated due to having vaginal and leg pain she cannot stop thinking about the facility. She had an appointment with her physician later during that day to discuss her symptoms. "I think they damaged me; it hurts to pee." She stated two nurses, and a "man" were in her room during her stay at the facility, the staff was pulling on her leg trying to insert a catheter. R1 stated she was screaming, "stop it is hurting me, I don't need this." She stated her husband was sleeping in her room and he woke and told staff to stop as well. She stated, "the man" was standing at the end of her bed looking at her "parts." She said the women were trying to pull her legs apart as she was trying to close them. R1 stated the staff told her they needed to put the catheter in because it was unhealthy. R1 stated she did tell the nurse manager, registered nurse (RN)-C and RN-D that staff placed a catheter	F 578		

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F 578	Continued From page 5	F 578		

inside her, that she did not want, and they hurt her.

Upon interview on 12/15/23 at 11:41 R1's family member (FM)-A stated R1 was yelling "stop you are hurting me; you are hurting me." He stated two female nurses were holding her legs apart and a male was there helping. "I told them to stop." He stated the staff stated if they could not get the urine out, she could become ill and must go to the hospital. She talks and cries about the trauma that the nurses caused every day since leaving the facility. A police report was filed by FM-A on 11/15/23 for the incident 10/30/23 and the care received at the facility.

Upon inquiry on 12/15/23 with the police department at 9:41 a.m. The department did not have a police report on file made by FM-A regarding R1.

Upon interview on 12/15/23 at 12:51 RN-E stated the day R1 was admitted on 10/30/23 was the day they had to straight catheterize her because her bladder scan contained over 350 cc; her bladder contained 550 cc's. She stated RN-B came to her and asked for assistance. RN-B told RN-E that he needed assistance as R1 was refusing the procedure. RN-E stated the procedure was explained to R1; however, she was "frantic" and did not feel the procedure was necessary. R1 started to cry before staff began procedure. RN-E stated that her and RN-B started the process and R1 started yelling "It hurts, it hurts, I don't need this." R1 was lying flat on her back with her knees bent up. RN-E tried to expand R1's legs as much as she could, but R1 was saying her right leg was painful all the time. RN-E stated her role was to hold R1's legs

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F 578	Continued From page 6 so RN-B could insert the straight catheter. RN-E and RN-B did not get the straight catheter in inserted, "we pulled back." RN-E stated she explained to the husband if the staff could not catheterize R1 that she may have to go back to the hospital. RN-B left the room to get another nurse to assist with the procedure. RN-F came into the room and assisted RN-B with holding R1's legs apart. R1 was yelling "why do we now have another person in the room." As RN-B and RN-F were holding R1's legs RN-E did get the straight catheter inserted with a return of 574 cc of urine. R1's husband was heard saying that he hoped the procedure would be over soon and he hopes it would never need to be performed again. RN-E stated, "We did attempt to try putting it in after she said stop." RN-E stated the procedure from start until finish lasted about 20 minutes. She denied trying any other interventions to try to get R1 to urinate or her own or any other interventions to ease R1's anxiety. She denied calling the nurse practitioner when R1 was refusing for further recommendation. RN-E stated she did not document anything about the procedure in R1's notes as she was not the nurse in charge of R1's cares that night. Upon interview on 12/15/23 at 2:36 p.m. RN-B stated R1 had an order to do a straight catheter procedure if her bladder scan residual showed over 350 cc. R1 was a larger lady who had anxiety, therefore RN-E was asked to assist. On the first attempt to insert the straight catheter R1 was yelling "you're ripping me apart." RN-B stated he did not insert the straight catheter yet and R1 was not being touched when she was screaming. R1 was closing her legs, so the insertion was not obtained with RN-E holding her legs and RN-B attempting in insert the straight	F 578		

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F 578	Continued From page 7	F 578		

catheter. RN-B stated he went to get another nurse to assist. R1's husband woke-up and RN-B did not recall what the husband was saying. RN-B stated he did not hear R1 say stop, rather she was yelling "you're ripping and putting it in the wrong hole" RN-B stated with the help of RN-D they were able to complete the procedure as RN-B and RN-D held R1's legs and RN-E inserted the straight catheter. RN-B stated R1 was saying it was vagina which was hurting not her leg. RN-B stated RN-F did say maybe the staff should pull back due to R1's resistance, but RN-E was about to get the "job done," so they proceeded. RN-B stated he did not recall if he wrote a progress note. He denied trying any relaxation interventions, education or notifying the NP for further instructions due to R1's anxiety or an update following the procedure. RN-B stated the entire procedure from start to finish took three minutes. The first attempt took two minutes and the second attempt one minute total time. RN-B stated he was aware that after procedure he was not allowed into R1's room per her request to not have male staff. RN-B stated he still proceeded with the procedure when she was because she was saying "just get it in the right hole."

Upon interview on 12/15/23 at 2:51 p.m. RN-D stated she worked the morning after R1 was straight catheterized. She stated that she knew R1 was upset about the catheterization and refused her bladder scans the rest of the night. RN-D stated she performed the bladder scan on R1 the following morning and she had 1000 cc's of residual urine in her bladder, which was a dangerous level. RN-D stated R1 was an extremely anxious resident and who was on "a lot" of anxiety medications and when the medications wore off R1 became "anxious and

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F 578	Continued From page 8 scared." RN-D stated she spent "a lot" of time with R1 and her husband and explained that she needed an indwelling foley catheter or to be straight catheterized again, but this time she would put in an indwelling foley catheter. RN-D stated she made sure R1 had her Ativan 0.5 milligrams (an antianxiety medication) and R1 and her husband consented to the indwelling foley catheter. She stated she and another nurse (unidentified) placed the straight catheter in without difficulty. Upon interview on 12/15/23 at 2:39 p.m. RN-C the nurse manager stated she was not aware that R1 was yelling stop and yelling out pain during the straight catheterization procedure. In addition, she was not aware that three staff were in her room attempting to perform the straight catheter procedure. She stated 574 cc's is not that much urine, so it was not emergent that staff catheter her. She stated her expectation of staff would have been to stop and to get further direction from the NP. The nurse manager stated, "There is no excuse, no means no." Upon interview on 12/15/23 at 3:06 p.m. RN-F stated RN-B requested her assistance with straight catheterization on a resident who was having anxiety. R1 was in her room and was very anxious when RN-F arrived, she was yelling. RN-F stated R1 was thrashing and flailing her legs around saying she was uncomfortable. RN-F did not recall her saying stop but recalled yelling. RN-F heard R1 say that she was not comfortable as RN-F and RN-B were holding back the skin folds of her legs and abdomen. RN-F stated she was uncertain of any interventions RN-B and RN-E providing before asking for her assistance. RN-F stated if resident	F 578		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, 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 578	Continued From page 9 does not want something done staff does not do it. Upon interview on 12/18/23 at 10:57 a.m. the director of nursing (DON) stated she heard that R1 at first did not want the straight catheter procedure, but then said she would allow it and the husband was present. She stated that she was not aware R1 was yelling. She stated if R1 was yelling, she would expect the staff to stop and come up with another plan. Upon interview on 12/18/23 at 11:21 p.m. the Administrator stated she was not aware of the straight catheter procedure for staff or residents, but if a resident were yelling, she would expect the staff to stop and explain risk and benefits to the resident. A facility policy titled Notification of Changes in residents-rehab/skilled dated 1/18/23 indicated the purpose was to ensure the resident receive prompt notification of changes in residents' rights. The facility provided the Care Providers of Minnesota Combined Federal and Minnesota State Bill of Rights version 6/8/19. Under the title Exercise of Rights indicated the facility must ensure the resident can exercise their rights without interference, coercion, discrimination, or reprisal from the facility. Under the title Planning and Implementing Care indicated the right to request, refuse, and/or discontinue treatment. Competent residents have the right to refuse treatment.	F 578		
F 583 SS=C	Personal Privacy/Confidentiality of Records CFR(s): 483.10(h)(1)-(3)(i)(ii)	F 583		1/12/24

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F 583	Continued From page 10 §483.10(h) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records. §483.10(h)(l) 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. §483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service. §483.10(h)(3) The resident has a right to secure and confidential personal and medical records. (i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel when	F 583	F583 The Resident has a right to personal privacy, including his or her oral, written and electronic communications. The right to secure and confidential	

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F 583	Continued From page 11 two unsecured cardboard boxes were left at a nurse's station that contained resident care plans and other resident medical information. The facility also failed to safeguard personal and medical information contained in the Electronic Medical Record (EMR) when three computers were left open in an area where any staff, visitor, or resident could view on three separate occasions. These deficient practices had the potential to affect all 61 residents who reside in the facility. Findings include: During an observation on 12/14/23 at 10:37 a.m., at the nursing station located on the first floor of the 102 wing, a computer at a nurse's station was unlocked for 5 minutes with resident care plan tasks visible. The nurse's station was in an open area in the middle of two resident care wings where any staff, visitor, or resident could walk behind. There was no staff sitting at the desk. During an observation on 12/14/23 at 10:50 a.m., at the nursing station located on the first floor, down the hallway of the 102 wing, a computer at a nurse's station was unlocked for 5 minutes with resident care plan tasks visible. The nurse's station was in an open area in the middle of two resident care wings where any staff, visitor, or resident could walk behind. There was no staff sitting at the desk. During an observation on 12/14/23 at 11:12 a.m., at the nursing station located on 2nd floor conjoining two wings of the facility, a computer at a nurse's station was unlocked for 5 minutes with resident care plan tasks visible. The nurse's station was in an open area in the middle of two	F 583	personal and medical records. Corrective action for personal privacy throughout the building. Unsecured cardboard boxes were removed from the nurses station was done immediately and replaced with secured locked Shred□It Bins for disposal of resident medical information. All staf were immediately educated on the importance of locking computer screens when not in use. All residents in the facility have the potential to be affected by the deficient practice All nursing stations and computers have been monitored for compliance with personal privacy and confidentiality of records. To ensure systemic changes are sustained DNS or designee will provide a re-education for all staff related to the HIPAA Policy and Procedure. This will be completed by 1/12/2024 These issues will be monitored in the following manner Director of Nursing and Nurse Managers will conduct audits to ensure compliance with protected health information. Audits	

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F 583	Continued From page 12 resident care wings where any staff, visitor, or resident could walk behind. There was no staff sitting at the desk. During an observation on 12/14/23 at 12:51 p.m., at the nursing station located on the 2nd floor in the post acute area, two full unsecured cardboard boxes were left under a desk at a nurse's station that contained resident's care plans and other resident medical information. The nurse's station is in an open area in the middle of four active areas in the building: two resident care wings, the kitchen, and a dining room. The nurse's station was easily accessible to any staff, visitor, or resident. The unsecured cardboard boxes were observed for one hour. Writer observed the nurse's station during the lunch hour and there was kitchen staff going to and from and kitchen to the dining room. There was no staff sitting at the desk. The cardboard boxes contained resident names, room numbers, and other medical and personal information on them. The cardboard boxes were overflowing with no lid. During an interview with the facility's social worker (SW) on 12/14/23 at 12:54 p.m., SW stated the 2 full unsecured cardboard boxes that were left under a desk at the nurse's station contained pertinent patient identifying information. SW stated this box should not have been there and these papers should have been shredded. SW stated that this would violate the resident's privacy. During an interview with director of nursing (DON) on 12/18/23 at 10:57 a.m., DON stated she would expect nursing staff to put patient identifying information, including care sheets, in a box under	F 583	will be completed weekly for one month, monthly for one quarter and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review.	

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F 583	Continued From page 13 the nurse's desk at the nurse's station or in a shred-it bin after each shift. DON stated she would expect staff to chart their cares and lock their computers after documenting. During an interview with the facility administrator on 12/18/23 at 11:21 a.m., the administrator stated her expectation would be for staff to place nursing care sheets or any patient identifying information to be placed in the shred-it bins at the end of their shift. Request was given to the facility for their Health Insurance Portability and Accountability Act (HIPAA) policy and procedure but was given the HIPAA Assigned Security Responsibilities-Enterprise policy that was reviewed and revised on 4/11/19. This policy did not indicate the facility's responsibilities for keeping resident's private, medical, or personal information secure and confidential.	F 583		
F 609 SS=D	Reporting of Alleged Violations CFR(s): 483.12(b)(5)(i)(A)(B)(c)(1)(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(1) Ensure that all alleged violations involving abuse, neglect, exploitation or mistreatment, including injuries of unknown source and misappropriation of resident property, are reported immediately, but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to	F 609		1/12/24

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F 609	Continued From page 14 the administrator of the facility and to other officials (including to the State Survey Agency and adult protective services where state law provides for jurisdiction in long-term care facilities) in accordance with State law through established procedures. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to immediate report, but not later than two hours after the allegation is made, to the state agency (SA) allegations of employee to resident physical and verbal abuse for 1 of 1 resident (R1) reviewed for abuse. R1's admission Minimal Data Set (MDS) date 11/5/23 indicated R1 had no cognitive deficits. R1 was dependent with toileting and lower body dressing and transfers. She required maximum assistance with upper body dressing and showering. R1's pertinent diagnoses were metastatic breast cancer, anxiety disorder, morbid obesity, and a pathological fracture of the left tibia (shin bone). A facility incident report dated 11/22/23 indicated R1 reported NA-A had yelled at her, telling her that no one liked her. R1 also stated NA-A ripped her brief off and hurt her hip during cares. NA-A made her feel bad for needing help. NA-A turned off all her lights and left her with no way to turn	F 609	F609 Reporting of Alleged Violations Corrective Action for Resident R1 Resident R1 has been discharged as of 11/30/2023. Immediately all staff were provided education on the Abuse and Neglect Policy including appropriate reporting. All residents in the facility have the potential to be affected by the deficient practice The facility Interdisciplinary Team to review all verbal and written grievances for potential Abuse and Neglect and report accordingly. To ensure systemic changes are sustained	

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F 609	Continued From page 15 the lights on or call for help. R1 stated she was being abused by NA-A because of the treatment and the way her brief was taken off by NA-A. R1 called the police. Upon interview on 12/15/23 at 8:46 a.m. R1 stated two nurses and a "guy" came into her room and were trying to place a catheter in her. She stated she repeatedly told them to stop, and she did not need the catheter. She stated her surgical leg was hurting as the staff was pushing on her legs. She described the male nurse as a younger man with dark hair. She stated four times during the interview how she told the staff to stop and how painful it was. R1 was crying throughout the telephone interview, having to take breaks between sentences due to the sobbing. She stated in addition, few days later nursing assistant (NA)-A came into her room one morning and was yelling at her that she did not belong in the facility and was "mistreating" her. She stated she had diarrhea in her incontinent pad and NA-A "torn it" from her causing pain to her surgical leg and then NA-A threw a box of Kleenexes at her. R1 stated she reported both incidents to the registered nurse (RN)-C and the facility social worker (SW)-A. Upon interview on 10/15/23 at 10:15 a.m. RN-C, the nurse manager, stated R1 did speak with her about the catheter, but did not provide any details, except it was uncomfortable and talked about the male in her room. "She was very emotional several times and difficult to read on the level of sorting out what is what." RN-C stated R1 stated it felt like someone was viewing her as a" pleasure thing." RN-C stated she did not investigate the allegation or file a report to the Minnesota Adult Abuse Reporting Center	F 609	DNS or designee will provide re-education for all staff to ensure compliance with the Abuse and Neglect Reporting Requirement. Education will be done by 1/12/2024 These issues will be monitored in the following manner Interdisciplinary Team will review written and verbal grievances brought forth to determine if they are reportable and do so within time frame of severity.	

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F 609	Continued From page 16 (MAARC). Upon interview on 12/15/23 at 2:15 p.m. SW-A stated R1 told her that an "NA was mean to her." The SW stated she was uncertain what the term "mean" meant from R1. She stated R1's husband called the police that day. SW-A did not speak with the police. She stated she spoke with the NA-A and NA-A was upset and did not want to work with R1 anymore because she was the one "abused." SW-A denied interviewing R1 about her allegations. She stated she sent the administrator an e-mail and told the nursing manager on the unit, RN-C about the incident. Upon interview on 12/15/23 at 2:56 p.m. RN-C stated she was uncertain why R1 did not want male staff in her room. She stated she did recall a couple of incidents that R1 had with NA-A, it was a "she-said-she-said." R1 stated that NA-A was rough with her and left her in the dark and aggressively ripped an incontinent brief from her. RN-C stated the facility did not find any abuse or maltreatment therefore they did not report the incident to MAARC. She stated the director or nursing, DON has a file about the incident. Upon interview on 12/18/23 the DON stated she was not aware of the allegation R1 had regarding her catheter insertion. She stated the other allegations were not reported because the nurse manager on the unit is new to her position, however stated the allegations should have been reported to the state agency. An abuse policy was requested however none was received.	F 609		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation	F 610		1/12/24

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F 610	Continued From page 17 CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure allegations of verbal and physical abuse were thoroughly investigated for 1 of 1 resident (R1) reviewed. R1 reported allegations of rough treatment leading to pain when staff would not stop a catheter procedure upon her request. In addition, R1 reported allegations of verbal and physical abuse by a nursing assistant (NA). A thorough investigation was not completed. Neither complaint allegations were reported to the state agency. The findings include: According to a facility incident report dated 11/22/23 R1's husband arrived at 1:30 p.m. to talk to R1 about what she believed happened to her	F 610	F610 Investigate, Prevent, Correct Alleged Violation Corrective action for resident R1 Resident R1 was discharged from the facility on 11/30/2023. All nursing supervisors and Social Workers were immediately educated on Policy and Procedure for Grievances, Suggestions and Concerns, including investigation Procedure and interview. How to identify other residents with the same issue The facility Interdisciplinary Team to	

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F 610	Continued From page 18 with an encounter with staff member, NA-A that morning. R1 reported NA-A yelled at her, saying no one liked her. R1 stated NA-A ripped her brief off and hurt her hip. NA-A made her feel bad for needing help. NA-A also turned off all her lights and left her with no way to turn the lights on or call for help. R1 stated she had been abused by NA-A because of this treatment and the way her brief was taken off by NA-A. R1 called the police saying she was being neglected. Registered nurse (RN)-C response on the incident report indicated she explained to R1 that while she had Covid-19 her cares must be grouped together as much possible. And she was not being ignored or neglected, the staff just needed to be more aware for the safety of others. RN-C told R1 that her services and everything they have to offer her were still available. RN-C explained to R1 the leaving against medical advice (AMA) policy as the R1 was ready to leave due to anxiety and problems with not getting help, and R1 did not feel like she could be in the room for ten days. RN-C explained to R1 that is her right and then R1 thought she would be kicked out. RN-C listened to all the patient concerns with R1 and reassured her that no one hated her and told her NA-A would not be working with her anymore. RN-C wrote "patient has extreme anxiety and can be difficult to reason with and explain reality to". RN-C then encouraged R1's husband to leave as he was also Covid positive and not to return until R1 was out of isolation. On the same incident report RN-C interviewed NA-A and wrote NA-A was in tears and telling how mean R1 was to her and yelling at her. NA-A reported R1 threw a bedside table over and yelled at her. NA-A also reported R1 is abusive to her	F 610	review all verbal and written grievances for appropriate investigation and reporting requirements. Recurrence will be prevented by Re-education provided to persons responsible for overseeing the grievance process. Interdisciplinary team will review all verbal and written grievances for thorough investigation and reporting requirements. Education completed by 1/12/2024 These issues will be monitored in the following manner The facility Interdisciplinary Team to review all verbal and written grievances for thorough investigation and reporting requirements.	

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F 610	Continued From page 19	F 610		

by yelling. The solution was NA-A was no longer to work with R1.

In the facility investigative folder there was one additional staff interview dated 11/22/23 by NA-C indicating NA-C had taken over cares for NA-A on 11/22/23. She answered R1's call light, gave her breakfast and changed her brief. The note also indicated NA-C went in R1's room at 12:30 p.m. stating R1 was upset and wanted to speak with management.

Email correspondence at 11/22/23 at 1:47 p.m. sent by social worker (SW)-A to the administrator indicated NA-A had informed SW-A that she was not comfortable working with R1 as R1 was angry and claiming nobody was caring for her and pushed her water pitcher off her tray table and threating to call the police. NA-A was told to talk to the nursing team about the incident.

R1's progress note dated 11/22/23 at 4:08 p.m. indicated R1 went "mad" this morning after receiving care after having diarrhea in her bed this morning. R1 was yelling and cursing at the staff there and threatens to call the police. The morning nurse was able to calm her down after listening to her and giving her morning medications and pain control medication. R1 did good until lunch time when she started calling her husband to come and get her. Management was aware of patient's frustration.

R1's care plan dated 12/14/23 did not identify R1 as having any anxiety or anger concerns as a vulnerable adult.

The investigation folder and medical record failed to include any documentation on any other staff,

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F 610	Continued From page 20 residents or witnesses interviewed. There was no documentation of any skin, injury, or pain assessments completed as R1 had complained of pain during cares and no psychological assessment was completed in response to R1's anxiety and behaviors. The nurse practitioner (NP) was not notified. The facility failed to offer R1 any interventions such as a psychiatry referral, social worker visits, clergy, or increased activities for R1 in her room under isolation. Upon interview on 12/15/23 at 3:15 p.m. RN-C stated she spoke with R1 following the allegations of the staff hurting her and refused to stop the catheterization procedure. RN-C stated she did not investigate the allegations as she only knew R1 complained of pain and a male was in her room trying to view her for pleasure. She stated she did not feel that warranted reporting or an investigation. She stated on the allegations of physical and verbal abuse by NA-A she spoke with R1 and called the allegations a "she-said-she-said" situation. She also she interviewed NA-A and did not have her work with R1 following the allegations. She denied interviewing any other witnesses, residents, or staff members regarding the allegations. She denied offering any other interventions. The resolution to the situation was not to have NA-A work with R1. She denied completing any nursing assessments following the allegations. Upon interview on 12/15/23 at 2:20 p.m. SW-A stated R1 would get angry and refuse care. She stated R1 told her NA-A was "mean" to her, she was unable to explain what R1 meant by "mean." SW-A stated she did not take any notes regarding the allegations. SW-A stated on R1's admission trauma assessment she did not identify any	F 610		

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

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F 610	Continued From page 21 trauma. SW-A denied completing any assessments following the allegations. She stated R1's behaviors were "on and off." SW-A was not aware of the allegations R1 had regarding her catheter cares. Upon interview on 12/18/23 at 10:57 a.m. the director of nursing, DON stated the nurse manager RN-C completed the incident report and the DON was she was aware NA-A was re-educated on the spot. She was unable to define or show any documentation of the scope of NA-A's re-education. The DON stated NA-A was not allowed to work with R1 after the incident. She did not believe any notifications were made to the NP or any other inventions implemented due to the allegations. The DON was uncertain about any assessments being completed following the allegations. The DON was unaware of the allegations regarding the catheter, therefor no investigation was completed. An abuse policy was requested however none received.	F 610		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -	F 656		1/12/24

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F 656	Continued From page 22 (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive person-centered care plan for mental and psychosocial needs including prevention,	F 656	F656 development/implement comprehensive care plan Corrective Action for resident R1 R1 discharged on 11/30/23.	

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F 656	Continued From page 23 interventions, measurable objectives, and goals for 1 of 1 resident (R1) reviewed. Findings include: R1's physician order dated 10/31/23 was for lorazepam (an anti-anxiety agent) oral tablet 0.5 milligrams (mg) three times a day. R1's care plan dated 10/31/23 - 12/5/23 did not indicate any focus, goal, or interventions for R1's anxiety. R1's physician order dated 10/31/23 was for Alprazolam (an anti-anxiety agent) tablet 0.25 mg by mouth every eight hours as needed for anxiety until 11/10/23. Notify provider on 11/10/23 of need to reassess medication. R1's physician order dated 10/31/23 was for hydroxyzine HCL (anti-anxiety agent) tablet 50 mg by mouth every six hours as needed for anxiety for ten days. Notify provider on 11/10/23 of need to reassess medication. R1's trauma assessment dated 10/31/23 consisted of one question, 1. Have you ever experienced some form of trauma or a stressful event, (i.e., serious accident or fire, a natural disaster, a physical or sexual assault or abuse, torture, a war, seeing someone killed or seriously injured or loss of a loved one. R1 indicated "no". There were not comments made on the assessment. R1's admission Minnesota Vulnerable Adult Assessment dated 10/31/23 question #4 Mood and Behavior none of the boxes were checked which included low self-esteem, high anxiety	F 656	How to identify other resident with the same issue. All current residents with mental and/or psychosocial needs will be identified and individual care plan will be in place to include prevention, interventions and measurable objectives and goals. Recurrence will be prevented by DNS or Designee will provide reeducation to person responsible for developing the person centered comprehensive care plan for mental and psychosocial needs. Education completed by 1/12/2024 These issues will be monitored in the following manor Nurse Managers will conduct audits of care plans to ensure person centered care plan for mental and psychosocial needs is developed. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 656	Continued From page 24 level, disruptive, wandering, history of elopement, inappropriate behaviors that could harm self or others. No comments were made in the comment box. R1's progress note dated 10/31/23 indicated R1 had a history of anxiety and was sensitive to touch and cares, and anxious about what will happen next. Scheduled Ativan (lorazepam) helped with that condition. R1's admission Minimal Data Set (MDS) date 11/5/23 indicated R1 had no cognitive deficits. R1 was dependent with toileting and lower body dressing and transfers. She required maximum assistance with upper body dressing and showering. R1's pertinent diagnoses were metastatic breast cancer, anxiety disorder, morbid obesity, and a pathological fracture of the left tibia (shin bone). R1's progress note dated 11/13/23 at 3:59 p.m. indicated R1 was very anxious that morning and no Ativan (lorazepam) had been given over the weekend. R1's progress note dated 11/22/23 indicated R1 was yelling at cursing at staff. The morning nurse spoke with her and calmed her down and then again about noon R1 called her husband to come and get her. R1 seemed more irritated the past few days. R1's physician order dated 11/21/23 indicated staff were to write a detailed note on any side effects or the effectiveness of lorazepam for anxiety. Staff was to write a note every Tuesday morning.	F 656		

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F 656	Continued From page 25 A facility incident report dated 11/22/23 indicated R1 was ready to leave the facility against medical advice (AMA) due to anxiety. In addition, the report indicated R1 had extreme anxiety and could be difficult to reason with and explain reality to. Upon interview on 10/15/23 at 10:14 a.m. registered nurse (RN)-C stated she had spoken with R1 on multiple occasions and R1 had been "emotional" several times and difficult to "read." RN-C stated she was not certain if any psychosocial behaviors or anxiety interventions were on R1's care plan. Upon interview on 10/15/23 at 11:10 a.m. nursing assistant (NA)-D stated she worked with R1 often and R1 had "high anxiety." She stated she had not been given any specific "items" on how to care for her anxiety. She stated she has worked very slowly and quietly around R1. Upon interview on 10/15/23 at 2:20 p.m. social worker (SW)-A stated R1 would often get angry and refuse cares. She stated she had many "meetings" with R1 and listened to her talk and calmed her down. SW-A denied taking any notes of "meetings" with R1. She stated she did not do any assessments other than the vulnerable adult and the trauma assessment upon admission. Upon interview on 10/15/23 at 10:57 a.m. the director of nursing, DON stated she was not certain of R1 had interventions for behaviors and anxiety on her care plan or not. A person-centered care plan policy was requested however none received.	F 656		

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F 842	Continued From page 26	F 842		
F 842 SS=D	Resident Records - Identifiable Information CFR(s): 483.20(f)(5), 483.70(i)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(i) Medical records. §483.70(i)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(i)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners,	F 842		1/12/24

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F 842	Continued From page 27 medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(i)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(i)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(i)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic services reports as required under §483.50. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to ensure a medical record was complete and accurately documented for nursing and/or other licensed professional notes for 1 of 1 resident (R1) reviewed when R1 had a straight catheterization procedure that was not recorded in the medical record for R1. Findings include:	F 842	F842 Residents Records □ Identifiable information Corrective Action for resident R1 R1 discharged on 11/30/23. All residents in the facility have the potential to be affected by the deficient practice All current residents with urinary catheters have been assessed for complete and	

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F 842	Continued From page 28 American Nursing Association, Principles for Nursing Documentation 2010, https://www.nursingworld.org/~4af4f2/globalassets/docs/ana/ethics/principles-of-nursing-documentation.pdf indicated documentation of nurses work is critical for effective communication with others and other disciplines. It provides a basis for demonstrating and understanding nursing contributions both to patient care outcomes and to the viability and effectiveness of the organizations that provide and support quality patient care. It is how nurses create a record of their services for use by communication within the health care team, communication with other professionals, credentialing, legal, regulation and legislation, reimbursement, research, and quality process and performance improvement. Documentation characteristics included accessibility, accurate, relevant, clear, concise, complete, readable, timely, contemporaneous, sequential, reflective of the nursing process, and retrievable. Documentation entries included entries that are accurate, valid, complete, authenticated, dated, time-stamped by persons who created the entry, and made using standardized terminology. R1's Minimal Data Set (MDS) dated 11/5/23 indicated R1 admitted to the facility on 10/30/23. R1's pertinent primary medical conditions indicated on the MDS included anxiety disorder, morbid obesity, metastatic breast cancer, pathological fracture of the left tibia (shin bone) and generalized muscle weakness. R1 had no cognitive deficits. R1 was dependent upon staff with toileting and lower body dressing and transfers. R1 required maximum assistance from staff with upper body dressing and bathing.	F 842	accurate documentation of procedure To ensure systemic changes are sustained DNS or Designee will provide re-education to all facility nurses on complete and accurate documentation for all urinary catheterization procedures. Education will be completed by 1/12/2024 These issues will be monitored in the following manor DNS and Nurse Managers will conduct audits to ensure completion of complete and accurate documentation of urinary catheterization procedures. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 842	Continued From page 29 R1's treatment administration record (TAR) with a start date 10/30/23 at 3:00 p.m., end date 10/31/23 at 4:01 p.m. indicated postvoid residuals (PVRs) (a scan of the bladder to determine the amount of residual urine after voiding) every shift for urine residual greater than 350 cubic centimeters (cc) to use a straight catheter (a soft, thin flexible tube is inserted into the urethra, until urine flows out, the catheter is then removed and discarded) three times. If straight catheterizations were greater than three times, reinsert an indwelling urinary catheter (an indwelling tube that stays in the urethra and bladder for urine voiding). - 10/30/23 evening shift R1 had a PVR of 550 cc's. - 10/30/23 to 10/31/23 night shift R1 had a PVR of 35 cc's. - 10/31/23 day shift R1 had a PVR of 1000 cc's. R1's progress notes from 10/30/23 to 11/30/23 indicated: - 10/30/23 at 12:28 p.m. R1 admitted to the facility from the hospital for skilled services following surgical repair of R1's left tibia. - 10/31/23 at 1:02 p.m. a summary of R1's skilled services indicated R1 was to receive skilled nursing services, physical therapy, and occupational therapy. R1 had anxiety, edema, urinary retention, incisional dressing, and pain was monitored. R1 was sensitive to touch and cares, anxious about what would happen next. Scheduled antianxiety medications helps with R1 conditions. R1 had urinary retention in the hospital. Had PVR orders. R1 attempted to void this morning but was unable, a PVR scan was completed that showed 1000 cc of urine in the bladder. R1 and R1's family member (FM)-A	F 842		

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F 842	Continued From page 30 requested an indwelling urinary catheter be placed. Next catheterization, including the hospital straight catheterizations, would be the fourth time. The indwelling urinary catheter procedure was tolerated by R1, returning 1200 cc of clear yellow urine. R1 was comfortable and less anxious. - 10/31/23 to 11/13/23 monitoring of the indwelling catheter was performed with no concerns from R1. - 11/14/23 at 4:25 p.m. R1 complained of pain and burning from the indwelling urinary catheter. An order was obtained for removal. R1's catheter was removed. - 11/30/23 at 3:26 p.m. R1 discharged from the facility. R1's medical record did not indicate the following pertaining to the straight catheterization on 10/30/23: - Hospital discharge and/or physician orders for treatment of straight catheterization as identified on the TAR for urinary retention upon admission on 10/30/23. - Documentation of education/rational/discussion of the straight catheterization procedure with R1. - If R1 agreed the straight catheterization procedure. - Documentation that a straight catheterization that was performed on R1 and how R1 tolerated the procedure. - The outcome/effectiveness of the procedure. Upon interview on 12/15/23 at 8:46 a.m. R1 stated she left the facility after one month due to how she was treated. She stated she has been in pain ever since the staff "forced catheterization" on her. She was sobbing during interview, having to stop between sentences,	F 842		

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F 842	Continued From page 31 saying "I'm sorry, I'm sorry, I hurt physically and emotionally." She stated due to having vaginal and leg pain she cannot stop thinking about the facility. She had an appointment with her physician later during that day to discuss her symptoms. "I think they damaged me; it hurts to pee." She stated two nurses, and a "man" were in her room during her stay at the facility, the staff was pulling on her leg trying to insert a catheter. R1 stated she was screaming, "stop it is hurting me, I don't need this." She stated her husband was sleeping in her room and he woke and told staff to stop as well. She stated, "the man" was standing at the end of her bed looking at her "parts." She said the women were trying to pull her legs apart as she was trying to close them. R1 stated the staff told her they needed to put the catheter in because it was unhealthy. R1 stated she did tell the nurse manager, registered nurse (RN)-C and RN-D that staff placed a catheter inside her, that she did not want, and they hurt her. Upon interview on 12/15/23 at 11:41 R1's family member (FM)-A stated R1 was yelling "stop you are hurting me; you are hurting me." He stated two female nurses were holding her legs apart and a male was there helping. "I told them to stop." He stated the staff stated if they could not get the urine out, she could become ill and must go to the hospital. She talks and cries about the trauma that the nurses caused every day since leaving the facility. Upon interview on 12/15/23 at 12:51 RN-E stated the day R1 was admitted on 10/30/23 was the day they had to straight catheterize her because her bladder scan contained over 350 cc; her bladder contained 550 cc's. She stated RN-B	F 842		

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F 842	Continued From page 32 came to her and asked for assistance. RN-B told RN-E that he needed assistance as R1 was refusing the procedure. RN-E stated the procedure was explained to R1; however, she was "frantic" and did not feel the procedure was necessary. R1 started to cry before staff began procedure. RN-E stated that her and RN-B started the process and R1 started yelling "It hurts, it hurts, I don't need this." R1 was lying flat on her back with her knees bent up. RN-E tried to expand R1's legs as much as she could, but R1 was saying her right leg was painful all the time. RN-E stated her role was to hold R1's legs so RN-B could insert the straight catheter. RN-E and RN-B did not get the straight catheter in inserted, "we pulled back." RN-E stated she explained to the husband if the staff could not catheterize R1 that she may have to go back to the hospital. RN-B left the room to get another nurse to assist with the procedure. RN-F came into the room and assisted RN-B with holding R1's legs apart. R1 was yelling "why do we now have another person in the room." As RN-B and RN-F were holding R1's legs RN-E did get the straight catheter inserted with a return of 574 cc of urine. R1's husband was heard saying that he hoped the procedure would be over soon and he hopes it would never need to be performed again. RN-E stated, "We did attempt to try putting it in after she said stop." RN-E stated the procedure from start until finish lasted about 20 minutes. RN-E She denied trying any other interventions to try to get R1 to urinate or her own or any other interventions to ease R1's anxiety. She denied calling the nurse practitioner when R1 was refusing for further recommendation. RN-E stated she did not document anything about the procedure in R1's notes as she was not the nurse in charge of R1's cares that night.	F 842		

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F 842	Continued From page 33 Upon interview on 12/15/23 at 2:36 p.m. RN-B stated R1 had an order to do a straight catheter procedure if her bladder scan residual showed over 350 cc. R1 was a larger lady who had anxiety, therefore RN-E was asked to assist. On the first attempt to insert the straight catheter R1 was yelling "you're ripping me apart." RN-B stated he did not insert the straight catheter yet and R1 was not being touched when she was screaming. R1 was closing her legs, so the insertion was not obtained with RN-E holding her legs and RN-B attempting in insert the straight catheter. RN-B stated he went to get another nurse to assist. R1's husband woke-up and RN-B did not recall what the husband was saying. RN-B stated he did not hear R1 say stop, rather she was yelling "you're ripping and putting it in the wrong hole" RN-B stated with the help of RN-D they were able to complete the procedure as RN-B and RN-D held R1's legs and RN-E inserted the straight catheter. RN-B stated R1 was saying it was vagina which was hurting not her leg. RN-B stated RN-F did say maybe the staff should pull back due to R1's resistance, but RN-E was about to get the "job done," so they proceeded. RN-B stated he did not recall if he wrote a progress note. He denied trying any relaxation interventions, education or notifying the NP for further instructions due to R1's anxiety or an update following the procedure. RN-B stated the entire procedure from start to finish took three minutes. The first attempt took two minutes and the second attempt one minute total time. RN-B stated he was aware that after procedure he was not allowed into R1's room per her request to not have male staff. RN-B stated he still proceeded with the procedure when she was because she was saying "just get it in the right hole."	F 842		

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F 842	Continued From page 34 Upon interview on 12/15/23 at 2:51 p.m. RN-D stated she worked the morning after R1 was straight catheterized. She stated that she knew R1 was upset about the catheterization and refused her bladder scans the rest of the night. RN-D stated she performed the bladder scan on R1 the following morning on 10/31/23 and she had 1000 cc's of residual urine in her bladder, which was a dangerous level. RN-D stated R1 was an extremely anxious resident and who was on "a lot" of anxiety medications and when the medications wore off R1 became "anxious and scared." RN-D stated she spent "a lot" of time with R1 and her husband and explained that she needed an indwelling foley catheter or to be straight catheterized again, but this time she would put in an indwelling foley catheter. RN-D stated she made sure R1 had her Ativan 0.5 milligrams (an antianxiety medication) and R1 and her husband consented to the indwelling foley catheter. She stated she and another nurse (unidentified) placed the straight catheter in without difficulty. Upon interview on 12/15/23 at 10:13 a.m. 2:39 p.m. RN-C nurse manager stated catheter orders and catheterization procedures should be in the treatment section of the electronic health record. The facility provided the Care Providers of Minnesota Combined Federal and Minnesota State Bill of Rights version 6/8/19 indicated residents have the right to refuse treatment with documentation in the individual medical record.	F 842		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f)	F 880		1/12/24

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

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F 880	Continued From page 36 depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review the facility failed to follow transmission-based precautions to prevent the spread of SARS-CoV2 (Covid-19), influenza, and clostridium difficile (c. diff) for 4 of 4 residents evaluated for infection control. The facility failed to practice proper hand hygiene, post the proper signage at a doorway, adhere to proper personal protective equipment (PPE), sanitize medical equipment following resident usage, and have proper doffing (taking off PPE) areas. This deficient practice had the potential to infect all 61	F 880	F880 Infection Prevention & Control Corrective Action for resident R6, R11, R5, R4 R4, R5, R6, and R11 were assessed by infection preventionist and immediately implemented correction to ensure all appropriate transmission based precautions were in place. All staff immediately re-educated on transmission based precautions. All residents in the facility have the potential to be affected by the deficient	

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F 880	Continued From page 37 residents who resided at the facility. A Minnesota Department of Health resource titled Covid-19 Source Control (Masking), PPE, and Testing grid dated 9/15/23, https://www.health.state.mn.us/diseases/coronavirus/hcp/ppegrid.pdf indicated when a resident has tested positive for COVID-19, staff's PPE should consist of respirator, eye protection, isolation gown, and gloves. A Minnesota Department of Health resource titled Interim Guidance for Influenza Outbreak Management in Long-Term Care Facilities dated 1/10/23, https://www.health.state.mn.us/diseases/flu/ltc/intguide.pdf indicated that when a resident has tested positive for Influenza, staff should follow Droplet Precautions, which includes wearing a mask. The Centers for Disease and Control and Prevention (CDC) website titled 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, https://www.cdc.gov/infectioncontrol/guidelines/isolation/index.html identified the level of precautions and PPE required when caring for residents with active C. difficile infections. Appendix A of this CDC publication, updated September 2018, identified C. difficile infection indicates the need to implement Standard Precautions in addition to Contact Precautions. Contact Precautions indicate the use of an isolation gown and gloves to prevent the unintended spread of infectious organisms through incidental contact with the healthcare personnel. Section III.B.1 indicated Contact	F 880	practice All current residents identified for transmission based precautions will be assessed for appropriate transmission based precautions per facility policy and procedure. To ensure systemic changes are sustained DNS or Designee will provide reeducation to all facility staff on transmission based precautions. Education will be completed by 1/12/2024 These issues will be monitored in the following manor DNS and Nurse Managers will conduct audits to ensure correct completion of transmission based precautions. Audits will be completed weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 880	Continued From page 38 Precautions should be observed whenever coming into contact with the resident, or the resident's environment, and should be discarded upon exit from the resident's room. In addition to Contact Precautions, Section IV.A.4. indicated hand hygiene must be completed by hand washing with soap and water, as traditional alcohol-based hand-sanitizer is not effective in neutralizing or removing C. difficile bacterial spores. A Minnesota Department of Health (MDH) resource titled Standard Precautions updated 10/20/22 at https://www.health.state.mn.us/facilities/patientsafety/infectioncontrol/pre/standard.html indicated standard precautions are the basic level of infection control that should be used in the care of all patients all the time. Patient care equipment identified equipment is to be cleaned, disinfected, or reprocess non-disposable equipment before reuse with another patient. A CDC poster for donning and doffing PPE retrieved 12/15/23 https://www.cdc.gov/HAI/pdfs/ppe/ppeposter148.pdf indicated except for respirator, remove PPE at doorway on in anteroom. A Minnesota Department of Health resource titled Hand Hygiene for Health Professionals updated 10/4/22 https://www.health.state.mn.us/people/handhygiene/hcp/index.html indicated: - Hand hygiene is indicated before: patient contact, donning gloves when inserting a central venous catheter (CVC), and inserting urinary catheters, peripheral vascular catheters, or other invasive devices that do not require surgery.	F 880		

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F 880	Continued From page 39 - Hand hygiene is also indicated after contact with a patient's intact skin, contact with body fluids or excretions, non-intact skin, or wound dressings, and after removing gloves. - Gloves should be used when a HCW has contact with blood or other body fluids in accordance with universal precautions. R6's Progress note dated 12/13/23 at 6:07 a.m., indicated R6 complained of a sore throat, body aches, and a mild dry cough, but a rapid covid test came back negative. R6's Progress note dated 12/13/23 at 8:39 p.m. indicated R6 was on contact and droplet precautions but did not indicate why the precautions were ordered. Upon observation on 12/14/23 at 10:10 a.m. an isolation sign hung outside of R6's room that indicated enhanced barrier precautions. The sign indicated everyone must clean their hands before entering and exiting the room. Providers and staff were also to wear gloves and a gown for resident care areas including: 1. Dressing. 2. Bathing/showering, 3. Transferring. 4. Changing linens. 5. Personal hygiene. 6. Changing of briefs and assisting with toilet. On the PPE supply cart outside of R6's room were three isolation signs titled contact precautions, droplet precautions and airborne precautions. The PPE cart was stocked with gloves, a sign in/out sheet, sanitation wipes, and surgical face mask. The cart did not contain and hand sanitizer or gowns. Upon observation on 12/14/23 at 10:10 a.m. a dietary staff (DT)-A was seen in room only wearing a surgical mask. DT-A was moving R6's tray table and visiting with R6. Upon interview on	F 880		

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F 880	Continued From page 40 12/14/23 at 10:14 a.m. DT-A stated she did see the signs and PPE cart outside of R6's room and saw the precautions signs on the cart. She stated she was confused as what PPE to wear. She stated she was only in the room making sure R6 was comfortable and getting her meal menu. DT-A was not certain if R6 had Covid-19. She was aware there was Covid-19 in the facility. Upon interview on 12/14/23 at 10:39 trained medication assistant (TMA) stated she was not certain which precautions R6 should be on when she was shown all three precaution signs on R6's PPE cart. TMA-A deferred all infection control questions to the infection preventionist. Upon interview on 12/14/23 at 10:42 a.m. the infection preventionist (IP) stated the sign that should be posted outside of R6's room should have been the airborne precaution sign. She stated all staff were to wear full PPE (gown, gloves, face shield, eye protection, and N95 mask) while in R6's room. IP states that she heard that R6 was symptomatic but unaware of the symptoms or diagnosis R6 is experiencing. R11's care plan dated 10/4/23 indicated R11 required a mechanical lift to be transferred from her bed to her wheelchair. Upon observation on 12/14/23 at 10:18 a.m. nursing assistant (NA)-D was wearing gloves, she repositioned R11 by turning her, provided incontinence cares by cleaning R11's peri area, and changing R11's soiled incontinence pad while R11 was in bed. NA-D did not change her gloves after discarding the soiled pad into the garbage in the bathroom. NA-D kept the same pair of gloves on and placed the mechanical lift sling on R11.	F 880		

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F 880	Continued From page 41 NA-D left R11's the room with the soiled gloves and came back in with another staff member to assist with the mechanical lift. NA-D took off her gloves, did not wash her hands and proceeded to lift R11 with the mechanical left and got her seated in her wheelchair. NA-D wheeled the mechanical lift out of R11's room and plugged it into the outlet in the hallway without sanitizing it. There were no sanitation wipes in the bag on the lift. At 10:30 a.m. the mechanical lift was still in the hallway without being sanitized. NA-D had left the hallway to assist in another hallway. Upon interview on 12/14/23 at 10:39 a.m. TMA-A stated all equipment is to be wiped down with sanitary wipes after use on a resident. R4's progress note dated 12/12/23 at 4:08 p.m. indicated R4 was on contact precautions for c.diff. Upon observation on 12/14/23 at 11:51 a.m. a contact precaution sign was hung on the wall outside R4's room indicating R4 was on contact precautions for c.diff. Gloves, a face mask and a gown was to be worn with any patient contact. You must wash your hands with soap and warm water after contact with any resident who has c.diff. A cart with PPE supplies was outside R4's door. Registered nurse (RN)-A entered R4's room wearing a surgical face mask, no gloves, and no gown. RN-A took a blanket from R4 's bed and draped it over R4, who was seated in a reclining chair. Upon interview on 12/14/23 at 12:10 p.m. RN-A stated, she did not need to wear any PPE as she did not make contact with R4, she stated "yes I gave her a blanket, but I did not touch her." RN-A did wash her hands with soap and water while in the bathroom after doffing, and then sanitized when exiting R4's	F 880		

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F 880	Continued From page 42 room. Upon observation on 12/14/23 at 12:46 p.m. nursing assistant (NA)-A donned a surgical mask, gown, and gloves. NA-A entered R4's room with a meal tray and placed the tray on R4's table, she removed the aluminum foil from the plate and removed the lids from the cups on the tray. R4 removed a blanket on R4's lap and placed it on her bed. NA-A doffed the PPE in R4's bathroom except for the surgical mask. She exited R4's room and did not wash her hands before delivering the next lunch tray. Upon interview on 12/14/23 at 12:55 p.m. NA-A stated she was not informed to wash hands between rooms when passing trays for residents in isolation. She stated, "they don't give us hand sanitizer for the meal tray carts." R5's progress note dated 12/14/23 at 2:37 p.m. indicated R5 had Covid-19 and was on airborne precautions. Upon observation and interview on 12/15/23 at 1:37 p.m. R5 had the airborne precaution sign outside of her room along with how to don and doff PPE. The PPE cart had been moved across the hallway next to another room. NA-B entered R5's room wearing only a surgical mask. NA-B closed R5's door. NA-B exited the room a minute later and stated she did not need to wear PPE because she was not going to touch the patient. NA-B stated she had infection control education. Upon observations from 12/14/23 at 10:30 a.m. through 2:20 p.m. R2, R4, R5 and R6's rooms had the PPE set-up to doff the PPE in the bathrooms of the resident isolation rooms. In	F 880		

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F 880	Continued From page 43 each of the rooms, the staff had to walk through the resident's room after doffing the PPE to exit into the hallway. Upon interview on 12/14/23 at 3:10 p.m. RN-B stated in all the isolation rooms the staff is doffing in the bathrooms. The bathrooms have linen carts in them for the any cloth PPE and a garbage bag was hung on the bathroom doors for disposable PPE. He stated that practice had the "chance" of contamination especially for airborne precautions as that left him inside the room without proper PPE. Upon interview on 12/18/23 at 10:25 a.m. the infection preventionist (IP) stated she expected all staff to follow the precaution signs outside of the resident's doors. She stated all staff had been trained and were up to date on infection control training. She stated new staff were trained at orientation and the current staff are given quarterly online infection control training. In addition, she stated she was not aware that the doffing for PPE in the isolation rooms was completed in the resident's bathroom. She stated, "They need to be doffing in the clean area right by the exiting door." The facilities Infection Prevention policy dated 8/22/23 indicated staff shall wear appropriate PPE (gowns, gloves, N95 or respirator plus eye protection) as a form of exposure control when caring for a patient with Covid-19. Staff must follow additional federal, state, and local regulatory guidelines against Covid-19. Request was given to the facility for their Influenza policy and procedure, but none was given.	F 880		

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F 880	Continued From page 44 Request was given to the facility for their c. diff policy and procedure, but none was given.	F 880		

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 12/14/23 - 12/18/23, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was NOT in compliance with the MN State Licensure, and the following licensing order(s) (was/were) issued. Please indicate in your electronic plan of correction you have reviewed	2 000		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 these orders and identify the date when they will be completed. The following complaints were reviewed with no licensing orders issued. H52217864C (MN98457) The following complaints were reviewed. H52217706C (MN98977) with a licensing orders issued at ST0565. In addition, the following incidental tags were issued ST0590, ST1840. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "CORRECTED" in the box available for text. You must then indicate in the	2 000		

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2 000	Continued From page 2 electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. The facility is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. _____ _____ _____	2 000		
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to develop a comprehensive person-centered care plan for mental and psychosocial needs including prevention, interventions, measurable objectives, and goals for 1 of 1 resident (R1) reviewed. Findings include:	2 565	Corrected	1/12/24

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2 565	Continued From page 3 R1's physician order dated 10/31/23 was for lorazepam (an anti-anxiety agent) oral tablet 0.5 milligrams (mg) three times a day. R1's care plan dated 10/31/23 - 12/5/23 did not indicate any focus, goal, or interventions for R1's anxiety. R1's physician order dated 10/31/23 was for Alprazolam (an anti-anxiety agent) tablet 0.25 mg by mouth every eight hours as needed for anxiety until 11/10/23. Notify provider on 11/10/23 of need to reassess medication. R1's physician order dated 10/31/23 was for hydroxyzine HCL (anti-anxiety agent) tablet 50 mg by mouth every six hours as needed for anxiety for ten days. Notify provider on 11/10/23 of need to reassess medication. R1's trauma assessment dated 10/31/23 consisted of one question, 1. Have you ever experienced some form of trauma or a stressful event, (i.e., serious accident or fire, a natural disaster, a physical or sexual assault or abuse, torture, a war, seeing someone killed or seriously injured or loss of a loved one. R1 indicated "no". There were not comments made on the assessment. R1's admission Minnesota Vulnerable Adult Assessment dated 10/31/23 question #4 Mood and Behavior none of the boxes were checked which included low self-esteem, high anxiety level, disruptive, wandering, history of elopement, inappropriate behaviors that could harm self or others. No comments were made in the comment box. R1's progress note dated 10/31/23 indicated R1	2 565		

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2 565	Continued From page 4 had a history of anxiety and was sensitive to touch and cares, and anxious about what will happen next. Scheduled Ativan (lorazepam) helped with that condition. R1's admission Minimal Data Set (MDS) date 11/5/23 indicated R1 had no cognitive deficits. R1 was dependent with toileting and lower body dressing and transfers. She required maximum assistance with upper body dressing and showering. R1's pertinent diagnoses were metastatic breast cancer, anxiety disorder, morbid obesity, and a pathological fracture of the left tibia (shin bone). R1's progress note dated 11/13/23 at 3:59 p.m. indicated R1 was very anxious that morning and no Ativan (lorazepam) had been given over the weekend. R1's progress note dated 11/22/23 indicated R1 was yelling at cursing at staff. The morning nurse spoke with her and calmed her down and then again about noon R1 called her husband to come and get her. R1 seemed more irritated the past few days. R1's physician order dated 11/21/23 indicated staff were to write a detailed note on any side effects or the effectiveness of lorazepam for anxiety. Staff was to write a note every Tuesday morning. A facility incident report dated 11/22/23 indicated R1 was ready to leave the facility against medical advice (AMA) due to anxiety. In addition, the report indicated R1 had extreme anxiety and could be difficult to reason with and explain reality to.	2 565		

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2 565	Continued From page 5 Upon interview on 10/15/23 at 10:14 a.m. registered nurse (RN)-C stated she had spoken with R1 on multiple occasions and R1 had been "emotional" several times and difficult to "read." RN-C stated she was not certain if any psychosocial behaviors or anxiety interventions were on R1's care plan. Upon interview on 10/15/23 at 11:10 a.m. nursing assistant (NA)-D stated she worked with R1 often and R1 had "high anxiety." She stated she had not been given any specific "items" on how to care for her anxiety. She stated she has worked very slowly and quietly around R1. Upon interview on 10/15/23 at 2:20 p.m. social worker (SW)-A stated R1 would often get angry and refuse cares. She stated she had many "meetings" with R1 and listened to her talk and calmed her down. SW-A denied taking any notes of "meetings" with R1. She stated she did not do any assessments other than the vulnerable adult and the trauma assessment upon admission. Upon interview on 10/15/23 at 10:57 a.m. the director of nursing, DON stated she was not certain of R1 had interventions for behaviors and anxiety on her care plan or not. A person-centered care plan policy was requested however none received. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee could monitor comprehensive person-centered care plans for mental and psychosocial needs. The director of nursing or designee could monitor for compliance.	2 565		

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2 565	Continued From page 6 TIME PERIOD FOR CORRECTION: Twenty One (21) days.	2 565		
2 590	MN Rule 4658.0435 Subp. 1 Confidentiality of Clinical Records and Info Subpart 1. Maintaining confidentiality of records. Information in the clinical records, regardless of form or storage methods, must be kept confidential according to Minnesota Statutes, chapter 13 and sections 144.335 and 144.651, and federal regulations. A resident's clinical information in a nursing home must be considered confidential but it must be made available to all persons in the nursing home who are responsible for the care of the resident. The clinical information must be open to inspection by representatives of the Department of Health and others legally authorized to obtain access. This MN Requirement is not met as evidenced by: Based on observation and interview, the facility failed to ensure resident records that contained private, medical, and personal information were not accessible to unauthorized personnel when two unsecured cardboard boxes were left at a nurse's station that contained resident care plans and other resident medical information. The facility also failed to safeguard personal and medical information contained in the Electronic Medical Record (EMR) when three computers were left open in an area where any staff, visitor, or resident could view on three separate occasions. These deficient practices had the potential to affect all 61 residents who reside in the facility.	2 590	Corrected	1/12/24

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2 590	Continued From page 7 Findings include: During an observation on 12/14/23 at 10:37 a.m., at the nursing station located on the first floor of the 102 wing, a computer at a nurse's station was unlocked for 5 minutes with resident care plan tasks visible. The nurse's station was in an open area in the middle of two resident care wings where any staff, visitor, or resident could walk behind. There was no staff sitting at the desk. During an observation on 12/14/23 at 10:50 a.m., at the nursing station located on the first floor, down the hallway of the 102 wing, a computer at a nurse's station was unlocked for 5 minutes with resident care plan tasks visible. The nurse's station was in an open area in the middle of two resident care wings where any staff, visitor, or resident could walk behind. There was no staff sitting at the desk. During an observation on 12/14/23 at 11:12 a.m., at the nursing station located on 2nd floor conjoining two wings of the facility, a computer at a nurse's station was unlocked for 5 minutes with resident care plan tasks visible. The nurse's station was in an open area in the middle of two resident care wings where any staff, visitor, or resident could walk behind. There was no staff sitting at the desk. During an observation on 12/14/23 at 12:51 p.m., at the nursing station located on the 2nd floor in the post acute area, two full unsecured cardboard boxes were left under a desk at a nurse's station that contained resident's care plans and other resident medical information. The nurse's station is in an open area in the middle of four active areas in the building: two resident care wings, the kitchen, and a dining room. The	2 590		

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2 590	Continued From page 8 nurse's station was easily accessible to any staff, visitor, or resident. The unsecured cardboard boxes were observed for one hour. Writer observed the nurse's station during the lunch hour and there was kitchen staff going to and from and kitchen to the dining room. There was no staff sitting at the desk. The cardboard boxes contained resident names, room numbers, and other medical and personal information on them. The cardboard boxes were overflowing with no lid. During an interview with the facility's social worker (SW) on 12/14/23 at 12:54 p.m., SW stated the 2 full unsecured cardboard boxes that were left under a desk at the nurse's station contained pertinent patient identifying information. SW stated this box should not have been there and these papers should have been shredded. SW stated that this would violate the resident's privacy. During an interview with director of nursing (DON) on 12/18/23 at 10:57 a.m., DON stated she would expect nursing staff to put patient identifying information, including care sheets, in a box under the nurse's desk at the nurse's station or in a shred-it bin after each shift. DON stated she would expect staff to chart their cares and lock their computers after documenting. During an interview with the facility administrator on 12/18/23 at 11:21 a.m., the administrator stated her expectation would be for staff to place nursing care sheets or any patient identifying information to be placed in the shred-it bins at the end of their shift. Request was given to the facility for their Health Insurance Portability and Accountability Act	2 590		

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2 590	Continued From page 9 (HIPAA) policy and procedure but was given the HIPAA Assigned Security Responsibilities-Enterprise policy that was reviewed and revised on 4/11/19. This policy did not indicate the facility's responsibilities for keeping resident's private, medical, or personal information secure and confidential. SUGGESTED METHOD FOR CORRECTION: The director of nursing and/or designeed could assure medical records are safeguarded, that policies and procedures are reviewed revised, staff trained, system monitored, assessed and evaluated to assure medical records are safeguarded. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 590		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record.	21840		1/12/24

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21840	Continued From page 10 This MN Requirement is not met as evidenced by: Based on interview and document review the facility failed to comply with resident rights to refuse treatment for 1 of 4 residents (R1) reviewed when staff proceeded with a urinary straight catheterization while R1 verbally and physically refused the procedure. R1 has had increased anxiety since the straight catheterization procedure. Findings include: R1's Minimal Data Set (MDS) dated 11/5/23 indicated R1 admitted to the facility on 10/30/23. R1's pertinent primary medical conditions indicated on the MDS included anxiety disorder, morbid obesity, metastatic breast cancer, pathological fracture of the left tibia (shin bone) and generalized muscle weakness. R1 had no cognitive deficits. R1 was dependent upon staff with toileting and lower body dressing and transfers. R1 required maximum assistance from staff with upper body dressing and bathing. R1's treatment administration record (TAR) with a start date 10/30/23 at 3:00 p.m., end date 10/31/23 at 4:01 p.m. indicated postvoid residuals (PVRs) (a scan of the bladder to determine the amount of residual urine after voiding) every shift for urine residual greater than 350 cubic centimeters (cc) to use a straight catheter (a soft, thin flexible tube is inserted into the urethra, until urine flows out, the catheter is then removed and discarded) three times. If straight catheterizations were greater than three times, reinsert an indwelling urinary catheter (an indwelling tube that stays in the urethra and bladder for urine voiding). - 10/30/23 evening shift R1 had a PVR of 550	21840	Corrected	

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21840	Continued From page 11 cc's. - 10/30/23 to 10/31/23 night shift R1 had a PVR of 35 cc's. - 10/31/23 day shift R1 had a PVR of 1000 cc's. R1's progress notes from 10/30/23 to 11/30/23 indicated: - 10/30/23 at 12:28 p.m. R1 admitted to the facility from the hospital for skilled services following surgical repair of R1's left tibia. - 10/31/23 at 1:02 p.m. a summary of R1's skilled services indicated R1 was to receive skilled nursing services, physical therapy, and occupational therapy. R1 had anxiety, edema, urinary retention, incisional dressing, and pain was monitored. R1 was sensitive to touch and cares, anxious about what would happen next. Scheduled antianxiety medications helps with R1 conditions. R1 had urinary retention in the hospital. Had PVR orders. R1 attempted to void this morning but was unable, a PVR scan was completed that showed 1000 cc of urine in the bladder. R1 and R1's family member (FM)-A requested an indwelling urinary catheter be placed. Next catheterization, including the hospital straight catheterizations, would be the fourth time. The indwelling urinary catheter procedure was tolerated by R1, returning 1200 cc of clear yellow urine. R1 was comfortable and less anxious. - 10/31/23 to 11/13/23 monitoring of the indwelling catheter was performed with no concerns from R1. - 11/14/23 at 4:25 p.m. R1 complained of pain and burning from the indwelling urinary catheter. An order was obtained for removal. R1's catheter was removed. - 11/30/23 at 3:26 p.m. R1 discharged from the facility.	21840		

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21840	Continued From page 12 R1's physician order dated 11/1/23 at 9:31 a.m. indicated indwelling urinary catheter, 16 French with 15 cc's in 30 cc balloon, to dependent drainage. Change catheter as needed if dislodged or plugged and unable to clear with irrigation. R1's physician order dated 11/14/23 at 7:00 a.m. indicated okay to remove indwelling urinary catheter if R1 wants. PVR every shift for 72 hours. Straight catheter if residual urine is 350 cc or greater. If straight catheter needed three times reinsert indwelling urinary catheter. Upon interview on 12/15/23 at 8:46 a.m. R1 stated she left the facility after one month due to how she was treated. She stated she has been in pain ever since the staff "forced catheterization" on her. She was sobbing during interview, having to stop between sentences, saying "I'm sorry, I'm sorry, I hurt physically and emotionally." She stated due to having vaginal and leg pain she cannot stop thinking about the facility. She had an appointment with her physician later during that day to discuss her symptoms. "I think they damaged me; it hurts to pee." She stated two nurses, and a "man" were in her room during her stay at the facility, the staff was pulling on her leg trying to insert a catheter. R1 stated she was screaming, "stop it is hurting me, I don't need this." She stated her husband was sleeping in her room and he woke and told staff to stop as well. She stated, "the man" was standing at the end of her bed looking at her "parts." She said the women were trying to pull her legs apart as she was trying to close them. R1 stated the staff told her they needed to put the catheter in because it was unhealthy. R1 stated she did tell the nurse manager, registered nurse (RN)-C and RN-D that staff placed a catheter	21840		

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21840	Continued From page 13 inside her, that she did not want, and they hurt her. Upon interview on 12/15/23 at 11:41 R1's family member (FM)-A stated R1 was yelling "stop you are hurting me; you are hurting me." He stated two female nurses were holding her legs apart and a male was there helping. "I told them to stop." He stated the staff stated if they could not get the urine out, she could become ill and must go to the hospital. She talks and cries about the trauma that the nurses caused every day since leaving the facility. A police report was filed by FM-A on 11/15/23 for the incident 10/30/23 and the care received at the facility. Upon inquiry on 12/15/23 with the police department at 9:41 a.m. The department did not have a police report on file made by FM-A regarding R1. Upon interview on 12/15/23 at 12:51 RN-E stated the day R1 was admitted on 10/30/23 was the day they had to straight catheterize her because her bladder scan contained over 350 cc; her bladder contained 550 cc's. She stated RN-B came to her and asked for assistance. RN-B told RN-E that he needed assistance as R1 was refusing the procedure. RN-E stated the procedure was explained to R1; however, she was "frantic" and did not feel the procedure was necessary. R1 started to cry before staff began procedure. RN-E stated that her and RN-B started the process and R1 started yelling "It hurts, it hurts, I don't need this." R1 was lying flat on her back with her knees bent up. RN-E tried to expand R1's legs as much as she could, but R1 was saying her right leg was painful all the time. RN-E stated her role was to hold R1's legs so RN-B could insert the straight catheter. RN-E	21840		

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21840	Continued From page 14 and RN-B did not get the straight catheter in inserted, "we pulled back." RN-E stated she explained to the husband if the staff could not catheterize R1 that she may have to go back to the hospital. RN-B left the room to get another nurse to assist with the procedure. RN-F came into the room and assisted RN-B with holding R1's legs apart. R1 was yelling "why do we now have another person in the room." As RN-B and RN-F were holding R1's legs RN-E did get the straight catheter inserted with a return of 574 cc of urine. R1's husband was heard saying that he hoped the procedure would be over soon and he hopes it would never need to be performed again. RN-E stated, "We did attempt to try putting it in after she said stop." RN-E stated the procedure from start until finish lasted about 20 minutes. She denied trying any other interventions to try to get R1 to urinate or her own or any other interventions to ease R1's anxiety. She denied calling the nurse practitioner when R1 was refusing for further recommendation. RN-E stated she did not document anything about the procedure in R1's notes as she was not the nurse in charge of R1's cares that night. Upon interview on 12/15/23 at 2:36 p.m. RN-B stated R1 had an order to do a straight catheter procedure if her bladder scan residual showed over 350 cc. R1 was a larger lady who had anxiety, therefore RN-E was asked to assist. On the first attempt to insert the straight catheter R1 was yelling "you're ripping me apart." RN-B stated he did not insert the straight catheter yet and R1 was not being touched when she was screaming. R1 was closing her legs, so the insertion was not obtained with RN-E holding her legs and RN-B attempting in insert the straight catheter. RN-B stated he went to get another nurse to assist. R1's husband woke-up and	21840		

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	00900	A. BUILDING: _____ B. WING _____	C 12/18/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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21840	Continued From page 15 RN-B did not recall what the husband was saying. RN-B stated he did not hear R1 say stop, rather she was yelling "you're ripping and putting it in the wrong hole" RN-B stated with the help of RN-D they were able to complete the procedure as RN-B and RN-D held R1's legs and RN-E inserted the straight catheter. RN-B stated R1 was saying it was vagina which was hurting not her leg. RN-B stated RN-F did say maybe the staff should pull back due to R1's resistance, but RN-E was about to get the "job done," so they proceeded. RN-B stated he did not recall if he wrote a progress note. He denied trying any relaxation interventions, education or notifying the NP for further instructions due to R1's anxiety or an update following the procedure. RN-B stated the entire procedure from start to finish took three minutes. The first attempt took two minutes and the second attempt one minute total time. RN-B stated he was aware that after procedure he was not allowed into R1's room per her request to not have male staff. RN-B stated he still proceeded with the procedure when she was because she was saying "just get it in the right hole." Upon interview on 12/15/23 at 2:51 p.m. RN-D stated she worked the morning after R1 was straight catheterized. She stated that she knew R1 was upset about the catheterization and refused her bladder scans the rest of the night. RN-D stated she performed the bladder scan on R1 the following morning and she had 1000 cc's of residual urine in her bladder, which was a dangerous level. RN-D stated R1 was an extremely anxious resident and who was on "a lot" of anxiety medications and when the medications wore off R1 became "anxious and scared." RN-D stated she spent "a lot" of time with R1 and her husband and explained that she needed an indwelling foley catheter or to be	21840		

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21840	Continued From page 16 straight catheterized again, but this time she would put in an indwelling foley catheter. RN-D stated she made sure R1 had her Ativan 0.5 milligrams (an antianxiety medication) and R1 and her husband consented to the indwelling foley catheter. She stated she and another nurse (unidentified) placed the straight catheter in without difficulty. Upon interview on 12/15/23 at 2:39 p.m. RN-C the nurse manager stated she was not aware that R1 was yelling stop and yelling out pain during the straight catheterization procedure. In addition, she was not aware that three staff were in her room attempting to perform the straight catheter procedure. She stated 574 cc's is not that much urine, so it was not emergent that staff catheter her. She stated her expectation of staff would have been to stop and to get further direction from the NP. The nurse manager stated, "There is no excuse, no means no." Upon interview on 12/15/23 at 3:06 p.m. RN-F stated RN-B requested her assistance with straight catheterization on a resident who was having anxiety. R1 was in her room and was very anxious when RN-F arrived, she was yelling. RN-F stated R1 was thrashing and flailing her legs around saying she was uncomfortable. RN-F did not recall her saying stop but recalled yelling. RN-F heard R1 say that she was not comfortable as RN-F and RN-B were holding back the skin folds of her legs and abdomen. RN-F stated she was uncertain of any interventions RN-B and RN-E providing before asking for her assistance. RN-F stated if resident does not want something done staff does not do it. Upon interview on 12/18/23 at 10:57 a.m. the	21840		

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21840	Continued From page 17 director of nursing (DON) stated she heard that R1 at first did not want the straight catheter procedure, but then said she would allow it and the husband was present. She stated that she was not aware R1 was yelling. She stated if R1 was yelling, she would expect the staff to stop and come up with another plan. Upon interview on 12/18/23 at 11:21 p.m. the Administrator stated she was not aware of the straight catheter procedure for staff or residents, but if a resident were yelling, she would expect the staff to stop and explain risk and benefits to the resident. A facility policy titled Notification of Changes in residents-rehab/skilled dated 1/18/23 indicated the purpose was to ensure the resident receive prompt notification of changes in residents' rights. The facility provided the Care Providers of Minnesota Combined Federal and Minnesota State Bill of Rights version 6/8/19. Under the title Exercise of Rights indicated the facility must ensure the resident can exercise their rights without interference, coercion, discrimination, or reprisal from the facility. Under the title Planning and Implementing Care indicated the right to request, refuse, and/or discontinue treatment. Competent residents have the right to refuse treatment. SUGGESTED METHOD FOR CORRECTION: The DON or designee(s) could review and revise as necessary the policies and procedures regarding the resident's refusal of care. The DON, or designee(s) could provide an in-service for all appropriate staff on providing treatment per each resident's plan of care. The DON, or	21840		

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21840	Continued From page 18 designee(s) could monitor to assure each resident's receives proper care. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21840		