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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6ZVH

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00146

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245403**
2.STATE VENDOR OR MEDICAID NO.
(L2) **150518100**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - BATTLE LAKE**
(L4) **105 GLENHAVEN DRIVE**
(L5) **BATTLE LAKE, MN** (L6) **56515**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/11/2021** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **55** (L18)
13.Total Certified Beds **55** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC
X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	55			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Susan Bachleitner, HFE - NE II 03/25/2021 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Joanne Simon, Enforcement Specialist 03/30/2021 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
12/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

Electronically delivered
March 5, 2021

Administrator
Good Samaritan Society - Battle Lake
105 Glenhaven Drive
Battle Lake, MN 56515

RE: CCN: 245403
Cycle Start Date: February 11, 2021

Dear Administrator:

On February 11, 2021, a survey was completed at your facility by the Minnesota Departments of Health and Public Safety, to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Office: (507) 344-2742 Mobile: (651) 368-3593

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

the latest correction date on the approved ePoC, unless it is determined that either correction actually occurred between the latest correction date on the ePoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the ePoC.

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

If substantial compliance with the regulations is not verified by May 11, 2021 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 11, 2021 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

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

William Abderhalden, Fire Safety Supervisor
Deputy State Fire Marshal
Health Care/Corrections Supervisor – Interim
Minnesota Department of Public Safety
445 Minnesota Street, Suite 145
St. Paul, MN 55101-5145
Cell: (507) 361-6204
Email: william.abderhalden@state.mn.us
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4117
Email: melissa.poepping@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING _____ B. WING _____	C 02/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments On 2/8/21, to 2/11/21, a survey for compliance with CMS Appendix Z Emergency Preparedness was conducted during a recertification survey. The facility was IN compliance with the Appendix Z Emergency Preparedness, Requirements for Long-Term Care (LTC) Facilities.	E 000		
F 000	INITIAL COMMENTS On 2/8/21, through 2/11/21, a standard recertification survey was conducted at your facility. A complaint investigation was also conducted. Your facility was found not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaints were found to be SUBSTANTIATED with no deficiencies: H5403016C (MN64785) H5403018C (MN62377) The following complaints were found to be UNSUBSTANTIATED: H5403014C (MN69679) H5403015C (MN58852) H5403017C (MN64291) The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to	F 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2021

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 000	Continued From page 1 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 676 SS=D	Activities Daily Living (ADLs)/Mntn Abilities CFR(s): 483.24(a)(1)(b)(1)-(5)(i)-(iii) §483.24(a) Based on the comprehensive assessment of a resident and consistent with the resident's needs and choices, the facility must provide the necessary care and services to ensure that a resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that such diminution was unavoidable. This includes the facility ensuring that: §483.24(a)(1) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including those specified in paragraph (b) of this section ... §483.24(b) Activities of daily living. The facility must provide care and services in accordance with paragraph (a) for the following activities of daily living: §483.24(b)(1) Hygiene -bathing, dressing, grooming, and oral care, §483.24(b)(2) Mobility-transfer and ambulation, including walking, §483.24(b)(3) Elimination-toileting, §483.24(b)(4) Dining-eating, including meals and snacks,	F 676		3/31/21

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F 676	Continued From page 2 §483.24(b)(5) Communication, including (i) Speech, (ii) Language, (iii) Other functional communication systems. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 3 residents (R12) who required assistance with hygiene, and were reviewed for activities of daily living. Findings Include: R12's quarterly Minimum Data Set (MDS) dated 11/13/20, identified R12 had severe cognitive impairment and had diagnoses which included: Alzheimer's disease, anxiety and heart failure. R12's MDS further identified required supervision with personal hygiene, dressing and toilet use. R12's comprehensive care plan dated 2/11/21, identified R12 had self care deficit related to dementia and had need for assistance with ADLs (activities of daily living). R12's comprehensive care plan interventions identified R12 required cuing at times for personal hygiene. R12's care plan did not include instructions to not assist R12 with shaving facial hair. On 2/08/21, at 6:35 p.m. R12 was observed in the hallway near her room dressed in street clothes. R12 had 6-8 1/4 inch long blonde facial hairs on her chin. On 2/09/21, at 9:26 a.m. R12 was observed lying in her bed with her eyes closed. R12 was dressed in street clothes, and continued to have 6-8 1/4 inch long blonde facial hairs on her chin.	F 676	1.R12 had her facial hair removed on 2/11/21. Rsdt prefers to be shaved. CP updated to reflect preference. 2.All current and future residents have the potential to be affected by this deficient practice. All current residents will be interviewed and care plans will be updated to reflect resident□s preference for shaving of facial hair. All future residents will be interviewed upon admission for shaving preference and have it documented in the care plan. 3.Procedure change has been implemented to add resident□s preference for shaving or not shaving on the care plan under personal hygiene intervention for ADLS. A Skills Fair was conducted on 2/24/21 with shaving competencies completed for those nursing staff in attendance. Follow up for current/working nursing staff not in attendance will be completed for shaving competencies in person or via phone by 3/31/21. This will be completed by DNS or designee. 4.Random audits for presence of facial hair will be completed daily x7 days and then weekly x3. All audit findings will be taken to the Quality Assurance committee for review and further recommendations.	

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F 676	Continued From page 3 During observation on 2/10/21, at 7:44 a.m. nursing assistant (NA)-A was in R12's room wearing gown, gloves, eye protection and mask while attempting to complete R12's morning cares. R12 was currently on transmission based precautions due to symptoms following her COVID vaccination. R12 was dressed in her same street clothes she wore the previous day and her hair was uncombed. R12 continued to have facial hair on her chin. R12 became anxious and began to refuse all cares offered while sitting in her padded chair in her room. NA-A indicated this was not R12's usual behavior, then she contacted registered nurse (RN)-A by walkie-talkie and informed her that R12 was refusing all cares. RN-A instructed NA-A to leave R12's room and re-approach R12 later. NA-A removed her gown and gloves, sanitized her hands and left R12's room. On 2/10/21, at 9:03 a.m. NA-A indicated R12 was rapidly declining and required extensive assistance with cares, but could participate with some hygiene, but R12 required cuing to keep her on track. NA-A indicated she had not shaven R12, and indicated it would be in R12's care plan if she could be shaven and that R12 would have an electric razor in her room. NA-A indicated some women preferred not to be shaven so they had it written in their care plan not be shave them. NA-A indicated she had never shaven R12 before and indicated she did not know if R12 was to be shaven. NA-A indicated she was not aware if R12 had a razor. On 2/10/21, at 11:00 a.m. R12 was observed sitting in the common area near the bird aviary dressed in street clothes and a sweater. R12	F 676	5.Completion date of 3/31/21	

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F 676	Continued From page 4	F 676		

continued to have facial hair on her chin.

On 2/10/21, at 12:58 p.m. surveyor attempted to contact R12's family member for interview, but unable to contact by phone.

On 2/10/21, at 1:13 p.m. RN-A confirmed R12 had a cognitive decline recently and now required more assistance. RN-A indicated she did not know R12's preference for removing facial hairs, and would have to check with clinical manager (CM)-A. RN-A indicated it should be on R12's care plan. On 2/11/21, at 9:22 a.m. RN-A indicated in a follow up interview that she had spoken to CM-A yesterday and confirmed that if a resident does not want their facial hair shaven it would be on their care plan. RN-A indicated the unit had only two women identified who were not to be shaven, and R12 was not one of those. RN-A indicated she would expect all female residents to be shaven unless identified not to on their care plan with their a.m. or p.m. cares.

On 2/11/21, at 8:18 a.m. CM-A indicated R12 was more confused and anxious and had a decline related to her dementia progression. CM-A indicated the facility staff should assist R12 with shaving of her facial hair. CM-A indicated R12 had been doing it independently before the decline. CM-A indicated the staff found R12's razor yesterday and she thought they shaved R12's facial hair last night. CM-A indicated the usual facility practice was for those residents who did not want their facial hair shaven, it would be care planned and for all others the staff should assist them with shaving. CM-A indicated it was her expectation that R12 would be shaven to remove facial hair as needed. CM-A confirmed the facility social worker had extra razors for staff

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F 676	Continued From page 5 to use if a resident did not have their own razor, but was not sure if the nursing assistants were aware of this. On 2/11/21, at 9:49 a.m. NA-B indicated R12 was more confused and required more assistance with ADLs now. NA-B indicated she thought R12 may have had her facial hairs removed while in the beauty shop, but was not sure. NA-B indicated it would be in R12's care plan if she did not wish to be shaven by staff. NA-B indicated her usual practice was to let CM-A know if a resident needed to be shaven and did not have a razor. On 2/11/21, at 11:09 a.m. director of nursing (DON) confirmed R12 had changed a lot and had been completely independent with cares with some supervision of some cares prior to having COVID. DON indicate since R12 had COVID her memory was worse, she had more behaviors and required more assistance with cares. DON indicated the usual facility practice was all residents received assistance with facial hair unless they refused and this would be on their care plan. DON confirmed it was her expectation that unless it was care planned to not be shaven, that all residents be shaven with cares as needed. The facility policy titled Shaving-Rehab/Skilled reviewed/revised 9/20/20 identified the policy purpose included to promote positive self-image and well-being. The policy further identified if a resident chose not to shave, to report to nurse or physician as appropriate.	F 676		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2)	F 677		3/31/21

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F 677	Continued From page 6 §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure facial hair was removed for 1 of 3 residents (R15) who required assistance with hygiene, and were reviewed for activities of daily living. Findings include: R15's diagnoses obtained from the face sheet dated 2/11/21, included cerebral infarction, dysphagia following cerebral infarction, anxiety, dementia, muscle weakness. R15's significant change Minimum Data Set (MDS) dated 11/20/20, identified R15 had severe cognitive impairment. MDS further identified R15 required extensive assistance with personal hygiene and dressing. R15's care area assessment (CAA) dated 11/20/20, indicated R15 had limited ability to perform personal hygiene due to loss of voluntary arm movement, functional limitation in upper extremity range of motion, impaired hand dexterity and decreased mobility. R15's care plan revised on 11/28/17, identified a self care deficit that required assistance of one to encourage R15 to participate as able. Care plan did not specify R15 not wanting facial grooming. On 2/8/21, at 4:12 p.m. R15 was observed with	F 677	F677 1.R15 had her facial hair removed on 2/11/21. Rsdt prefers to be shaved. CP updated to reflect preference. 2.All current and future resident□s in the facility have the potential to be affected by this deficient practice. All current residents will be interviewed and care plans will be updated to reflect resident□s preference for shaving of facial hair to include need for assist. All future residents will be interviewed upon admission for shaving preference and have it documented in the care plan along with need for assist. 3.Procedure change has been implemented to add resident□s preference for shaving or not shaving on the care plan under personal hygiene intervention for ADLS. A Skills Fair was conducted on 2/24/21 with shaving competencies completed for those nursing staff in attendance. Follow up for current/working nursing staff not in attendance will be completed for shaving competencies in person or via phone by 3/31/21. This will be completed by DNS or designee. 4.Random audits for presence of facial	

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F 677	Continued From page 7 three long white chin hairs that were approximately 1 inch in length. R15 stated the chin hairs bothered her and would like them removed. On 2/9/21, at 1:53 p.m. R15 was observed rubbing her chin hairs and stated it bothered her. R15 did not recall if staff offered to remove the chin hairs. On 2/10/21, at 11:45 a.m. R15 was observed sleeping in recliner and three white chin hairs approximately 1 inch in length remained. On 2/10/21, at 1:24 p.m. interview with nursing assistant (NA)-A stated R15 had not verbalized concerns with facial hair. NA-A stated she was not aware of this special request of grooming chin hairs to be included on R15's care plan. NA-A stated R15 bathroom did not have an electric razor which would also indicate to groom R15 chin hairs. On 2/10/21, at 1:34 p.m. interview with clinical manager (CM)-A stated the care plan would indicate if a resident did not want their facial hair trimmed. CM-A stated R15 should have her chin hair trimmed by the nursing assistant. CM-A said if R15 does not have an electric razor the facility would provide one and store in R15 bathroom. On 2/10/21, at 1:40 p.m. it was observed no electric razor in R15 bathroom. On 2/11/21, at 9:29 a.m. interview with director of nursing (DON) stated the nursing assistants were to follow the care plan. The DON stated the care plan would state if a resident did not want facial grooming. The DON stated if there was nothing	F 677	hair will be completed daily x7 days and then weekly x3. All audit findings will be taken to the Quality Assurance committee for review and further recommendations. 5.Completion date of 3/31/21	

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F 677	Continued From page 8 stated in the care plan about grooming it is then expected the nursing assistant would provide facial grooming or trimming of chin hair even on female residents. The DON stated R15 care plan did not indicate to not provide facial grooming. The facility policy titled Activities of Daily Living-Rehab/Skilled revised 12/28/20, identified the purpose of the procedure is to provide residents with appropriate treatment and services to maintain or improve abilities in activities of daily living for the well-being of mind, body and soul. The policy further directed ADLs are those necessary tasks conducted in the normal course of a resident's daily life. General personal, daily hygiene/grooming: care of hair, hands, face, shaving, applying makeup, skin, nails and oral care.	F 677		
F 679 SS=D	Activities Meet Interest/Needs Each Resident CFR(s): 483.24(c)(1) §483.24(c) Activities. §483.24(c)(1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide meaningful and engaging activities for 1 of 3 residents (R17) with cognitive impairments who were reviewed for	F 679	F679 1.R17 had a care plan focus for possible activity deficit added on 2/11/21 along with	3/31/21

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F 679	Continued From page 9 activities. Findings include: R17's quarterly Minimum Data Set (MDS) dated 12/1/20, identified R17 as having severe cognitive impairment with diagnoses which included: non traumatic brain dysfunction, Alzheimer's disease, anxiety, psychotic disorder and hallucinations. R17 had moderate hearing difficulty and required speaker to increase volume and speak distinctly. R17 had moderately impaired vision. R17's MDS further identified R17 did not walk and required extensive assistance with activities of daily living. R17's annual MDS dated 6/17/20, identified R17 had significant cognitive impairment and moderate hearing and vision impairment. R17's MDS further identified listening to music, doing things with a group of people was somewhat important and religious services were very important to R17. R17's comprehensive care plan dated 2/11/21, identified R17 had a potential for psychosocial well-being deficit related to visitor restrictions secondary to COVID-19. Interventions included to increase communication between R17 and family and assist R17 with phone calls. R17's interventions also included 1:1 visits, take for walks around building and outside when weather was warmer. On 2/8/21, at 12:35 p.m. R17 was dressed in street clothes, in his wheelchair in his room. R17 had a blanket over his legs, eyes open, he was facing his doorway. R17's radio and television were off. R17 opened his eyes when surveyor entered the room, but did not respond verbally.	F 679	goal and interventions implemented. 2.All current and future residents have the potential to be affected by the deficient practice. All current resident□s care plans will be reviewed to determine if interventions are in place for those at risk for activity deficits. 3.Due to lessened COVID restrictions resident now comes to dining room for 3 meals a day and is able to attend other group activities as he prefers. Education/reminders given to activity staff on importance of providing meaningful activities per rsdt preference by activity director on 3/16/21. 4.Random focus audits for activity care plans and documentation will be completed on 5 residents weekly x4 then bi-monthly x2. Results will be reviewed by Quality Assurance committee for review and further recommendations. 5.Completion date of 3/31/21	

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On 2/8/21, at 12:44 p.m. R17 was in his wheelchair in his room, being fed by nursing assistant/activity aide (AA)-A. AA-A talked at times with R17 while feeding him.

On 2/8/21, at 2:37 p.m. R17 was lying in his bed, eyes closed, door open.

On 2/8/21, at 6:36 p.m. R17 was in his wheelchair in his room, eyes slightly closed facing the doorway, no television or music was on.

On 2/8/21, R17 was not observed in any group activities or 1:1 activities.

On 2/9/21, at 12:38 p.m. R17 was dressed in street clothes sitting in his doorway to his room. Registered nurse (RN)-A stopped and asked R17 if she could help him back to his room, and informed him they were bringing lunch soon. RN-A pushed R17 backwards into his room, attached his call light to his wheelchair then turned on his radio, which then played music softly.

On 2/9/21, at 2:15 p.m. R17 was lying on his back in his bed, eyes closed, his door was open.

On 2/9/21, at 3:24 p.m. R17 continued in his bed, eyes closed. At 3:29 p.m. nursing assistant (NA)-C and RN-C transferred R17 from his bed to his wheelchair. R17's radio was softly playing music, and difficult to hear unless near the radio. NA-C propelled R17 in his wheelchair to the sun room where R17 was visited by the priest.

On 2/10/21, at 8:59 a.m. R17 was dressed in street clothes in his wheelchair, in his room, being

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fed by NA-B.

On 2/10/21, at 1:06 p.m. R17 was sitting in his wheelchair, in his room, eyes open, his radio was on, playing polka music softly, which could only be heard near his radio.

On 2/10/21, R17 was not observed in any group activities or 1:1 activities.

Review of R17's progress notes from 7/1/20, to 2/11/21 identified the following:

-7/14/20, activities quarterly note, R17 had dementia with disorganized thinking. He is hard of hearing and wears hearing aides but stills struggles to hear. R17 also had left side vision impairment and staff assist R17 to specific destination. R17's family used to visit often prior to COVID visitor restrictions. R17 enjoys music, and has a Wi-Fi radio in his room, but even turned up loud cannot hear it. R17 had a television in his room, but again due to poor vision was unable to see it. R17 enjoyed snacks and hot chocolate. R17 was barely in his room, but would take a nap in the afternoon. Staff provided R17 1:1 visits, would take him outdoors and strolls throughout the building.

-12/11/20, care plan review identified R17 had several children who would call and visit as able. Family member now an essential care giver so would start coming now. Continue with interventions.

-2/5/21, family member requested priest come and bless R17 today.

Review of R17's Activity Interest Date Collection

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Tool dated 7/14/20, identified R17 preferred spending time with others and talking/conversion, listening to others and preferred television shows was news. R17's tool identified R17 had support of family and enjoyed Polka and Waltz music.

Review of the untitled undated document which identified 1:1 visits for facility residents identified R17 received PRN (as needed) 1:1 visits.

Review of R17's activity Follow Up Question Report 1:1 visits dated 1/11/21, to 2/11/21 identified the following:

-1/14/21, social, staff visit
-1/15/21, social, staff visit
-1/17/21, social, staff visit
-1/18/21, educational/cognitive, library cart
-1/20/21, social, staff visit
-1/22/21, social, other visit
-1/25/21, social, family/friend visit
-2/1/21, educational/cognitive, library cart
-2/3/21, social, family/friend visit
-2/5/21, spiritual, clergy visit
-2/8/21, educational/cognitive, coffee/tea
-2/9/21, sensory stimulation, radio/Ipod, staff visit

Review of R17's activity Follow Up Question Report of group/self directed activities dated 1/11/21, to 2/11/21 identified documentation of social-communication with others, walking/wheeling, bird watching, TV and radio/Ipod on most days. On Sundays, it was documented spiritual, religious services. On group activities of exercise or bingo, it was documented not available or refused.

On 2/10/21, at 9:12 a.m. NA-A indicated R17 did not participate in activities. NA-A indicated he

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was hard of hearing and had vision loss. NA-A indicated before COVID-19, R17 was out and about, liked to have snacks in the dining room and liked to talk and R17 was social.

On 2/10/21, at 12:49 p.m. family member (FM)-A during a phone interview indicated since COVID she felt R17 spent a lot of his time alone in his room with lack of stimulation. FM-A indicated R17 liked 1:1 visits. FM-A indicated R17 could not hear well and had vision problems, so he did not do well in groups, but felt 1:1 visits were best. FM-A indicated R17 liked to be in the common area in the recliner by the television.

On 2/10/21, at 1:26 p.m. RN-A indicated R17 loved polka music, but it was hard to tell if R17 could hear the music from his radio. RN-A indicated R17 probably did not receive other activities since the pandemic, but indicated R17 used to come out to the dining room in the afternoon for coffee and was more alert then. RN-A indicated his family comes for essential care visits about 1 time a week, and yesterday R17 had a visit from the priest. RN-A indicated R17 enjoyed topics such as farming and auctions.

On 2/10/21, at 1:42 p.m. AA-A indicated R17 had cognitive impairment and was difficult to keep on track. AA-A indicated R17 had strong faith and liked to watch television, listen to the radio and observe activities. AA-A indicated R17 did not participate in activities, but visited, had coffee and cookies and on Sundays would watch Catholic services on television. AA-A indicated she had not done much with R17 in the past week, usually AA-A would feed R17, like she did on 2/8/21. AA-A indicated she had not done any activities with R17 recently. AA-A indicated R17 was

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scheduled for 1:1 visits PRN (as needed). AA-A indicated R17 was hard of hearing but liked someone by him and liked snacks like hot chocolate, cookies and milk. AA-A indicated a good activity was to give him rides around the facility, but it had been a while since that had been done. AA-A indicated the nursing assistants put him in his recliner, wheelchair or bed. AA-A indicated activities were hard for R17, as he was an observer. AA-A indicated she did not take him to group activities like bingo or exercises to participate or observe. AA-A showed surveyor how she documented in R17's electronic record, and indicated some of the documentation, such as social, indicated communication with others, such as when nursing assistant staff spoke to R17 while providing cares, not necessarily activity staff providing 1:1 visits.

On 2/11/21, at 8:29 a.m. RN clinical manager (CM)-A indicted R17 liked to visit, was hard of hearing and had poor vision and liked polka music. CM-A indicated she was not sure if R17 could hear the music played on his radio in his room and felt because of his hearing loss, the music would have to be turned up. CM-A indicated R17 liked to visit about farming and she thought activities completed 1:1 visits with R17.

On 2/11/21, at 8:38 a.m. activity director (AD)-A indicated activities they provided for R17 included taking him out when weather was nice, turn on polka music and offer snacks. AD-A indicated they do 1:1 visits with him at times, or push him through the facility if he was restless. AD-A indicated R17 liked to talk about farming, his family and his faith was important to him. AD-A indicated his family used to visit often, but more sporadic now. AD-A indicated R17 would go out

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to the common areas, but now rests often. AD-A reviewed R17's activity follow up report and indicated television, birds, and radio, were listed, and he was often resting after lunch. AD-A indicated she thought R17 received 1:1 at least daily by AA-A, and indicated she was not aware of why R17 did not go out of his room this week. AD-A indicated prior to the pandemic they had weekly entertainment that R17 would attend. AD-A confirmed R17 was very hard of hearing, and was not sure if R17 could hear the music on his radio in his room, and confirmed R17 did not use headphones. At 10:38 a.m. during follow up visit, AD-A confirmed R17 received 1:1 visits PRN because sometimes he was resting and sometimes would be agitated.

On 2/11/21, at 9:43 a.m. NA-B indicated since the pandemic the facility did not provide any activities to speak of, but the facility was working on some group activities that were being worked back in. NA-B indicated they turned on Catholic services on the television for R17 on Sundays, but felt he could not hear or see it. NA-B indicated prior to the pandemic he had visitors with kids almost every day. NA-B indicated she could not tell if R17 could hear his radio when it was on, but indicated he could hear staff at times when they spoke to him. NA-B indicated she did not think R17 received 1:1 visits at this time and had not seen R17 receive a 1:1 visit in a while, but was not sure. NA-B indicated prior to the pandemic residents received 1:1 visits on the PM shift, but was not sure if this was being done now.

On 2/11/21, at 11:07 a.m. director of nursing confirmed AD-A was the activity director. The DON indicated prior to COVID they had 3 activity staff, but only had AA-A and AD-A at this time.

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F 679	Continued From page 16 The DON indicated the facility was working on rebuilding their small group activities now and indicated AD-A completed the activity assessments for the residents in the facility. The facility policy titled Activities Program -ACT dated 6/22/20, identified activities as any endeavor in which a resident participates that is intended to enhance her or his sense of well-being and to enhance or promote physical, cognitive and emotional health. The policy also identified based on their comprehensive assessment and care plan and preferences, the facility would provide an ongoing program to support resident choices in their choices of activities.	F 679		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration. (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(1) Maintains acceptable parameters of nutritional status, such as usual body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible or resident preferences indicate otherwise; §483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health; §483.25(g)(3) Is offered a therapeutic diet when	F 692		3/31/21

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F 692	Continued From page 17 there is a nutritional problem and the health care provider orders a therapeutic diet. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to develop interventions to address unplanned weight loss for 1 of 2 residents (R12) reviewed for nutrition. Findings include: R12's quarterly Minimum Data Set (MDS) dated 11/13/20, identified R12 had severe cognitive impairment and had diagnoses which included: Alzheimer's disease, anxiety and heart failure. R12's MDS further identified required supervision with eating, personal hygiene, dressing and toilet use. R12's MDS identified current weight of 146 with no known weight loss. R12's annual MDS dated 5/26/20, identified R12's current weight of 160 with no known weight loss. R12's MDS further identified R12 required extensive assistance with dressing and was independent in all other activities of daily living (ADL) including eating. R12's care area assessments (CAAs) dated 6/4/20, identified R12 ate independently with occasional set up help provided. R12's CAAs also identified R12 was able to eat independently with good appetite despite dementia history and anxiety symptoms. R12's comprehensive care plan dated 2/11/21, identified R12 had self care deficit related to dementia and required assistance with ADLs. R12's comprehensive care plan interventions identified R12 was able to feed self after set up	F 692	F692 1.Care plan focus added on 2/11/21 with goal for maintaining weight and interventions of weighing weekly for monitoring and addition of scheduled snack of carnation instant breakfast (no chocolate) with whole milk and cookie or a snack of her choosing between meals and at HS. 2.All current and future residents have the potential to be affected by the deficient practice. Risk committee will continue meeting on a regular basis to review weights and address any current residents with weight loss to ensure appropriate follow up or interventions including update of care plans for those at risk or needing interventions. 3.R12 discharged to a memory care facility on 3/1/21. Risk committee will continue meeting on a regular basis to review weights and address any current residents with weight loss to ensure appropriate follow up or interventions. Risk committee met on 3/25/21 to review process for risk meetings, assigning meeting tasks to specific individuals completed by DNS and all findings will be discussed at weekly risk meetings going forward. 4.Random Audits to identify weight loss	

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F 692	Continued From page 18 help. On 2/8/21, at 6:25 p.m. R12 was finished eating in the dining room. R12 ate 2/3 of her hamburger, none of her tomato slices or berry cobbler desert. On 2/10/21, at 7:48 a.m. nursing assistant (NA)-A was in R12's room attempting to assist R12 with morning cares. R12 refused assistance. NA-A told R12 that they would bring breakfast shortly, R12 said she was not really hungry. At 8:52 a.m. director of nursing (DON) was leaving R12's room and indicated R12 ate about 1/2 of her breakfast and R12 had told DON she could not eat all of it. Review of R12's Order Summary Report signed 1/19/21, identified: - diet order- NAS (no added salt) regular texture, regular fluid consistency. -POLST (provider orders for life sustaining treatment), artificially administered nutrition- Offer food by mouth if feasible. Defined trial period of artificial nutrition by tube. R12's order's did not indicate any further supplements or fortified foods ordered. Review of R12's progress notes from 8/10/20, to 2/11/21 identified the following: -11/10/20, R12 positive for COVID infection -11/24/20, dietary/nutrition-regular texture with NAS foods recommended and smaller portions not to overwhelm her. R12's weight 145.5 which is below previous weights, but not significant and BMI (body mass index) is not out of normal range, BMI at 26.6. Continue to monitor and record intakes and weights per facility protocol and observe for changes that may alter dietary interventions and review weights to be sure	F 692	and interventions will be completed weekly on 5 residents during risk committee meeting x4. Results will be reviewed by Quality Assurance committee for review and further recommendations. 5.Completion date of 3/31/21	

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weight loss does not become significant.
-12/2/20, R12 significant weight loss, appetite quite poor for approximately 2 weeks with positive COVID infection, slightly improved now will update GNP (general nurse practitioner) on rounds today with recent weights.
-12/9/20, consultant pharmacist recommendation, R12's weight loss does not appear to be medication related, but rather acute illness.
-12/20/20, R12 reviewed at risk meeting, decreased appetite, noted to eat better in the dining room, will reassess options for this. R12 some recent weight loss since COVID infection, increased confusion, R12 likes cheese sticks, but does not snack as much as previously, will look at alternative snacks and alert staff to offer snacks with 1:1 for wandering etc.
-12/17/20, R12 reviewed at risk meeting today. R12 had some recent weight loss and decline in appetite. Recently started Celexa for decline in mood and anxiety.
-1/12/21, nutritional status-R12 had weight decline/intakes, does much walking during the day, small appetite, weight 138.5. BMI 25.3 normal weight status. Weight was 143 30 days prior, 154.5 180 days prior, and weight 160 1 year ago. R12 had had a weight loss trend in past 60 days, meal intake remains greater than 75%, plan to offer snacks for activity between meals.
-1/20/21, R12 reviewed at risk meeting, slight weight gain noted, more hungry, better intake.
-2/11/21, R12 has not had much of appetite, some meals does eat more. R12 offered snacks throughout the day as she is willing to have them. Weight is down 4 pounds this week.

R12's GNP progress note dated 11/4/20, identified R12 had significant weight loss of 9

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pounds in the past 4 months, 14 pounds in the past 8 months and current weight was 145.5, down from 150 in September. R12's GNP note also identified R12 appeared well nourished. R12's progress note identified slow weight loss, R12 walked hall continuously which likely contributed to slow weight loss.

R12's primary physician telehealth progress note dated 1/19/21, identified R12 in stable condition with some weight loss, suspected this was doing well, and would recheck R12's A1C (diabetic blood test to test blood sugar levels) in the future.

On 2/10/21, at 9:03 a.m. NA-A indicated R12 was declining rapidly and required more assistance and help keeping on track to participate in cares. NA-A indicated it was more of a struggle and was harder and harder to get R12 to eat. NA-A indicated R12 was eating less and less and she could tell by R12's jeans that she had lost weight.

On 2/10/21, at 1:13 p.m. registered nurse (RN)-A indicated R12 had been declining and thought she had noticed R12 had more of a cognitive decline recently with more wandering in the past 2 weeks. RN-A indicated R12 had declined quite a bit with her eating and RN-A indicated she had noted a weight loss with R12. RN-A indicated R12 had a steady decline since she had COVID-19 and her intake had declined also. RN-A indicated there had been no changes in her diet, and that staff provided redirection and encouragement. RN-A indicated R12 had no nutritional supplements ordered. RN-A indicated her usual practice included checking on resident weights that were completed, compared them to previous weights and reported changes in the electronic shift communications and during

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report.

On 2/11/21, at 8:18 a.m. RN clinical manager (CM)-A confirmed R12 had Alzheimer's disease and was declining. CM-A indicated R12 was now more confused, anxious and walking more. CM-A indicated R12 had a change in her appetite with more anxiety and confusion after she had COVID-19. CM-A indicated they had recently started Celexa (anti-depressant) for her mood, weight loss, sleep and for quality of life. CM-A indicated R12 had quite a bit of weight loss with COVID and they offered her snacks and she felt R12's appetite had improved. CM-A indicated the usual facility practice for weight loss was to try foods first, then alternatives and get to the root cause of the reason for weight loss, before beginning supplements.

On 2/11/21, at 9:49 a.m. NA-B indicated R12 had declined and she was more confused since she had COVID in November. NA-B indicated R12 was on a regular diet and ate independently in the dining room. NA-B indicated she felt R12 was not eating as well, and not eating as much as in the past. NA-B indicated until recently she was fine, but now R12 had more concerns about others eating than herself and was hard to redirect. NA-B indicated she was not sure but felt R12 had lost weight.

On 2/11/21, at 10:13 a.m. during a phone interview dietician (D)-A indicated she was at the facility a couple of times monthly. D-A indicated she understood R12 was more distracted at meals and would not sit long at meals, which may have affected her appetite and intake. D-A indicated her last assessment for R12 was in January. D-A indicated she was aware R12 was

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walking more and constantly on the move. D-A indicated she thought R12 was on a weight loss trend. D-A indicated the usual facility policy was to first offer snacks, and use foods first for weight loss. D-A indicated the facility also had some high calorie drinks they offered some residents and indicated she was not sure if R12 was receiving supplements. D-A indicated her usual practice was to review the residents' weights by reviewing the weight loss reports and also said the electronic health records gave weight alert warnings she also reviewed. D-A indicated the facility also would make her aware of any concerns through their monthly risk meetings that they held. D-A indicated the clinical managers would make the physicians aware of any weight loss. D-A reviewed R12's electronic health record during the interview and indicated her last annual nutritional assessment was completed in June. At that time R12's intake was over 75% of her meals. D-A indicated she would be concerned if R12 developed fast weight loss. D-A indicated R12's weight began changing in November and she last charted on her 1/12/21. D-A indicated R12 had a small appetite at that time and was doing much walking during the day. D-A indicated at that time she weighed 138.5 and was now at 134, which was an additional 4 pound weight loss, but comparing her to 6 months ago, her weight loss could have been triggered. D-A indicated the interventions for R12 in January was to offer snacks. D-A indicated they could look at a trial kind of drink and look at medical supplements for R12 or fortified foods. D-A indicated the facility opted for fortified foods first. D-A indicated at this point with further evaluation, she felt that even though R12 had gained 1/2 pound with her last weight, she felt that she was now completely aware of R12's weight loss and

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would put a plan in place. D-A indicated she would follow up with the facility and see what could be done and to try something different to stop R12 from any further weight loss. D-A indicated they had to keep the residents' advanced directives in mind first. D-A indicated R12's advance directive review indicated they wanted to do a trial tube feeding for R12, but would not recommend this. D-A indicated now that she was aware of R12's weight loss R12 needed more than meals and snacks.

On 2/11/21, at 11:09 a.m. the DON indicated R12 had changed a lot since she had COVID-19 . The DON stated R12 was previously independent with some supervision with ADLs. The DON indicated she was aware of R12's weight loss and that she was not eating as well or completing her meals she received in the dining room. The DON indicated her expectation was that if the nurse or dietician noticed weight loss of a resident, she would expect they make recommendations for interventions and involve R12's primary physician. The DON indicated they expected the addition of Celexa would help and confirmed Celexa was not ordered for her weight loss or appetite, but for her mood. The DON indicated she would expect D-A to follow up on R12's weight loss. DON confirmed R12 had continued weight loss.

The facility policy titled Responsibilities for Dietician-Food and Nutrition Services dated 7/8/20, identified the dietician was an active member of the dietary risk committee and the interdisciplinary team and conducted assessment of nutritional status on site.

The facility policy titled Nutrition Documentation-Food And Nutrition Services

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F 692	Continued From page 24 dated 7/8/20, identified the purpose was to identify the nutritional status and needs of the residents and to assess the residents needs and plan appropriate nutrition for each resident. The policy further identified the dietician would document monthly on residents identified to be at nutritional risk in the progress notes. The policy also identified if the nutritional interventions had not been effective, to new goals and interventions would be added to the care plan.	F 692		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any,	F 756		3/31/21

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F 756	Continued From page 25 action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed to properly monitor for potential side effects for 1 of 3 residents (R32) reviewed for antipsychotic medication use. Findings included: R32's face sheet indicated R32's diagnosis included anxiety disorder, hallucinations, major depressive disorder and post-traumatic stress disorder (PTSD). R32's quarterly Minimum Data Set (MDS) dated 12/29/20 indicated R32 had moderate cognitive impairment. R32's medication orders, signed 1/14/21, included buspirone (medication used to treat anxiety) and quetiapine (an antipsychotic medication used to treat mood and mental conditions). R32's Abnormal Involuntary Movement Scale (AIMS) used to assess for dyskinesias (movement disorders that are characterized by	F 756	F756 1.AIMS assessment review completed on 2/10/21. Telehealth visit with psychiatry completed on 2/23/21 with new orders for trial reduction of antipsychotic meds. Care plan was updated to reflect use of mood/behavior medication and monitoring for SE related to use of said medications on 3/10/21. 2.All current and future residents on antipsychotic medications have the potential to be affected by the deficient practice. All current residents on antipsychotic medications will be reviewed to ensure AIMS assessments have been completed appropriately and are accurate related to resident s/s of possible TD. 3.Written education provided by DNS/designee to all nursing staff and activity staff to observe for SE of antipsychotic medications in residents including: uncontrolled facial or hand	

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F 756	Continued From page 26 involuntary muscle movements) in residents taking neuroleptic medications dated 12/22/20, indicated facial and oral movements were not noted. According to facility document, possible areas of movements included the forehead, eyebrows, periorbital (around the eye), cheeks, lips, perioral (around the mouth), jaw and tongue. R32's consulting pharmacist progress note dated 1/11/21 indicated R32 had a long history of PTSD, recurrent depression and hallucinations which warranted current medication use which included quetiapine. The progress note indicated R32 was tolerating dosages of medications well and recommended adjustments to psychotropic medications (medication that affects behavior, mood, thoughts or perception) be left to psychiatry. The progress note indicated R32 was to see psychiatry in the near future. R32's primary provider progress notes dated 1/14/21, did not identify R32 was having adverse effects from use of psychotropic medications. R32's progress notes did not include any notes identifying facial or hand movements. R32's treatment sheets and current care plan did not identify the need to observe for uncontrolled facial or hand movements related to medication use. On 2/8/21, at 12:26 p.m. R32 was observed continuously moving his mouth, as though he was chewing on something and smacking his lips. R32 denied having food, fluid, or other object in his mouth. On 2/8/21, at 5:40 p.m. R32 was observed to	F 756	movements. Direction given to report any observations of SE immediately to charge nurse or RN case manager for further follow up. 4.Random audits of 5 residents on antipsychotics will be completed weekly x4, then monthly x2, observing for uncontrolled facial or hand movements. Results will be reviewed by Quality Assurance committee for review and further recommendations. 5.Completion date of 3/31/21	

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continuously move his mouth, as though he was chewing on something. Movements not noted when R32 was talking but would immediately return when he stopped talking. R32 was able to stop these movements when made aware of them, but they returned in less than a minute. Infrequent pill rolling (circular movements of the tips of the index finger and thumb) observed in R32's right hand.

On 2/9/21, at 12:42 p.m. R32 was observed sitting up in bed, but leaning against pillows between him and the wall. Noted continuous facial movements, as if he was chewing on something and smacking his lips. R32 confirmed he did not have anything in his mouth and denied chewing on his tongue. The facial movements would stop when R32 was talking but would immediately return when he stopped talking. Pill rolling not noted in right or left hands, but R32 was hanging onto the television remote with is right hand at the time of observation and declined to put it down.

On 2/9/21, at 2:09 p.m. R32 was observed to continue with facial movements. Mouth slightly open during this observation. Noted his tongue remained in his mouth but was frequently moving forward and back and along his gum line. Pill rolling of right hand not noted but had the television remote in his hand.

On 2/10/21, at 7:52 a.m. R32 was observed resting in bed with his eyes closed. He did not respond to quiet mention of his name. No facial or tongue movements noted. R32's hands were not visible at the time of this observation.

On 2/10/21, at 8:13 a.m. R32 stated he was not

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aware of the facial movements and had not been asked about them by staff, including licensed staff.

On 2/10/21, at 8:15 a.m. R32 was observed lying bed, but with eyes open. Facial movements, as if he was chewing on something, noted but were not continuous. These movements were less severe that previously noted. R32 able to stop the movements when asked about them, but quickly returned between episodes of R32 talking. Pill rolling not noted in R32's right or left hands.

On 2/10/21, at 11:20 a.m. R32 was observed resting in bed with his eyes closed. No facial movements noted.

On 2/10/21, at 1:13 p.m. nursing assistant (NA)-D stated she has worked with R32 frequently. NA-D has noted facial movements, other than when talking, off and on and R32 has days when the movements are not as noticeable. NA-D indicated being told the reason for the facial movements when NA-D first started at the facility but didn't remember what that reason was. NA-D stated the facial movements has not been reported to a nurse because NA-D assumed the nurses were aware of it and as long as the nurses were aware of it, then it was okay with NA-D.

On 2/10/21, at 1:27 p.m. registered nurse (RN)-B stated R32's facial movements were noticed once in a while. RN-B stated noting increased shaking in R32's hands as well. RN-B did not recall when the facial movements started, RN-B stated being used to seeing it so has not noticed it as much. RN-B confirmed these movements of R32's mouth and hands could be a side effect of the psychotropic medication R32 is taking. RN-B

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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 756	Continued From page 29	F 756		

confirmed she had not reported the facial or hand movements to another nurse, including the MDS Coordinator (RN)-B or the Director of Nursing (DON). RN-B indicate she assumed they were already aware.

On 2/10/21, at 1:39 p.m. case manager (CM)-A stated she had not noticed R32 having a facial tremor and had not been told about it. CM-A indicated residents who receive psychotropic medications receive an AIMS assessment upon admission or start of medication, quarterly after that and as needed. CM-A stated she completed an AIMS assessment with R32 with his last MDS and confirmed her findings indicated no involuntary movements, of R32's face or hands, at the time of the assessment. CM-A stated this assessment is completed face-to-face. At this time, CM-A observed R32 and interviewed him regarding facial movements. After CM-A interview with R32, CM-A confirmed she had not been previously told about the facial movements and that they were well pronounced and not easily ignored.

On 2/10/21, at 2:13 p.m. the director of nursing (DON) confirmed the AIMS assessment is completed face-to-face, it is a visual assessment of movements of face and hands. The DON stated, if unlicensed staff notice new or worsening facial or hand movements, they should report these concerns to the floor nurse. If the floor nurse notices new or worsening hand or facial movements, these should be documented and reported to the MDS Coordinator. The MDS Coordinator would be expected to complete an AIMS assessment to determine severity of these movements. The DON indicated she was not aware of R32 having facial or hand movements.

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	245403	A. BUILDING _____ B. WING _____	C 02/11/2021

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F 756	Continued From page 30	F 756		

She had spent up to 10 minutes with him the morning of 2/8/21 and had not noticed facial or hand movements. The DON confirmed R32 had a facial mask on at that time.

On 2/11/21, at 3:16 p.m. R32's primary provider confirmed he did not notice facial movements during telehealth visit with R32 on 1/14/21. R32's primary provider indicated, during telehealth visits, the resident does not wear a mask so facial movements would be seen, if they were present. R32's primary provider confirmed R32 receives psychotropic medication and may have side effects that included uncontrolled facial movements. The presence of these movements as well as the severity may vary. R32's primary provider indicated it is possible to have the facial movements on some days, but not on others. R32's primary provider indicated he had not been made aware of R32's facial movements prior to 2/10/21 when the facility updated him on the facial movements.

Facility policy: Interact- Change In Condition Evaluation revision date 12/11/20, indicated a change in condition alert can be created to communicate or remind nurses to keep a closer eye on a resident when something seems different.

Facility policy: Psychotropic Medications-Rehab/Skilled revision date 11/19/20, indicated residents using psychotropic medications are to be monitored for side effects of the medication. If a side effect occurs or worsening of a known side effect is noted, the nurse will make a note in the progress notes and notify the physician and family/legal representative of this change in condition.

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE BATTLE LAKE, MN 56515**

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2021**

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey Good Samaritan Society Battle Lake, 01 Main Building was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. "If participating in the E-POC process, a paper copy of the plan of correction is not required." PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2021

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2021**

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GOOD SAMARITAN SOCIETY - BATTLE LAKE	**105 GLENHAVEN DRIVE** **BATTLE LAKE, MN 56515**

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K 000	Continued From page 1 State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101 Or by e-mail to: FM.HC.Inspections@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Good Samaritan Society Battle Lake is a 1-story building, without a basement. The original building was built in 1973 and was determined to be Type II(000) construction. The southeast addition was determined to be Type II (000) construction. In 2004 a small vestibule was added to the west wing, which included a walk-in freezer, which is Type II (000) construction. In 2007 a connecting link, to the new assisted living apartments, was added to the south wing and was determined to be Type V (111) and is separated by a 2-hour fire barrier. In 2010 an entrance addition was constructed to the north of the dining room which is 1-story, with no basement and Type II (000) construction. In 2011, a 16-bed addition was added to the east of the north wing and was determined to be Type II (111) and an 8-bed addition was added to the east of the south east wing and was determined	K 000		

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	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2021**

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K 000	Continued From page 2 to be Type II (111) construction. The building is divided into 3 smoke compartments by 30 minute rated fire barriers. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72, "The National Fire Alarm Code" that is monitored for automatic fire department notification. The facility has a capacity of 55 beds with a census of 42 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 133 SS=F	Multiple Occupancies - Construction Type CFR(s): NFPA 101 Multiple Occupancies - Construction Type Where separated occupancies are in accordance with 18/19.1.3.2 or 18/19.1.3.4, the most stringent construction type is provided throughout the building, unless a 2-hour separation is provided in accordance with 8.2.1.3, in which case the construction type is determined as follows: * The construction type and supporting construction of the health care occupancy is based on the story in which it is located in the building in accordance with 18/19.1.6 and Tables 18/19.1.6.1 * The construction type of the areas of the building enclosing the other occupancies shall be	K 133		3/11/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**02/10/2021**

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K 133	Continued From page 3 based on the applicable occupancy chapters. 18.1.3.5, 19.1.3.5, 8.2.1.3 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain the protective rating in one 2 hour fire barrier as listed in the Life Safety Code NFPA 101 2012 edition, section 8.2.1.3 and 8.3.5 through 8.3.5.1.4. This deficient practice could cause a fire to spread more quickly through a compartment and affect 12 of the 55 residents and an undetermined amount of staff and visitors. Findings include: On the facility tour between 10:00 am to 1:00 pm on 02/10/2021, observations revealed 2 large penetrations in the 2-hour fire barrier in the Heritage Wing along the wall in the oxygen room. This deficient condition was confirmed by the facility Administrator.	K 133	1.All 2-hour fire barriers in the building have been inspected, and repairs have been made as necessary. The 2-hour fire barrier noted in the POC with the 2 large penetrations have been filled with fire caulk. 2.3/11/2021 3.Maintenance Supervisor or designee, is in charge of ensuring hour 2-hour fire barriers are compliant moving forward. He or a designee will perform semi-annual inspections of all 2-hour fire barriers to ensure compliance. His findings will be reported to the Safety Committee, which reports to our QAPI committee.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245403	A. BUILDING **03 - PT/OT BUILDING** B. WING _____	**02/10/2021**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety State Fire Marshal Division. At the time of this survey Good Samaritan Society Battle Lake, 03 was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care and the 2012 edition of NFPA 99, Health Care Facilities Code. In 1994 additions to the north of the north wing (Occupational and Physical Therapy - OT/PT) was constructed. The 1994 addition was determined to be Type V(111) construction and is separated by a 2-hour fire barrier. The entire building is sprinkler protected with a system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems. A fire alarm system with corridor smoke detection and smoke detection in common areas which was updated in 2010 in accordance with NFPA 72 "The National Fire Alarm Code" that is monitored for automatic fire department notification. The facility has a capacity of 55 beds with a census of 42 residents at the time of the inspection. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/11/2021

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