DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 12, 2023

Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245285
Cycle Start Date: November 16, 2022

Dear Administrator:

On November 30, 2022, we notified you a remedy was imposed. On January 5, 2023 the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of December 23, 2022.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective January 14, 2023 did not go into effect. (42 CFR 488.417 (b))

In our letter of November 30, 2022, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 14, 2023 due to denial of payment for new admissions. Since your facility attained substantial compliance on December 23, 2022, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

January 12, 2023

Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

Re: Reinspection Results
Event ID: EO7J12

Dear Administrator:

On January 5, 2023 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 November 16, 2022. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

DEPARTMENT OF HEALTH

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Electronically delivered
November 30, 2022

Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

RE: CCN: 245285
Cycle Start Date: November 16, 2022

Dear Administrator:

On November 16, 2022, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 14, 2023.

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

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 14, 2023. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 14, 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:

- Civil money penalty (42 CFR 488.430 through 488.444). You will receive a formal notice from the CMS RO only if CMS agrees with our recommendation.

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $11,292; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by January 14, 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 - Inver Grove Heights will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from January 14, 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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 May 16, 2023 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) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact 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://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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically delivered
November 30, 2022

Administrator
Good Samaritan Society - Inver Grove Heights
1301 50th Street East
Inver Grove Heights, MN 55077

Re: State Nursing Home Licensing Orders
Event ID: EO7J11

Dear Administrator:

The above facility was surveyed on November 15, 2022 through November 16, 2022 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor
Rochester District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904-5506
Email: jennifer.kolsrud@state.mn.us
Office: (507) 206-2727 Mobile: (507) 461-9125

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,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245285	A. BUILDING _____ B. WING _____	C 11/16/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/15/22-11/16/22, a COVID-19 Focused Infection Control survey was conducted at your facility by the Minnesota Department of Health to determine compliance with §483.73 Infection Control. The facility was determined to be NOT in compliance. AND The following complaints were found to be SUBSTANTIATED: H52855717C (MN00088259) and H52855960C (MN00088478), with a deficiency cited at F880, F883, F886, 887, and F689. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains	F 689		12/23/22

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

Electronically Signed | 12/09/2022

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

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F 689	Continued From page 1 as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and update care plans and develop new interventions to provide adequate supervision to prevent addition falls for 1 of 3 residents (R8) reviewed for falls. Findings include: R8's admission Minimum Data Set (MDS) assessment dated 9/20/22, indicated R8 required limited assistance for bed mobility, transfers, toileting, and personal hygiene. R8's significant change MDS dated 10/18/22, indicated R8 had moderately impaired cognition. R8 had no delusions, hallucinations, and had no physical behavioral symptoms, verbal behavioral symptoms, or other behavioral symptoms such as pacing and behavior was not exhibited for rejection of cares. The MDS indicated R8 was limited assist for bed mobility, supervision cueing for toileting, and activity did not occur for transferring. R8's diagnoses included: nondisplaced intertrochanteric fracture of right femur, adult failure to thrive, hypertension, heart failure, mild cognitive impairment, and depression. R8's activities of daily living care plan revised on 10/16/22, indicated R8 had bilateral lower extremity weakness and needed one assist for	F 689	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed soley because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the centers allegation of complaince in accordance with section 7305 of the State Operation Manuel. 1.Resident 8 was discharged to Assisted Living facility on 11-22-22 per planned discharged. 2.All residents who have had a fall in the past 30 days have been reviewed to ensure they were comprehensively reassessed with care plans updated with new interventions to prevent recurrence as appropriate. 3.DNS or designee will provide re-education for nursing staff on GSS P&P for falls follow up. Including comprehensive assessment and care	

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F 689	Continued From page 2 bed mobility, transfers, eating, dressing, toilet use and personal hygiene. R8's care plan revised on 10/16/20, indicated R8 was at risk for falls due to immobility as evidenced by a superior pubic fracture. The care plan included the following interventions for falls prevention that were dated 10/16/22: Remind resident not to bend over to pick up dropped items. Encourage use of a grabber or to ask for assistance, and encourage R8 to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as physical and occupational therapy exercises. The care plan lacked interventions for safety checks throughout the day and the type of walker R8 required as recommended by therapy. R8's care area assessment (CAA) dated 10/18/22, for falls indicated R8 had fallen on 10/9/22, with a note to see doctor orders. The CAA indicated falls would be addressed on the care plan to minimize risks and avoid complications. The CAA indicated the interdisciplinary team would monitor R8 and update the care plan as needed. It also indicated that staff would ensure to toilet R8 in a timely manner, clean and change when wet or soiled to preserve dignity, keep resident safe and injury free, and monitor for the effectiveness of pain and antidepressant medications and any adverse side effects. The care plan lacked an intervention to ensure toileting in a timely manner to prevent falls. In addition, the care plan lacked an intervention, R8 required glasses. R8 had fall tools (which helped to identify the	F 689	planning for prevention of falls and addressing a fall event on 12-13-22. A falls packet has been developed including a fall scene huddle form, an investigation page and a falls checklist. Nursing staff will complete this packet with each fall that occurs. The IDT team will meet the next business day post fall to complete a comprehensive review the incident and ensure appropriate documentation and interventions have been put into place. The IDT will also meet weekly to review falls that occurred in the prior week to determine if interventions put in place are effective and will update care plan as appropriate. 4.DNS or designee will conduct audits to ensure falls follow-up as described above. These audits will be done with each fall that occurs for 1 week, then 2 random fall events weekly X 3, then monthly X 2. Results will be brought to the Quality committee for further recommendations.	

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F 689	Continued From page 3 potential risk for falls, possible causes for actual falls and provided guidance for interventions) dated 9/14/22, 10/9/22, 10/12/22, 10/24/22, 11/11/22, and 11/14/22. The tools identified R8 as being at risk for falling with risk factors included taking more than two medications such as sedatives, anti-depressants, anti-Parkinson's, diuretics, antihypertensive's, or hypnotics, one or more psychological factors such as depression, or impaired cognition, impaired balance, impulsive or risk taking behavior, restlessness, confusion, poor sleep pattern, equipment safety, muscle weakness, impaired balance, pain, change in weight bearing ability, confusion, visual problems of not wearing glasses, and poor memory. The action plan on the tools included checked boxes to refer to therapy, refer to the provider, refer to restorative nursing, refer to the registered dietitian, and update the care plan. R8's incident reports dated 10/24/22, 11/11/22, and 11/14/22, indicated predisposing factors for the falls included checked boxes for a wheeled walker, and wheelchair, confusion, gait imbalance, recent changes in medications, equipment or assistive devices. R8's occupational therapy discharge summary notes dated 11/7/22, indicated R8 was at a high risk for falls because R8 did not remember to use a call light, self transferred, and had inconsistent use of her walker. The discharge plan indicated R8 have safety checks through out the day, assist with a.m. and p.m. cares, and assistance with all activities of daily living. R8's physical therapy discharge instructions dated 11/7/22, indicated a recommendation to have safety checks throughout the day, assist with a.m. and p.m. cares, and assistance with all functional mobility.	F 689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - INVER GROVE HEIGHTS	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

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F 689	Continued From page 4	F 689		

The note also indicated that R8 was not safe with a four wheeled walker and recommended a front wheeled walker with hands on assistance of one person due to risk for falls.

During observation on 11/16/22, from 10:50 a.m. through 11:37 a.m. staff had not gone into R8's room to offer assistance to toilet.

During interview and observation on 11/16/22, at 10:58 a.m. occupational therapist (OT)-G stated R8 had fallen and went to the hospital for an evaluation and was brought back. OT-G stated after the fall, signs that indicated not to get up by yourself were put on the bathroom door and staff checked on resident. Prior to R8's fall, R8 was independent and was about to discharge to an assisted living before getting Covid-19 and was no longer able to ambulate by herself.

During observation and interview on 11/16/22, at 11:19 a.m. R8 was in her bed and her grabber was not located next to her and R8 stated she did not know where her grabber was and that she had pulled her wheelchair over.

During observation on 11/16/22, at 11:37 a.m. R8 self transferred to her wheelchair and went into the bathroom stating "I have to go to the bathroom right now." Physical therapist assistant (PTA)-F looked into R8's room while with another resident.

During observation on 11/16/22, at 11:40 a.m. R8's toilet flushed and at 11:44 a.m. R8 self transferred into bed. There were no nursing assistants observed in the hallway.

During interview on 11/16/22, at 11:47 a.m. PTA-F

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F 689	Continued From page 5 stated R8 completed both occupational and physical therapy and was going to go to memory care. PTA-F stated R8 had a couple of falls, but R8 was not able to tell them how or why she fell. They provided strengthening and pain management and stated R8 was doing well and was transferring herself, but for safety needed someone to go into the bathroom with her and stated that R8 should have been transferred. PTA-F stated R8 should use a call light, but didn't know if R8 would remember to use the light. PTA-F stated signs on the bathroom door were not effective as R8 disregarded them due to her cognition. PTA-F also stated R8 got up on her own and wanders, trying to find her late spouse. During interview on 11/16/22, at 12:54 p.m. nursing assistant (NA)-D stated in order to know what cares a resident required, they checked the care plan or would ask the nurse if there was a new resident. NA-D stated R8 was confused and stated staff spoke with them about checking on R8 frequently and making sure items were nearby and her toileting needs were met. NA-D stated R8 fell a month ago and ended up in the hospital trying to go to the bathroom. During observation on 11/16/22, at 1:11 p.m. R8 did not have the grabber in place as recommended on the care plan. During interview on 11/16/22, at 1:17 p.m. NA-D stated she did not recall if R8 was on a restorative type program. During interview on 11/16/22, at 1:34 p.m. NA-B stated if a resident was on an exercise program such as ambulation or range of motion, it would be on the care plan.	F 689		

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F 689	Continued From page 6 During interview and observation on 11/16/22, at 1:42 p.m. RN-A stated R8 was confused, had weakness, pain and a questionable urinary tract infection and was a high falls risk. RN-A stated R8 had a call light next to her, but did not use because she was forgetful and stated the signs on the door were also not helpful for R8 as she was impulsive. RN-A stated that physical therapy would have a grabber, RN-A checked R8's drawer and stated she did not see the grabber anywhere in her room and even if R8 had a grabber, she would not use it because she could not remember to use her call light. RN-A viewed R8's care plan and stated there were interventions that could have been added to R8's falls care plan which included maintaining the bed in a low position, anticipate needs, offer toileting, and frequent visual checks. RN-A stated R8 fell on 10/24/22, 11/11/22, and 11/14/22 and nothing had been documented that the care plan was reviewed. RN-A further stated on 11/11/22, R8 was found on the floor due to losing her balance and did not have her walker or wheelchair near her and stated she should have put something in the care plan and the care plan was not reviewed after R8 fell. RN-A stated after R8 fell 10/24/22 that the care plan had not been updated and she did not think what R8 had on the care plan was sufficient and stated she had not been trained on how to update the care plan. During interview on 11/16/22, at 2:06 p.m. the interim director of nursing (DON)-D stated when a resident falls, a fall assessment is completed at the time of the fall, and the interdisciplinary team meets the next business day to discuss. The DON stated she expected the nurse who completed the fall assessment would also update	F 689		

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F 689	Continued From page 7 the care plan, but stated she was aware the documentation was lacking. the DON stated R8 had occupational and physical therapy to her knowledge. A policy reviewed or revised on 9/22/22, Care Plan R/S, LTC, Therapy and Rehab, indicated care plans were reviewed quarterly and reviewed, evaluated, and updated when there was a significant change in the resident's condition. A policy reviewed or revised on 3/30/22, Fall Prevention And Management-Rehab/Skilled, Therapy and Rehab, indicated steps taken when a resident has fallen included updating the care plan with any new changes or interventions.	F 689		
F 880 SS=F	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention 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	F 880		12/23/22

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F 880	Continued From page 8 arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed 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	F 880		

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F 880	Continued From page 9 transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19 to prevent or minimize the transmission of COVID-19 for 4 of 5 residents (R2, R4, R5, R7) reviewed for transmission-based precautions (TBP). Furthermore, the facility failed to ensure a resident positive for COVID-19 (R1) remained in TBP. This had the potential to affect all 39 residents who reside in the facility. Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 10/22/22, indicated R2 was cognitively intact and was receiving hospice care. R2's diagnoses list printed 11/16/22, indicated R2 had diagnoses of COVID-19, heart disease, and chronic obstructive pulmonary disease (COPD). R2's clinical monitoring for infection/suspected infection dated 11/15/22, indicated R2's symptoms included diarrhea, nonproductive cough, and labored breathing. An observation on 11/15/22, at 10:12 a.m. R2's door was open and had a sign that read, "red room". R2's door sign instructed staff to have	F 880	1. For R-2 the hospice company was contacted regarding the hospice aide who did not follow Isolation precautions on 12-6-22. She will be provided re-education with a competency by the Hospice RN and verification of such will be provided to the DNS. R-4 has been discharged. Lab tech□s supervisor was notified and she will provide re-training to for the lab tech on appropriate PPE use for resident□s in isolation. R-5 and R-7 have both recovered from their COVID infection and no longer require transmission based precautions. R-1- has recovered from COVID infection and no longer requires transmission-based precautions. 2.No other residents are at risk of this deficient practice at this time as there are no longer any cases of COVID or other contagious infections in the facility. Facility will do the following for future positive Covid residents: Ensure staff and vendors follow correct protocols when caring for someone under TBP. Ensure staff attemp to redirect residents and provide education to residents on the need for isolation and to wear a mask when out of their room.	

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F 880	Continued From page 10 N95, face shield, gloves, and gown on upon entering. An observation on 11/15/22, at 10:15 a.m. hospice aid (HA)-A entered R2's room used hand sanitizer and donned gloves to assist R2 with cares. HA-A was wearing a surgical mask but had not donned a N95 mask, gown and was not wearing any eye protection. R2 was sitting in a chair and HA-A kneeled next to R2 and assisted shaving with an electric razor. At 10:20, HA-A completed shaving R2 and offered to heat up R2's breakfast. HA-A then walked out of R2's room with the breakfast container and walked down the hall to the kitchen area. HA-A had not removed gloves or performed hand hygiene. HA-A proceeded to microwave R2's breakfast and returned to R2's room. HA-A re-entered R2's room without performing hand hygiene and without donning a gown, N95 mask or eye protection. HA-A set R2 up with breakfast. At 10:26 a.m. HA-A exited R2's room without glove removal or hand hygiene performed. HA-A walked to kitchen area and was handed a bowl of oatmeal and returned to R2's room. HA-A re-entered R2's room without performing hand hygiene and without donning a gown, N95 mask or eye protection. HA-A delivered oatmeal, removed gloves, and performed hand hygiene upon exit. When interviewed on 11/15/22, at 10:35 a.m. HA-A verified R2's door sign and stated R2 was positive for COVID-19 and was on isolation. HA-A acknowledged she had not worn the required PPE and was in and out of R2's room without hand hygiene or glove removal. HA-A further stated the vaccine was supposed to protect staff and residents and isolation	F 880	3.Education and competency verification was requested of R-2 hospice provider and R-4 Lab tech. If this is not received by the facility, training and competency verification will be done by the DNS or designee upon her next visit. All staff have been provided with re-education on proper protocols for TBP including donning and doffing procedures and what PPE is required for residents in isolation. Competency verifications have been done for all on 11-16 and 11-17-22. Staff not present on those dates will have re-education and competency done before the start of their next shift. All staff have been provided with re-education on attempting to redirect and provide education on need for isolation if they encounter a resident leaving their isolation room as well as anticipating needs to help in preventing the resident□s desire to leave their room. 4. DNS or designee will conduct audits for appropriate PPE use for all staff. These audits will be conducted on all shifts 4x week for one week, then twice weekly for one week. Audits will continue until 100% compliance is met. Results will be brought to Quality Committee for further recommendations.	

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F 880	Continued From page 11	F 880		

precautions were not important as most of the residents in the facility were COVID-19 positive.

When observed on 11/15/22, at 2:43 p.m. nursing assistant (NA)-A entered R2's room. NA-A had donned a gown, face shield and gloves. NA-A also donned a N95 mask, however had placed it over a surgical mask and had left the bottom strap of the N95 mask unsecured and hanging below his face. NA-A helped R2 with toileting. NA-A removed the gown, gloves, and both masks upon exiting R2's room. NA-A performed hand hygiene, placed a new surgical mask and cleaned his face shield.

When interviewed on 11/15/22, at 3:16 p.m. NA-A verified R2 was on isolation precautions for COVID-19. NA-A acknowledged wearing a surgical mask under a N95 mask and not having both straps attached was not how the N95 should be worn. NA-A further stated he shouldn't have worn it that way but felt more protected with two masks.

R4

R4's admission MDS 10/29/22, indicated R4 was cognitively intact.

R12's diagnoses list printed 11/16/22, indicated R4 had diagnoses of COVID-19, chronic kidney disease, and hypertension.

R4's clinical monitoring infection/suspected infection dated 11/16/22, indicated R4 was afebrile, without cough, and had lung crackles (description of lung sounds indicate fluid buildup).

An observation on 11/16/22, at 7:31 a.m. R4's

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F 880	Continued From page 12	F 880		

door was open and had a sign that stated, "red room". R4's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. Upon exit of R4's room, lab technician (LT)-A had eye protection on and had removed a gown and gloves. LT-A then removed a surgical mask and reviled as second surgical mask was underneath. LT-A performed hand hygiene and entered R6's room.

When interviewed on 11/16/22, at 7:36 a.m. LT-A confirmed R4 was on isolation for COVID-19 and had noted the sign on R4's door upon entering R4's room. LT-A stated verified a N95 mask was required and further stated usually a N95 mask was worn. LT-A acknowledged she had not used one today and instead used two surgical masks.

R5

R5's quarterly MDS dated 8/17/22, indicated R5 was cognitively impaired.

R5's diagnoses list printed 11/16/22, indicated R5 had diagnoses of COVID-19, dementia, and hypertension.

R5's clinical monitoring infection/suspected infection dated 11/13/22, indicated R5 was afebrile and had no respiratory symptoms.

An observation on 11/15/22, at 11:45 a.m. R5's door was shut and had a sign that stated, "red room". R2's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. Licensed practical nurse (LPN)- A entered R5's room wearing a gown, N95 mask, and gloves. LPN-A had on prescription glasses however was not wearing goggles or a face

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F 880	Continued From page 13 shield. LPN-A had removed the PPE and performed hand hygiene upon exit of R5's room. When interviewed on 11/15/22, at 11:52 p.m. LPN-A verified R5 was COVID-19 positive and TBP including eye protection was required. LPN-A stated R5 was almost off isolation precautions and felt just her prescription glasses were ok to use. LPN-A further stated she usually did not use eye protection as it makes it harder to see over her prescription glasses. R7 R7's significant change MDS dated 10/26/22, indicated R7 was cognitively intact. R7's diagnoses list printed 11/16/22, indicated R7 had diagnoses of COVID-19 and heart disease. R7's clinical monitoring infection/suspected infection dated 11/16/22, indicated R7 was afebrile and had no respiratory symptoms. An observation on 11/16/22, at 7:52 a.m. R7's door was shut and had a sign that stated, "red room". R7's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. NA-D exited R7's room wearing a surgical mask under a N95 mask. The lower strap of the N95 mask was not in place and was hanging below R7's chin. NA-D removed both masks performed hand hygiene and placed a new surgical mask. When interviewed on 11/16/22, at 8:30 a.m. NA-D verified R7 was positive for COVID-19 and TBP was required. NA-A verified wearing a surgical mask under the N95 mask and further stated "we	F 880		

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F 880	Continued From page 14 are not supposed to" and should be removing the surgical mask before donning the N95 mask. R1 R1's quarterly MDS dated 8/16/22, indicated R1 was cognitively intact. R1's diagnoses list printed 11/16/22, indicated R1 had COVID-19, hypertension, and heart disease. An observation on 11/15/22, at 12:40 p.m. R1 was observed self propelling in his wheelchair outside of his room. R1 had on a N95 mask with one strap in place and was holding a gray insulated mug with no cover. R1 wheeled down to the opposite end of the hallway to the kitchen area. R1 had wheeled past NA-C. Upon arriving to the kitchen area R1 filled a gray mug with ice from an automated ice machine. R1 briefly stated hello to the administrator who was located by the nursing desk as he passed by going back down the hallway. LPN-A stopped R1 and asked about lunch but failed to educate or redirect R1 to his room. R1 wheeled down the hallway back into his room. When interviewed on 11/15/22, at 12:56 p.m. NA-C acknowledged R1 was in TBP for COVID-19 and should not be out in the hallway or going to the kitchen. NA-C acknowledged seeing R1 out of his room and had not redirected or remind R1 to return to his room. When interviewed on 11/15/22, at 1:30 p.m. R1 stated he tested positive for COVID-19 a week ago and still had a slight cough but overall was feeling better. R1 stated he was aware he was supposed to stay in the room, but it was easier to	F 880		

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F 880	Continued From page 15 just go grab ice rather then put the call light on. R1 further stated at times he leaves the room to get ice as it was a quick trip. R1 acknowledged staff see him do this so he thought since it was a quick trip it was ok. When interviewed on 11/15/22, at 4:15 p.m. the interim director of nursing (DON) expected all staff to be wearing the proper PPE when entering rooms of residents who were positive for COVID-19. PPE included gown, gloves, N95 mask, and eye protection. Residents who are COVID-19 positive should remain in their rooms until isolation was discontinued. DON stated she was aware of some staff wanting to double mask and stated discussions with staff have occurred. The DON further stated the N95 mask could still be tight but acknowledged there was not a way to determine if the fit was correct with a surgical mask under. When interviewed on 11/16/22, at 2:18 p.m. the administrator stated staff and contracted vendors/employees were expected to be wearing the correct PPE when working with residents who were positive for COVID-19. During a follow up interview on 11/16/22, at 5:10 p.m. the DON stated ensuring correct PPE was important to help contain the infection and prevent spread to other residents or staff. A facility policy titled Infection Prevention: Acute Respiratory Syndromes (COVID), revised 10/24/22, directed isolation and appropriate use of PPE and respiratory protection was needed when providing cares for residents with known or suspected COVID-19. Appropriate PPE included gown, gloves, eye protection, and N95 mask.	F 880		

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F 883 SS=E	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is	F 883		12/23/22

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 883	Continued From page 17 medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents influenza and pneumococcal vaccination status was verified or documented for 5 of 5 residents (R4, R6, R7, R9, R10) reviewed for immunizations. Furthermore, the facility failed to ensure the influenzas vaccine was offered or received for 4 of 5 residents (R4, R6, R7, R9). The facility also failed to ensure 4 of 5 residents (R4, R6, R9, R10) were offered or received the pneumococcal pneumonia vaccine in accordance with the Center for Disease Control (CDC) recommendations. Findings include: R4 R4's admission MDS 10/29/22, indicated R4 was cognitively intact and had diagnoses of chronic kidney disease and hypertension. R4's face sheet printed 11/16/22, indicated R4	F 883	1. R-4 was discharged on 11-21-22 to a facility closer to her family as planned. R-6 had received the influenza vaccination prior to admission to our facility per MIIC. Also is current with pneumonia vaccination per MIIC R-7 received the influenza vaccination on 10-2-22 prior to admission per MIIC. Also is current with pneumonia vaccination per MIIC. 2. R-10 received the influenza on 10-23-22 and pneumonia vaccines are up to date per MIIC. All residents will be reviewed to ensure their vaccination status is up to date and documented in their medical record per CDC and CMS guidelines. 3. All residents will have their vaccination status determined using MIIC upon admission and will be offered/provided	

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F 883	Continued From page 18 was admitted to the facility in 10/2022. R4' immunization report printed 11/16/22, indicated R4 had refused the influenza vaccine. R4's medical record lacked evidence a refusal was signed or R4 was educated for the influenza vaccine. R4's medical record lacked evidence R4 had been educated on, declined, or received the pneumococcal vaccine. R6 R6's admission MDS dated 10/12/22, indicated R6 was had mild cognitive impairment and diagnoses of heart failure, diabetes, and dementia. R6's face sheet printed 11/2/22, indicated R6 was admitted to the facility in 10/2022. R6's medical record lacked evidence R6 had been offered, declined, or received the influenza and pneumococcal vaccine. R7 R7's significant change MDS dated 10/26/22, indicated R7 was cognitively intact and had a diagnosis of heart disease. R7's face sheet printed 11/16/22, indicated R7 was admitted to the facility in 10/2022. R7's medical record lacked evidence R7 had been offered, declined, or received the influenza vaccine. R9	F 883	with the appropriate vaccinations as required by CMS and CDC. The medical records will reflect the correct vaccination status. 4. All new admissions will be audited by the DNS or designee to ensure vaccinations are up to date and documented in their medical record weekly X 4 then 2 random new admissions will be audited monthly X 2. Results will be taken to the Quality Committee for further recommendations.	

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F 883	Continued From page 19 R9's admission MDS dated 10/13/22, indicated R9 was cognitively intact and had diagnoses of myocardial infarction (heart attack) and kidney disease. R9's face sheet printed 11/16/22, indicated R7 was admitted to the facility in 10/2022. R9's medical record lacked evidence R8 had been offered, declined, or received the influenza and pneumococcal vaccine. R10 R10's admission MDS, dated 10/17/22, indicated R10 was cognitively intact and had diagnoses of lung transplant and hip fracture. R10's face sheet printed 11/16/22, indicated R10 was admitted to the facility in 10/2022. R10's medical record lacked evidence R10 had been offered, declined, or received pneumococcal vaccine. When interviewed on 11/16/22, at 5:10 p.m. the interim Director of Nursing (DON) confirmed the influenza and pneumococcal vaccination status of R4, R6, R7, R9, and R10 was not completed upon admission and had not been updated in the medical records until today. R10 was the only resident who had been offered the influenza vaccination and had an administration documented. DON further confirmed R7 was the only resident who was reviewed who had documentation of a pneumococcal vaccination. The remainder residents (R4, R6, R9, R10) pneumococcal vaccination status was not known, and more work was needed to determine their	F 883		

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F 883	Continued From page 20 status. DON expected resident influenza and pneumococcal vaccination status to be reviewed upon admission. If the vaccination status was information was not included in hospital records staff were expected to make efforts to call family or providers to determine if immunizations were due. If a pneumococcal or influenza vaccine was due, documentation of consent, refusal and education was required. A facility policy titled Immunizations/Vaccinations for Residents Influenza, Pneumococcal, COVID, Other revised 3/8/22, directed staff to review current vaccinations upon resident admission, provide and document education, risks, and potential side effects of eligible vaccinations. Furthermore, staff were directed to obtain and document consent or declination of eligible vaccination.	F 883		
F 886 SS=F	COVID-19 Testing-Residents & Staff CFR(s): 483.80 (h)(1)-(6) §483.80 (h) COVID-19 Testing. The LTC facility must test residents and facility staff, including individuals providing services under arrangement and volunteers, for COVID-19. At a minimum, for all residents and facility staff, including individuals providing services under arrangement and volunteers, the LTC facility must: §483.80 (h)((1) Conduct testing based on parameters set forth by the Secretary, including but not limited to: (i) Testing frequency; (ii) The identification of any individual specified in this paragraph diagnosed with COVID-19 in the facility;	F 886		12/23/22

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F 886	Continued From page 21 (iii) The identification of any individual specified in this paragraph with symptoms consistent with COVID-19 or with known or suspected exposure to COVID-19; (iv) The criteria for conducting testing of asymptomatic individuals specified in this paragraph, such as the positivity rate of COVID-19 in a county; (v) The response time for test results; and (vi) Other factors specified by the Secretary that help identify and prevent the transmission of COVID-19. §483.80 (h)((2) Conduct testing in a manner that is consistent with current standards of practice for conducting COVID-19 tests; §483.80 (h)((3) For each instance of testing: (i) Document that testing was completed and the results of each staff test; and (ii) Document in the resident records that testing was offered, completed (as appropriate to the resident's testing status), and the results of each test. §483.80 (h)((4) Upon the identification of an individual specified in this paragraph with symptoms consistent with COVID-19, or who tests positive for COVID-19, take actions to prevent the transmission of COVID-19. §483.80 (h)((5) Have procedures for addressing residents and staff, including individuals providing services under arrangement and volunteers, who refuse testing or are unable to be tested. §483.80 (h)((6) When necessary, such as in	F 886		

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F 886	Continued From page 22 emergencies due to testing supply shortages, contact state and local health departments to assist in testing efforts, such as obtaining testing supplies or processing test results. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to test staff for COVID-19 according to Centers for Medicare and Medicaid (CMS) guidance for outbreak testing requirements for 3 of 3 staff [licensed practical nurse (LPN)-A, LPN-D, and nursing assistant (NA)-E] reviewed for COVID-19 testing. This deficient practice had the potential to affect all 39 residents in the facility, all staff, and any visitors to the facility. Findings include: The CMS QSO-20-38-NH memo revised 9/23/22, directed, upon identification of a single new case of COVID-19 infection in any staff or residents, outbreak testing should begin immediately. Furthermore, the memo directed testing should be repeated every 3-7 days until no new cases are identified for 14 days. An untitled and undated facility form indicated R14 had tested positive for COVID-19 on 10/31/22. On 11/15/22, at 4:14 p.m. the Director of Nursing (DON) verified facility wide testing for facility outbreak status started on 10/31/22 and all residents and staff were tested. A review of staff COVID-19 testing results and staff time sheets between the dates of 10/31/22-11/12/22, showed the following:	F 886	1. All staff were tested on 11-17-22 date following manufacturer recommendations for conducting the test. 2. All residents, staff, and visitors are at risk for exposure to a positive who had not tested to know their status. 3. The facility initiated daily testing for all staff prior to the start of their shift starting on 11-18-22 date. This facility requirement was communicated to staff on 11-17. Records are kept of the staff who were positive and the date 30 days post their positive result for them to restart testing. 4. Audits have been conducted to ensure staff compliance with testing daily X 2 weeks then weekly x 4 and monthly x 2 by the DNS or designee. Results will be brought to Quality Committee for further recommendations.	

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F 886	Continued From page 23 -LPN-A had worked 10 shifts in the facility during the above time and had not tested for COVID-19. -LPN-D had worked 4 shifts in the facility during the above time and had not tested for COVID-19. -NA-E had worked 5 shifts in the facility during the above time and had not tested for COVID-19. When interviewed on 11/15/22, at 11:52 a.m. LPN-A stated an alert was sent out to staff yesterday to start COVID-19 testing twice a week. LPN-A stated staff self-tested prior to the start of the shift. Prior to that notice, staff had not been required to test unless not feeling well. LPN-A verified there was multiple staff out with COVID-19 for a few weeks. When interviewed on 11/16/22, at 7:35 a.m. LPN-D stated staff were supposed to test twice a week. LPN-D stated testing could be done anytime during the shift and twice a week testing started this week. At 7:39 a.m. LPN-D entered the testing room to complete her test. On the table was a document with staff names, dates tested and results. The log had missing results of staff testing from the day prior. Three test packets were sitting on the table with staff names on them, but no date or time noted. LPN-D stated sometimes they leave the test in and come back to see what the result was. LPN-D completed the test and placed her test down on table to result. LPN-D then left the room at 7:43 a.m. When interviewed on 11/21/22, at 7:47 a.m. DON stated the three test kits laying on the table and stated they all are negative. DON verified the	F 886		

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F 886	Continued From page 24 document was incomplete and missing COVID-19 test results from yesterday 11/15/22. DON verified the facility implemented facility wide testing for staff and residents on 10/31/22, and all staff were expected to test and continue testing twice a week until the facility was out of outbreak status. Staff were expected to wait the 15 minutes required for the COVID-19 test to result. DON then took the tests on the table, wrote negative in the results section of the document, and threw the tests away. DON was not aware of LPN-D's test had not met the 15 minutes to result as she expected tests to be completed before their shift started and acknowledged LPN-D will need to retest. When interviewed on 11/21/22, at 2:18 p.m. the administrator expected staff to be testing for COVID twice a week during outbreak status. Furthermore, the administrator verified the process of ensuring staff testing was challenging when testing logs were disorganized. The administrator acknowledged the facility was working on a better system. A facility policy titled Emerging Threats: Acute Respiratory Threats COVID revised on 10/24/22, directed staff complete COVID-19 testing per state and federal guidelines.	F 886		
F 887 SS=F	COVID-19 Immunization CFR(s): 483.80(d)(3)(i)-(vii) §483.80(d) (3) COVID-19 immunizations. The LTC facility must develop and implement policies and procedures to ensure all the following: (i) When COVID-19 vaccine is available to the facility, each resident and staff member is offered the COVID-19 vaccine unless the	F 887		12/23/22

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F 887	Continued From page 25 immunization is medically contraindicated or the resident or staff member has already been immunized; (ii) Before offering COVID-19 vaccine, all staff members are provided with education regarding the benefits and risks and potential side effects associated with the vaccine; (iii) Before offering COVID-19 vaccine, each resident or the resident representative receives education regarding the benefits and risks and potential side effects associated with the COVID-19 vaccine; (iv) In situations where COVID-19 vaccination requires multiple doses, the resident, resident representative, or staff member is provided with current information regarding those additional doses, including any changes in the benefits or risks and potential side effects associated with the COVID-19 vaccine, before requesting consent for administration of any additional doses; (v) The resident, resident representative, or staff member has the opportunity to accept or refuse a COVID-19 vaccine, and change their decision; (vi) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident representative was provided education regarding the benefits and potential risks associated with COVID-19 vaccine; and (B) Each dose of COVID-19 vaccine administered to the resident; or (C) If the resident did not receive the COVID-19 vaccine due to medical contraindications or refusal; and (vii) The facility maintains documentation related to staff COVID-19 vaccination that	F 887		

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F 887	Continued From page 26 includes at a minimum, the following: (A) That staff were provided education regarding the benefits and potential risks associated with COVID-19 vaccine; (B) Staff were offered the COVID-19 vaccine or information on obtaining COVID-19 vaccine; and (C) The COVID-19 vaccine status of staff and related information as indicated by the Centers for Disease Control and Prevention's National Healthcare Safety Network (NHSN). This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure COVID-19 vaccination doses were offered to 3 of 5 residents (R4, R6, R9,) reviewed for COVID-19 vaccination status. Findings include: R4 R4's admission MDS 10/29/22, indicated R4 was cognitively intact and had diagnoses of chronic kidney disease and hypertension. R4's face sheet printed 11/16/22, indicated R4 was admitted to the facility in 10/2022. R4's immunization report printed 11/16/22, indicated R4 had refused the COVID-19 vaccination. R4's medical record lacked information that a refusal was signed, or education was provided. R6 R6's admission MDS dated 10/12/22, indicated R6 was had mild cognitive impairment and diagnoses of heart failure, diabetes, and	F 887	1. Resident 4 discharged while still in the 90 day window from having a COVID infection. Resident 6 is still in the 90 window from having a COVID infection. The covid booster will be offered after the 90 day period per CDC guidance Resident 9 has refused the COVID series and any boosters. This is now documented in her EMR. 2. All residents have been reviewed to ensure their COVID vaccinations are up to date, have been offered and received or declined and documentation is in the medical record to reflect this. 3. Residents will be offered COVID vaccinations per CDC guidelines. Nursing staff has been provided with education on GSS P&P and CDC guidelines for offering and administering COVID vaccinations and documenting them in the medical record for residents. 4. Audits will be conducted by DNS or designee for all residents to ensure their	

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F 887	Continued From page 27 dementia. R6's face sheet printed 11/2/22, indicated R6 was admitted to the facility in 10/2022. R6's medical record lacked evidence R6 had been offered, declined, or received the COVID-19 vaccine. R9 R9's admission MDS dated 10/13/22, indicated R9 was cognitively intact and had diagnoses of myocardial infarction (heart attack) and kidney disease. R9's face sheet printed 11/16/22, indicated R7 was admitted to the facility in 10/2022. R9's immunization report printed 11/16/22, indicated R7 had refused the COVID-19 vaccine. R9's medical record lacked evidence R9 had been offered, declined, or received the COVID-19 vaccine. R9's medical record lacked information that a refusal was signed, or education was provided. When interviewed on 11/16/22, at 5:10 p.m. the interim Director of Nursing (DON) confirmed the COVID-19 vaccination status of R4, R6, and R9 was not completed upon admission and had not been updated in the medical records until today. R4's medical record was updated with a refusal due to hospital documentation of a refusal of the COVID-19 vaccine and the refusal had not been discussed with R4. DON further confirmed R9 had verbally refused today so that was entered, but no education or refusal form was completed.	F 887	medical record reflects appropriate COVID vaccinations have been offered and given as requested by residents. Ongoing audits will done weekly X 4, then monthly X 2. Results will be taken to Quality Committee for further recommendations.	

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F 887	Continued From page 28 DON expected resident COVID-19 vaccination status to be reviewed upon admission. If the vaccination status was information was not included in hospital records staff were expected to make efforts to call family or providers to determine if immunizations were due. If a COVID-19 vaccine was due, documentation of consent, refusal and education was required. A facility policy titled Immunizations/Vaccinations for Residents Influenza, Pneumococcal, COVID, Other revised 3/8/22, directed staff to review current vaccinations upon resident admission, provide and document education, risks, and potential side effects of eligible vaccinations. Furthermore, staff were directed to obtain and document consent or declination of eligible vaccination.	F 887		

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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 11/15/22-11/16/22, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaints was found to be SUBSTANTIATED: H52855717C (MN00088259), with a licensing order issued at 1375. H52855960C (MN00088478), with a licensing order issued at 0830. 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 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 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	2 000		

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	00022	A. BUILDING: _____ B. WING _____	C 11/16/2022

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2 000	Continued From page 2 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		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively reassess and update care plans and develop new interventions to provide adequate supervision to prevent addition falls for 1 of 3 residents (R8) reviewed for falls. Findings include:	2 830	corrected	12/23/22

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2 830	Continued From page 3 R8's admission Minimum Data Set (MDS) assessment dated 9/20/22, indicated R8 required limited assistance for bed mobility, transfers, toileting, and personal hygiene. R8's significant change MDS dated 10/18/22, indicated R8 had moderately impaired cognition. R8 had no delusions, hallucinations, and had no physical behavioral symptoms, verbal behavioral symptoms, or other behavioral symptoms such as pacing and behavior was not exhibited for rejection of cares. The MDS indicated R8 was limited assist for bed mobility, supervision cueing for toileting, and activity did not occur for transferring. R8's diagnoses included: nondisplaced intertrochanteric fracture of right femur, adult failure to thrive, hypertension, heart failure, mild cognitive impairment, and depression. R8's activities of daily living care plan revised on 10/16/22, indicated R8 had bilateral lower extremity weakness and needed one assist for bed mobility, transfers, eating, dressing, toilet use and personal hygiene. R8's care plan revised on 10/16/20, indicated R8 was at risk for falls due to immobility as evidenced by a superior pubic fracture. The care plan included the following interventions for falls prevention that were dated 10/16/22: Remind resident not to bend over to pick up dropped items. Encourage use of a grabber or to ask for assistance, and encourage R8 to participate in activities that promote exercise, physical activity for strengthening and improved mobility such as physical and occupational therapy exercises. The care plan lacked interventions for safety checks throughout the day and the type of walker R8 required as recommended by therapy.	2 830		

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2 830	Continued From page 4 R8's care area assessment (CAA) dated 10/18/22, for falls indicated R8 had fallen on 10/9/22, with a note to see doctor orders. The CAA indicated falls would be addressed on the care plan to minimize risks and avoid complications. The CAA indicated the interdisciplinary team would monitor R8 and update the care plan as needed. It also indicated that staff would ensure to toilet R8 in a timely manner, clean and change when wet or soiled to preserve dignity, keep resident safe and injury free, and monitor for the effectiveness of pain and antidepressant medications and any adverse side effects. The care plan lacked an intervention to ensure toileting in a timely manner to prevent falls. In addition, the care plan lacked an intervention, R8 required glasses. R8 had fall tools (which helped to identify the potential risk for falls, possible causes for actual falls and provided guidance for interventions) dated 9/14/22, 10/9/22, 10/12/22, 10/24/22, 11/11/22, and 11/14/22. The tools identified R8 as being at risk for falling with risk factors included taking more than two medications such as sedatives, anti-depressants, anti-Parkinson's, diuretics, antihypertensive's, or hypnotics, one or more psychological factors such as depression, or impaired cognition, impaired balance, impulsive or risk taking behavior, restlessness, confusion, poor sleep pattern, equipment safety, muscle weakness, impaired balance, pain, change in weight bearing ability, confusion, visual problems of not wearing glasses, and poor memory. The action plan on the tools included checked boxes to refer to therapy, refer to the provider, refer to restorative nursing, refer to the	2 830		

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2 830	Continued From page 5 registered dietitian, and update the care plan. R8's incident reports dated 10/24/22, 11/11/22, and 11/14/22, indicated predisposing factors for the falls included checked boxes for a wheeled walker, and wheelchair, confusion, gait imbalance, recent changes in medications, equipment or assistive devices. R8's occupational therapy discharge summary notes dated 11/7/22, indicated R8 was at a high risk for falls because R8 did not remember to use a call light, self transferred, and had inconsistent use of her walker. The discharge plan indicated R8 have safety checks through out the day, assist with a.m. and p.m. cares, and assistance with all activities of daily living. R8's physical therapy discharge instructions dated 11/7/22, indicated a recommendation to have safety checks throughout the day, assist with a.m. and p.m. cares, and assistance with all functional mobility. The note also indicated that R8 was not safe with a four wheeled walker and recommended a front wheeled walker with hands on assistance of one person due to risk for falls. During observation on 11/16/22, from 10:50 a.m. through 11:37 a.m. staff had not gone into R8's room to offer assistance to toilet. During interview and observation on 11/16/22, at 10:58 a.m. occupational therapist (OT)-G stated R8 had fallen and went to the hospital for an evaluation and was brought back. OT-G stated after the fall, signs that indicated not to get up by yourself were put on the bathroom door and staff checked on resident. Prior to R8's fall, R8 was independent and was about to discharge to an assisted living before getting Covid-19 and was no longer able to ambulate by herself.	2 830		

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2 830	Continued From page 6 During observation and interview on 11/16/22, at 11:19 a.m. R8 was in her bed and her grabber was not located next to her and R8 stated she did not know where her grabber was and that she had pulled her wheelchair over. During observation on 11/16/22, at 11:37 a.m. R8 self transferred to her wheelchair and went into the bathroom stating "I have to go to the bathroom right now." Physical therapist assistant (PTA)-F looked into R8's room while with another resident. During observation on 11/16/22, at 11:40 a.m. R8's toilet flushed and at 11:44 a.m. R8 self transferred into bed. There were no nursing assistants observed in the hallway. During interview on 11/16/22, at 11:47 a.m. PTA-F stated R8 completed both occupational and physical therapy and was going to go to memory care. PTA-F stated R8 had a couple of falls, but R8 was not able to tell them how or why she fell. They provided strengthening and pain management and stated R8 was doing well and was transferring herself, but for safety needed someone to go into the bathroom with her and stated that R8 should have been transferred. PTA-F stated R8 should use a call light, but didn't know if R8 would remember to use the light. PTA-F stated signs on the bathroom door were not effective as R8 disregarded them due to her cognition. PTA-F also stated R8 got up on her own and wanders, trying to find her late spouse. During interview on 11/16/22, at 12:54 p.m. nursing assistant (NA)-D stated in order to know what cares a resident required, they checked the care plan or would ask the nurse if there was a	2 830		

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2 830	Continued From page 7 new resident. NA-D stated R8 was confused and stated staff spoke with them about checking on R8 frequently and making sure items were nearby and her toileting needs were met. NA-D stated R8 fell a month ago and ended up in the hospital trying to go to the bathroom. During observation on 11/16/22, at 1:11 p.m. R8 did not have the grabber in place as recommended on the care plan. During interview on 11/16/22, at 1:17 p.m. NA-D stated she did not recall if R8 was on a restorative type program. During interview on 11/16/22, at 1:34 p.m. NA-B stated if a resident was on an exercise program such as ambulation or range of motion, it would be on the care plan. During interview and observation on 11/16/22, at 1:42 p.m. RN-A stated R8 was confused, had weakness, pain and a questionable urinary tract infection and was a high falls risk. RN-A stated R8 had a call light next to her, but did not use because she was forgetful and stated the signs on the door were also not helpful for R8 as she was impulsive. RN-A stated that physical therapy would have a grabber, RN-A checked R8's drawer and stated she did not see the grabber anywhere in her room and even if R8 had a grabber, she would not use it because she could not remember to use her call light. RN-A viewed R8's care plan and stated there were interventions that could have been added to R8's falls care plan which included maintaining the bed in a low position, anticipate needs, offer toileting, and frequent visual checks. RN-A stated R8 fell on 10/24/22, 11/11/22, and 11/14/22 and nothing had been documented that the care plan was	2 830		

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2 830	Continued From page 8 reviewed. RN-A further stated on 11/11/22, R8 was found on the floor due to losing her balance and did not have her walker or wheelchair near her and stated she should have put something in the care plan and the care plan was not reviewed after R8 fell. RN-A stated after R8 fell 10/24/22 that the care plan had not been updated and she did not think what R8 had on the care plan was sufficient and stated she had not been trained on how to update the care plan. During interview on 11/16/22, at 2:06 p.m. the interim director of nursing (DON)-D stated when a resident falls, a fall assessment is completed at the time of the fall, and the interdisciplinary team meets the next business day to discuss. The DON stated she expected the nurse who completed the fall assessment would also update the care plan, but stated she was aware the documentation was lacking. the DON stated R8 had occupational and physical therapy to her knowledge. A policy reviewed or revised on 9/22/22, Care Plan R/S, LTC, Therapy and Rehab, indicated care plans were reviewed quarterly and reviewed, evaluated, and updated when there was a significant change in the resident's condition. A policy reviewed or revised on 3/30/22, Fall Prevention And Management-Rehab/Skilled, Therapy and Rehab, indicated steps taken when a resident has fallen included updating the care plan with any new changes or interventions. SUGGESTED METHOD OF CORRECTION: The facility's director of nursing and/or the designee could review policies/procedures and revise as necessary. The facility could review all	2 830		

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2 830	Continued From page 9 residents at a high risk for falls to assess whether current interventions are pertinent, appropriate and effective. After assessment, care plans could be updated with any new/changed interventions. All staff could be re-educated on fall prevention techniques and procedures. An audit tool could be developed to evaluate on-going compliance and results of those audits could be shared with the facility's quality assessment and assurance committee. TIME PERIOD FOR CORRECTION: Fourteen (14) days.	2 830		
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to follow Centers for Disease Control (CDC) and Centers for Medicare and Medicaid Services (CMS) guidelines for COVID-19 to prevent or minimize the transmission of COVID-19 for 4 of 5 residents (R2, R4, R5, R7) reviewed for transmission-based precautions (TBP). Furthermore, the facility failed to ensure a resident positive for COVID-19 (R1) remained in TBP. This had the potential to affect all 39 residents who reside in the facility.	21375	Corrected	12/23/22

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21375	Continued From page 10 Findings include: R2's quarterly Minimum Data Set (MDS) assessment dated 10/22/22, indicated R2 was cognitively intact and was receiving hospice care. R2's diagnoses list printed 11/16/22, indicated R2 had diagnoses of COVID-19, heart disease, and chronic obstructive pulmonary disease (COPD). R2's clinical monitoring for infection/suspected infection dated 11/15/22, indicated R2's symptoms included diarrhea, nonproductive cough, and labored breathing. An observation on 11/15/22, at 10:12 a.m. R2's door was open and had a sign that read, "red room". R2's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. An observation on 11/15/22, at 10:15 a.m. hospice aid (HA)-A entered R2's room used hand sanitizer and donned gloves to assist R2 with cares. HA-A was wearing a surgical mask but had not donned a N95 mask, gown and was not wearing any eye protection. R2 was sitting in a chair and HA-A kneeled next to R2 and assisted shaving with an electric razor. At 10:20, HA-A completed shaving R2 and offered to heat up R2's breakfast. HA-A then walked out of R2's room with the breakfast container and walked down the hall to the kitchen area. HA-A had not removed gloves or performed hand hygiene. HA-A proceeded to microwave R2's breakfast and returned to R2's room. HA-A re-entered R2's room without performing hand hygiene and without donning a gown, N95 mask or eye protection. HA-A set R2 up with breakfast. At 10:26 a.m. HA-A exited R2's room without glove	21375		

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21375	Continued From page 11 removal or hand hygiene performed. HA-A walked to kitchen area and was handed a bowl of oatmeal and returned to R2's room. HA-A re-entered R2's room without performing hand hygiene and without donning a gown, N95 mask or eye protection. HA-A delivered oatmeal, removed gloves, and performed hand hygiene upon exit. When interviewed on 11/15/22, at 10:35 a.m. HA-A verified R2's door sign and stated R2 was positive for COVID-19 and was on isolation. HA-A acknowledged she had not worn the required PPE and was in and out of R2's room without hand hygiene or glove removal. HA-A further stated the vaccine was supposed to protect staff and residents and isolation precautions were not important as most of the residents in the facility were COVID-19 positive. When observed on 11/15/22, at 2:43 p.m. nursing assistant (NA)-A entered R2's room. NA-A had donned a gown, face shield and gloves. NA-A also donned a N95 mask, however had placed it over a surgical mask and had left the bottom strap of the N95 mask unsecured and hanging below his face. NA-A helped R2 with toileting. NA-A removed the gown, gloves, and both masks upon exiting R2's room. NA-A performed hand hygiene, placed a new surgical mask and cleaned his face shield. When interviewed on 11/15/22, at 3:16 p.m. NA-A verified R2 was on isolation precautions for COVID-19. NA-A acknowledged wearing a surgical mask under a N95 mask and not having both straps attached was not how the N95 should be worn. NA-A further stated he shouldn't have worn it that way but felt more protected with two masks.	21375		

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21375	Continued From page 12 R4 R4's admission MDS 10/29/22, indicated R4 was cognitively intact. R12's diagnoses list printed 11/16/22, indicated R4 had diagnoses of COVID-19, chronic kidney disease, and hypertension. R4's clinical monitoring infection/suspected infection dated 11/16/22, indicated R4 was afebrile, without cough, and had lung crackles (description of lung sounds indicate fluid buildup). An observation on 11/16/22, at 7:31 a.m. R4's door was open and had a sign that stated, "red room". R4's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. Upon exit of R4's room, lab technician (LT)-A had eye protection on and had removed a gown and gloves. LT-A then removed a surgical mask and reviled as second surgical mask was underneath. LT-A performed hand hygiene and entered R6's room. When interviewed on 11/16/22, at 7:36 a.m. LT-A confirmed R4 was on isolation for COVID-19 and had noted the sign on R4's door upon entering R4's room. LT-A stated verified a N95 mask was required and further stated usually a N95 mask was worn. LT-A acknowledged she had not used one today and instead used two surgical masks. R5 R5's quarterly MDS dated 8/17/22, indicated R5 was cognitively impaired. R5's diagnoses list printed 11/16/22, indicated R5	21375		

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21375	Continued From page 13 had diagnoses of COVID-19, dementia, and hypertension. R5's clinical monitoring infection/suspected infection dated 11/13/22, indicated R5 was afebrile and had no respiratory symptoms. An observation on 11/15/22, at 11:45 a.m. R5's door was shut and had a sign that stated, "red room". R2's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. Licensed practical nurse (LPN)- A entered R5's room wearing a gown, N95 mask, and gloves. LPN-A had on prescription glasses however was not wearing goggles or a face shield. LPN-A had removed the PPE and performed hand hygiene upon exit of R5's room. When interviewed on 11/15/22, at 11:52 p.m. LPN-A verified R5 was COVID-19 positive and TBP including eye protection was required. LPN-A stated R5 was almost off isolation precautions and felt just her prescription glasses were ok to use. LPN-A further stated she usually did not use eye protection as it makes it harder to see over her prescription glasses. R7 R7's significant change MDS dated 10/26/22, indicated R7 was cognitively intact. R7's diagnoses list printed 11/16/22, indicated R7 had diagnoses of COVID-19 and heart disease. R7's clinical monitoring infection/suspected infection dated 11/16/22, indicated R7 was afebrile and had no respiratory symptoms. An observation on 11/16/22, at 7:52 a.m. R7's	21375		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - INVER GROVE	1301 50TH STREET EAST INVER GROVE HEIGHTS, MN 55077

(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
21375	Continued From page 14 door was shut and had a sign that stated, "red room". R7's door sign instructed staff to have N95, face shield, gloves, and gown on upon entering. NA-D exited R7's room wearing a surgical mask under a N95 mask. The lower strap of the N95 mask was not in place and was hanging below R7's chin. NA-D removed both masks performed hand hygiene and placed a new surgical mask. When interviewed on 11/16/22, at 8:30 a.m. NA-D verified R7 was positive for COVID-19 and TBP was required. NA-A verified wearing a surgical mask under the N95 mask and further stated "we are not supposed to" and should be removing the surgical mask before donning the N95 mask. R1 R1's quarterly MDS dated 8/16/22, indicated R1 was cognitively intact. R1's diagnoses list printed 11/16/22, indicated R1 had COVID-19, hypertension, and heart disease. An observation on 11/15/22, at 12:40 p.m. R1 was observed self propelling in his wheelchair outside of his room. R1 had on a N95 mask with one strap in place and was holding a gray insulated mug with no cover. R1 wheeled down to the opposite end of the hallway to the kitchen area. R1 had wheeled past NA-C. Upon arriving to the kitchen area R1 filled a gray mug with ice from an automated ice machine. R1 briefly stated hello to the administrator who was located by the nursing desk as he passed by going back down the hallway. LPN-A stopped R1 and asked about lunch but failed to educate or redirect R1 to his room. R1 wheeled down the hallway back into his room.	21375		

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21375	Continued From page 15 When interviewed on 11/15/22, at 12:56 p.m. NA-C acknowledged R1 was in TBP for COVID-19 and should not be out in the hallway or going to the kitchen. NA-C acknowledged seeing R1 out of his room and had not redirected or remind R1 to return to his room. When interviewed on 11/15/22, at 1:30 p.m. R1 stated he tested positive for COVID-19 a week ago and still had a slight cough but overall was feeling better. R1 stated he was aware he was supposed to stay in the room, but it was easier to just go grab ice rather then put the call light on. R1 further stated at times he leaves the room to get ice as it was a quick trip. R1 acknowledged staff see him do this so he thought since it was a quick trip it was ok. When interviewed on 11/15/22, at 4:15 p.m. the interim director of nursing (DON) expected all staff to be wearing the proper PPE when entering rooms of residents who were positive for COVID-19. PPE included gown, gloves, N95 mask, and eye protection. Residents who are COVID-19 positive should remain in their rooms until isolation was discontinued. DON stated she was aware of some staff wanting to double mask and stated discussions with staff have occurred. The DON further stated the N95 mask could still be tight but acknowledged there was not a way to determine if the fit was correct with a surgical mask under. When interviewed on 11/16/22, at 2:18 p.m. the administrator stated staff and contracted vendors/employees were expected to be wearing the correct PPE when working with residents who were positive for COVID-19.	21375		

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21375	Continued From page 16 During a follow up interview on 11/16/22, at 5:10 p.m. the DON stated ensuring correct PPE was important to help contain the infection and prevent spread to other residents or staff. A facility policy titled Infection Prevention: Acute Respiratory Syndromes (COVID), revised 10/24/22, directed isolation and appropriate use of PPE and respiratory protection was needed when providing cares for residents with known or suspected COVID-19. Appropriate PPE included gown, gloves, eye protection, and N95 mask. SUGGESTED METHOD OF CORRECTION: The director of nursing (DON), or designee, could review applicable policies and procedures on resident immunizaiton, PPE use and COVID-19 testing to ensure compliance with CMS and/or MDH requirements. Then educate direct care staff to ensure knowledge, and audit to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Seven (7) days	21375		