



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
February 28, 2024

Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

RE: CCN: 245568
Cycle Start Date: February 8, 2024

Dear Administrator:

On February 8, 2024, a survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

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

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

The state agency may, in lieu of an onsite revisit, determine correction and compliance by accepting

the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

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

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

DEPARTMENT CONTACT

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

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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 8, 2024 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b).

In addition, if substantial compliance with the regulations is not verified by August 8, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Good Samaritan Society - Mary Jane Brown

February 28, 2024

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Feel free to contact me if you have questions.

Sincerely,

A handwritten signature in cursive script that reads "Kamala Fiske-Downing".

Kamala Fiske-Downing

Minnesota Department of Health

Health Regulation Division

Telephone: (651) 201-4112

Email: Kamala.Fiske-Downing@state.mn.us



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Administrator
Good Samaritan Society - Mary Jane Brown
110 South Walnut Avenue
Luverne, MN 56156

Re: State Nursing Home Licensing Orders
Event ID: ZSUN11

Dear Administrator:

The above facility was surveyed on February 6, 2024 through February 8, 2024 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.

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February 28, 2024

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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:

Susie Haben, Rapid Response
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Midtown Square
3333 Division Street, Suite 212
Saint Cloud, Minnesota 56301-4557
Email: susie.haben@state.mn.us
Office: (320) 223-7356 Mobile: (651) 230-2334

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

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

PRINTED: 03/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245568	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 02/08/2024
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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MARY JANE BROWN	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LUVERNE, MN 56156
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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
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F 000	<p>INITIAL COMMENTS</p> <p>On 2/6/24 through 2/8/24, a standard abbreviated survey was conducted at your facility. Your facility was not in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities.</p> <p>The following complaints were reviewed:</p> <p>H55689627C (MN00098601);</p> <p>H55689583C (MN00100483) with a deficiency issued at F558 and F684.</p> <p>As a result of the investigation, deficiencies were cited F610, and F692.</p> <p>The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance.</p> <p>Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.</p>	F 000		
F 558 SS=D	<p>Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3)</p> <p>§483.10(e)(3) The right to reside and receive</p>	F 558		3/6/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/07/2024
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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 558	<p>Continued From page 1</p> <p>services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observation, interview, and record review, the facility failed to accommodate the needs for 1 of 1 residents (R1) who required a two-handled cup for drinking liquids.</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 1/3/24, indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia.</p> <p>R1's care plan revised on 1/5/24, directed staff to place table over bed lined up with paper on the wall, in front of R1 but not over his hands. R1 requires moderately thick water to be on the table in a double handled cup with a lid.</p> <p>On 2/6/24 at 4:51 p.m., R1 was observed laying in his bed which was along the wall, bed side table was noted to be in the middle of the room and had a one handled water pitcher on it. There was a bright orange sign posted on the wall, on R1's right side, that directed staff to place bedside table lined up with the paper and moderately thick water to be placed on the table in a double handle cup with a lid. There was also a plastic disposable cup with thickened water placed on R1's nightstand. R1 confirmed he was not able to reach either cup of water without having to call for staff assistance.</p> <p>On 2/6/24 at 5:06 p.m., nursing assistant (NA)-A</p>	F 558	<ol style="list-style-type: none"> 1. Resident 1 is a current resident in our facility. As soon as we were informed of the resident not having the proper two-handled cup, we gave them the proper cup and ensured it was within resident's reach. Staff caring for Res#1 were provided with reminders/re-education on following the care plan for adaptive cup. 2. All residents requiring an Assistive Device, such as a two handled cup, have the potential to be affected by this practice. We reviewed Care plans and observed all residents requiring adaptive cups to ensure they were being used. No other residents were found to be affected. 3. All Nursing and Dietary staff educated on R1's requirement for a two-handled cup as well as any other resident who requires an Assistive Device. 4. Audits will be completed by Food and Nutrition Director or Designee daily x 5, weekly x4, and monthly x2 to ensure care plans for assistive devices are being followed. Data will be reviewed for 2 months at QAPI or until the QAPI committee has determined compliance has been sustained. 5. March 6th, 2024 	

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F 558	<p>Continued From page 2</p> <p>and NA-B enter R1's room to assist R1 and upon exiting R1's room NA-B offered R1 a drink from the plastic disposable cup however, R1 declined. After exiting the room, NA-B was asked about the sign posted to R1's wall, however NA-B was unaware of the sign. NA-B stated she had never seen R1 have a double handled cup and was unaware he required one. NA-B stated usually R1 had a one handled mug and a disposable plastic cup with thickened water in his room. NA-B continued to walk down the hallway and did not return to R1's room with a two handled cup of thickened water and did not move R1's bedside table to be within reach of R1. At 5:56 p.m., R1 continued to be in his room, bed side table remained in the middle of his room with a one handled pitcher on it and out of reach for R1.</p> <p>On 2/7/24 at 2:21 p.m., NA-C stated R1 required moderately thick liquids with a double handled cup and staff were directed to ensure bed side table within front of R1 within reach.</p> <p>On 2/7/24 at 3:40 p.m., licensed practical nurse (LPN)-A stated R1 required thickened liquids in a two handled cup due to limited movement in his arms.</p> <p>On 2/8/24 at 10:06 a.m., registered nurse (RN)-A stated R1 was admitted to the facility following an accident which resulted in a neck fracture and now was unable to move legs and had some movement of arms. R1 required thickened liquids in a two handled cup so he would be able to independently take a drink when desired.</p> <p>On 2/8/24 at 1:15 p.m., director of nursing (DON) stated R1 required total assistance by staff for activities of daily living (ADLs). Further, DON</p>	F 558		

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F 558	Continued From page 3 stated R1 required thickened liquids in a two handled cup as the handles were easier for R1 to grab onto with his limited mobility of arms and hands. Review of facility policy titled Care Plan revise 11/1/23, revealed each resident would have individualized, person-centered, comprehensive plan of care that would include measurable goals directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.	F 558		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an injury of	F 610	1. R1 is a current resident in our facility. Facility completed an investigation into the	3/6/24

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F 610	<p>Continued From page 4</p> <p>unknown was consistently assessed and monitored for healing progress for 1 of 3 residents (R1) reviewed.</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 1/3/24, indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia.</p> <p>R1's care plan revised on 1/4/24, indicated R1 was at risk for pressure ulcer development and R1 always required heel protectors on while in bed.</p> <p>R1's physician progress note dated 1/9/24, revealed R1 was assessed, and no skin concerns were identified.</p> <p>R1's Skin Observation revealed:</p> <p>-On 1/21/24, R1 was noted to have a small brown area on left heel.</p> <p>-On 1/28/24, lacked evidence of R1's heel progress.</p> <p>-On 2/4/24, R1's left outer heel had a small, scabbed area.</p> <p>R1's Wound Data Collection dated 2/6/24, indicated R1 had a distal scabbed area on left heel and was noted to be 2 centimeters (cm) in length and 1 cm wide. Scab was noted to be firmly attached and no redness or drainage was noted. Further, documented indicated scabbed area was left open to air and heel protectors were on.</p> <p>On 2/8/24 at 1:15 p.m., director of nursing (DON)</p>	F 610	<p>injury of unknown origin.</p> <p>2. All residents with injuries of unknown origin have the potential to be affected by this deficient practice. We reviewed incident reports for the last 1 month to ensure any injury of unknown origin was assessed and monitored for healing progress.</p> <p>3. All Licensed Nursing staff were educated by DNS on 2/21/24 on a procedure to ensure we follow up for any injury of unknown origin. CNAs were provided with re-education on immediately reporting to nurse any new injuries.</p> <p>4. Audits will be completed by DNS or Designee Weekly x 4 and then Monthly x2 to ensure all injuries of unknown origin are assessed and monitored for healing progress. Data will be reviewed for 3 months at QAPI or until the QAPI committee has determined compliance has been sustained.</p> <p>5. March 6th, 2024</p>	

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F 610	<p>Continued From page 5</p> <p>stated R1 was at risk for developing pressure ulcers due to diagnosis or paraplegia as well as incontinent of bowel. DON stated she was made aware of the wound on R1's heel on 1/17/24 by R1's family. DON stated she observed and assessed the wound on 1/17/24 and noted there was a small, scabbed area. DON stated she was unsure how R1 obtained the wound on his heel, since R1 was quadriplegic and unable to move his legs and required heel protectors on while in bed. DON stated she only interviewed staff that were on shift on the evening of 1/17/24 when she was made aware of the scab and did not have evidence for those interviews.</p> <p>R1's record lacked evidence of an incident occurring between 1/9/24, when R1 was assessed by a physician, and 1/17/24, when facility management were made aware by family of a wound on R1's ankle. R1's record lacked evidence of new and/or revised interventions following a new wound on his ankle as well as any additional staff monitoring/auditing to ensure staff were utilizing R1's heel protectors appropriately to prevent wounds on R1's ankles.</p> <p>Review of facility policy titled Abuse and Neglect revised on 7/6/23, indicated the investigation team will review all incidents no later than the next working day following the incident, ensure someone was assigned to complete the investigation and that the care plan has been updated with any new interventions. Further, policy indicated the investigation may include interviewing employees, residents or other witnesses to the incident, interview all involved including the resident.</p>	F 610		
F 684 SS=D	Quality of Care	F 684		3/6/24

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F 684	<p>Continued From page 6 CFR(s): 483.25</p> <p>§ 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to ensure an injury of unknown was consistently assessed and monitored for healing progress for 1 of 3 residents (R1) reviewed.</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 1/3/24, indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia.</p> <p>R1's care plan revised on 1/4/24, indicated R1 was at risk for pressure ulcer development and R1 always required heel protectors on while in bed.</p> <p>R1's physician progress note dated 1/9/24, revealed R1 was assessed, and no skin concerns were identified.</p> <p>R1's Skin Observation revealed:</p> <p>-On 1/21/24, R1 was noted to have a small brown area on left heel. -On 1/28/24, lacked evidence of R1's heel</p>	F 684	<ol style="list-style-type: none"> 1. R1 is a current resident in our facility. Facility completed an investigation into the injury of unknown origin. 2. All residents with injuries of unknown origin have the potential to be affected by this deficient practice. We reviewed incident reports for the last 1 month to ensure any injury of unknown origin was assessed and monitored for healing progress. 3. All Licensed Nursing staff were educated by DNS on 2/21/24 on a procedure to ensure we follow up for any injury of unknown origin. CNAs were provided with re-education on immediately reporting to nurse any new injuries. 4. Audits will be completed by DNS or Designee Weekly x 4 and then Monthly x2 to ensure all injuries of unknown origin are assessed and monitored for healing progress. Data will be reviewed for 3 months at QAPI or until the QAPI committee has determined compliance has been sustained. 5. March 6th, 2024 	

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245568	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 02/08/2024
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MARY JANE BROWN		STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LIVERNE, MN 56156		
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F 684	<p>Continued From page 7 progress.</p> <p>-On 2/4/24, R1's left outer heel had a small, scabbed area.</p> <p>R1's Wound Data Collection dated 2/6/24, indicated R1 had a distal scabbed area on left heel and was noted to be 2 centimeters (cm) in length and 1 cm wide. Scab was noted to be firmly attached and no redness or drainage was noted. Further, documented indicated scabbed area was left open to air and heel protectors were on.</p> <p>On 2/7/24 at 8:30 a.m., family member (FM)-A stated on the day of R1's care conference, R1 had a pressure ulcer on his left heel and FM-A had reported it to staff as well as reiterating the importance of staff utilizing R1's heel protectors while he was in bed. FM-A stated staff were not aware of R1's heel and there had been nothing documented at that time in R1's medical record regarding his heel.</p> <p>On 2/7/24 at 2:21 p.m., nursing assistant (NA)-C stated R1 required total assistance with all activities of daily living (ADLs). Further, NA-C stated R1 had one sore on his heel and required heel protectors on while he was in bed.</p> <p>On 2/7/24 at 3:06 p.m., NA-B stated R1 was required to wear heel protectors while in bed however was not aware of any wounds on R1's heels.</p> <p>On 2/7/24 at 3:40 p.m., licensed practical nurse (LPN)-A stated licensed nursing staff were expected to complete a skin assessment at least weekly and when no skin impairments are observed. LPN-A stated if there are new skin</p>	F 684		

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F 684	<p>Continued From page 8</p> <p>impairments noted, registered nurse (RN)-A would be notified as well to assess the resident. Further, LPN-A stated R1 was quadriplegic and required heel protectors. LPN-A stated there was no open sore on R1's heel currently.</p> <p>On 2/8/24 at 9:04 a.m., LPN-B stated R1 had a small circle wound on his heel but had not seen his heel for a while so was unsure what it currently looked like. LPN-B stated the wound was pressure related due to R1 spending prolonged time in bed however R1 always wears heel protectors. At 9:13 a.m. LPN-B entered R1's room, removed R1's heel protector and stated there was an area on his left heel that appeared to be scabbed over and looked like it was healing.</p> <p>On 2/8/24 at 10:06 a.m., RN-A stated a skin observation assessment would be expected to be completed by a licensed nurse weekly on each bath day and if something new was noted. A wound assessment would be completed if a wound was identified which would be completed by the resident's case manager. Further, RN-A stated R1 was admitted to the facility following a fall which resulted in a neck fracture, and R1 was unable to move his legs but had some movement in his arms. RN-A stated she was made aware of R1's wound on his heel in January and stated the wound could be pressure related but looks like a regular scab currently. RN-A stated R1 was at risk for pressure ulcers and staff were to apply heel protector boots onto both of R1's feet. RN-A stated staff were utilizing R1's heel protector boots but was unsure how a wound could have occurred on R1's heels but stated the wound has not changed since RN-A first saw it on 1/17/24. RN-A was unsure what could have caused the wound on R1's heel and stated the wound could</p>	F 684		

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F 684	Continued From page 9 be pressure related or and incident had occurred with staff bumping R1's ankle on something. However, RN-A had not received any incident reports regarding any incidents. Further, LPN-A confirmed once R1's wound on his left heel was identified, the licensed nurse should have been monitoring the wound at least weekly and documenting the assessment in R1's medical record. On 2/8/24 at 1:15 p.m., director of nursing (DON) stated R1 was at risk for developing pressure ulcers due to diagnosis or paraplegia as well as incontinent of bowel. DON stated she was made aware of the wound on R1's heel on 1/17/24 by R1's family. DON stated she observed and assessed the wound on 1/17/24 and noted there was a small, scabbed area. DON stated she did not think R1's wound was pressure related but was unsure if a licensed nurse completed an assessment in R1's medical record regarding the wound. Further, DON stated if a wound was identified, RN-A would be expected to complete a weekly wound assessment until the wound was healed. Review of facility policy titled Skin Assessment Pressure Ulcer Prevention and Documentation revised on 4/26/23, directed staff if a bruise, contusion, skin tear, or abrasion was noted it should be monitored weekly and any changes and/or progress toward healing should be documented on the Skin Observation assessment and on the resident's care plan.	F 684		
F 692 SS=D	Nutrition/Hydration Status Maintenance CFR(s): 483.25(g)(1)-(3) §483.25(g) Assisted nutrition and hydration.	F 692		3/6/24

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F 692	<p>Continued From page 10</p> <p>(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-</p> <p>§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;</p> <p>§483.25(g)(2) Is offered sufficient fluid intake to maintain proper hydration and health;</p> <p>§483.25(g)(3) Is offered a therapeutic diet when 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 provide an altered diet as prescribed for 1 of 2 residents (R3) reviewed for nutrition.</p> <p>Findings include:</p> <p>R3's quarterly Minimal Data Set (MDS) dated 1/17/24, indicated R3 had diagnoses which included dementia, diabetes, and dysphagia. Further, MDS revealed R3 had severely impaired cognition and required a mechanically altered and therapeutic diet.</p> <p>R3's physician orders dated 10/2/23, indicated R3 required a pureed textured diet.</p>	F 692	<ol style="list-style-type: none"> 1. R3 is no longer a current resident in our facility, but while she was residing in our facility she was given the correct diet until she no longer resided in our facility. Audits were completed every mealtime for 3 days to ensure compliance. 2. All residents with an altered diet have the potential to be affected by this deficient practice. We reviewed all residents with altered diets to ensure they received the correct diet. No other residents were identified. 3. All staff were provided with re-education on serving correct diets by the DNS. All kitchen staff were re-educated by Administrator on following process for knowing the resident's diet 	

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F 692	<p>Continued From page 11</p> <p>R3's care plan as of 2/6/24, indicated R3 was able to independently eat at times however required cues from staff as R3 was noted to stop chewing. Staff were expected to assist R3 was eating if needed and give R3 small bites.</p> <p>On 2/6/24 at 5:45 p.m., R3 was served her dinner plate by dietary aid (DA)-A. Nursing assistant (NA)-A was seated on R3's right side, assisting R3 with her meal. NA-A was noted to say R3 would not eat for NA-A. R3 was observed to have mashed potatoes and pasta noodles with red sauce on her plate. NA-A stated she was assisting R3 with her meal but was unsure what kind of diet R3 required. At 5:51 p.m., NA-B confirmed R3 required pureed food and stated, she was unsure why her pasta was like everyone else's and was so "noodly". NA-B removed R3's dinner plate and brings the plate to the kitchen window where director of nursing (DON) was standing and stated R3 needed a new plate as she required pureed food. At 5:54 p.m., NA-A confirmed R3 did not eat any of the pasta, but NA-A attempted to give R3 bites of the pasta. DON brought R3 a different plate with pureed food. R3 was not observed to be coughing or in any distress during the observation.</p> <p>On 2/7/24 at 12:02 p.m. cook (C)-A stated the cook would be expected to dish each resident's meal according to their diet order which was located at the top of each resident's diet card. Prior to giving the plate to the resident, staff would be expected to verify the plate was the correct diet and the plate was going to the correct resident.</p> <p>On 2/7/24 at 1:49 p.m., C-B stated staff were expected to refer to each resident's dietary order</p>	F 692	<p>order. We reminded staff of the current process for double checking a Resident's diet order. A third step was put in place wherein addition a new process for having the Food Service Assistant place the dietary card face down on the table with the resident's food so CNAs can verify correct diet before assisting with meals.</p> <p>4. Observation will be completed by Dietary Manager or Designee Weekly x 4 and then Monthly x2 to ensure Resident's with altered Diets receive the correct Diet. Data will be reviewed for 3 months at QAPI or until the QAPI committee has determined compliance has been sustained.</p> <p>5. March 6th, 2024</p>	

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F 692	<p>Continued From page 12</p> <p>that was listed on their dietary card while dishing up food to the plate. Once the food was on the plate, the plate and card were given to the next staff who would then ensure they have the right person and the correct diet.</p> <p>On 2/7/24 at 1:52 p.m., C-C stated each resident's diet order was on their dietary card that staff were expected to reference while dishing up the resident's plate. C-C stated the plate then was handed to another staff and they are expected to verify the plate matches the diet order and the correct resident prior to serving the resident the plate. Further, C-C stated on the evening of 2/6/24, the two dietary aids began to lay out the dietary cards for the cook and they would get them mixed up. C-C stated she recalled R3's plate returning to the kitchen as it was not the correct diet or the correct resident the plate was given too. C-C stated on that same evening this happened approximately 2-3 times plates were brought back due to the dietary aids "not paying attention" and "not jiving".</p> <p>On 2/7/24 at 2:21 p.m., NA-C stated each resident's diet was listed in their chart in the electronic record system as well as the dietary staff had dietary cards that listed the diet order as well. NA-C stated each staff would be expected to verify the dietary card prior to serving the plate to the resident to ensure they receive the correct diet. Further, NA-C stated R3 required pureed food and was not aware of any incidents of R3 choking or not receiving the correct diet.</p> <p>On 2/7/24 at 3:06 p.m., NA-B stated each resident's diet was listed on their care plan or on their dietary card. However, NA-B stated if staff were assisting a resident at the table and did not</p>	F 692		

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F 692	<p>Continued From page 13</p> <p>assist with serving the plate or if the staff was new, staff would not be aware of the resident's diet order as the staff who delivers the plate to the resident would be expected to verify the plate with the diet order prior to serving the plate and takes the dietary card back to the kitchen. Further, NA-B stated she was unsure what had exactly happened on 2/6/24, but stated the dietary aids did not do their double check to verify it was the correct resident and correct diet prior to serving when R3 was served a regular diet meal instead of pureed. NA-B stated there have not been any incidents of R3 choking that she was aware of.</p> <p>On 2/7/24, DA-A stated each resident had their own dietary card which staff would be expected to verify the plate with the dietary card to ensure they match prior to delivering the plate to the resident. Further, DA-A stated on the evening of 2/6/24, was chaotic and confirmed he did not complete the double check to verify the diet order and the plate matched prior to serving R3 her meal.</p> <p>On 2/7/24 at 3:29 p.m., DON stated the cook was expected to verify resident's diet order when dishing up their plate, then hand the plate and dietary card to another staff member who will look at the dietary card and plate and verify the correct diet and deliver the plate to the resident. DON stated she was aware R3 did not receive pureed diet and has since re-educated all staff on the facility process for verifying diets.</p> <p>Review of facility policy titled Diet Orders- Food and Nutrition revised 5/3/23, revealed a diet card is a communication tool that informs employees of resident diet information and preferences. The</p>	F 692		

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F 692	Continued From page 14 policy lacked staff direction of meal delivery process to ensure resident's receive correct diet per physician orders.	F 692		

Minnesota Department of Health

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2 000	<p>Initial Comments</p> <p style="text-align: center;">*****ATTENTION*****</p> <p style="text-align: center;">NH LICENSING CORRECTION ORDER</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>INITIAL COMMENTS: On 2/6/24 through 2/8/24, a complaint survey was conducted at your facility by surveyors from the Minnesota Department of Health (MDH). Your facility was not in compliance with the MN State Licensure, and the following licensing orders were issued. Please indicate in your electronic plan of correction you have reviewed these orders</p>	2 000		
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Minnesota Department of Health LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Electronically Signed	TITLE	(X6) DATE 03/07/24
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2 000	<p>Continued From page 1</p> <p>and identify the date when they will be completed.</p> <p>The following complaints were reviewed:</p> <p>H55689627C (MN00098601);</p> <p>H55689583C (MN00100483).</p> <p>As a result of the investigation, additional licensing orders were cited at 0965 and 1810.</p> <p>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.</p> <p>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</p>	2 000		

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2 000	<p>Continued From page 2</p> <p>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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of state form.</p> <p>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.</p>	2 000		
2 965	<p>MN Rule 4658.0600 Subp. 2 Dietary Service -Nutritional Status</p> <p>Subpart. 2. Nutritional status. The nursing home must ensure that a resident is offered a diet which supplies the caloric and nutrient needs as determined by the comprehensive resident assessment. Substitutes of similar nutritive value must be offered to residents who refuse food served.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to provide an altered diet as prescribed for 1 of 2 residents (R3) reviewed for nutrition.</p> <p>Findings include:</p>	2 965	Corrected.	3/6/24

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NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - MARY JANE BF	STREET ADDRESS, CITY, STATE, ZIP CODE 110 SOUTH WALNUT AVENUE LIVERNE, MN 56156
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2 965	<p>Continued From page 3</p> <p>R3's quarterly Minimal Data Set (MDS) dated 1/17/24, indicated R3 had diagnoses which included dementia, diabetes, and dysphagia. Further, MDS revealed R3 had severely impaired cognition and required a mechanically altered and therapeutic diet.</p> <p>R3's physician orders dated 10/2/23, indicated R3 required a pureed textured diet.</p> <p>R3's care plan as of 2/6/24, indicated R3 was able to independently eat at times however required cues from staff as R3 was noted to stop chewing. Staff were expected to assist R3 was eating if needed and give R3 small bites.</p> <p>On 2/6/24 at 5:45 p.m., R3 was served her dinner plate by dietary aid (DA)-A. Nursing assistant (NA)-A was seated on R3's right side, assisting R3 with her meal. NA-A was noted to say R3 would not eat for NA-A. R3 was observed to have mashed potatoes and pasta noodles with red sauce on her plate. NA-A stated she was assisting R3 with her meal but was unsure what kind of diet R3 required. At 5:51 p.m., NA-B confirmed R3 required pureed food and stated, she was unsure why her pasta was like everyone else's and was so "noodly". NA-B removed R3's dinner plate and brings the plate to the kitchen window where director of nursing (DON) was standing and stated R3 needed a new plate as she required pureed food. At 5:54 p.m., NA-A confirmed R3 did not eat any of the pasta, but NA-A attempted to give R3 bites of the pasta. DON brought R3 a different plate with pureed food. R3 was not observed to be coughing or in any distress during the observation.</p> <p>On 2/7/24 at 12:02 p.m. cook (C)-A stated the</p>	2 965		
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2 965	<p>Continued From page 4</p> <p>cook would be expected to dish each resident's meal according to their diet order which was located at the top of each resident's diet card. Prior to giving the plate to the resident, staff would be expected to verify the plate was the correct diet and the plate was going to the correct resident.</p> <p>On 2/7/24 at 1:49 p.m., C-B stated staff were expected to refer to each resident's dietary order that was listed on their dietary card while dishing up food to the plate. Once the food was on the plate, the plate and card were given to the next staff who would then ensure they have the right person and the correct diet.</p> <p>On 2/7/24 at 1:52 p.m., C-C stated each resident's diet order was on their dietary card that staff were expected to reference while dishing up the resident's plate. C-C stated the plate then was handed to another staff and they are expected to verify the plate matches the diet order and the correct resident prior to serving the resident the plate. Further, C-C stated on the evening of 2/6/24, the two dietary aids began to lay out the dietary cards for the cook and they would get them mixed up. C-C stated she recalled R3's plate returning to the kitchen as it was not the correct diet or the correct resident the plate was given too. C-C stated on that same evening this happened approximately 2-3 times plates were brought back due to the dietary aids "not paying attention" and "not jiving".</p> <p>On 2/7/24 at 2:21 p.m., NA-C stated each resident's diet was listed in their chart in the electronic record system as well as the dietary staff had dietary cards that listed the diet order as well. NA-C stated each staff would be expected to verify the dietary card prior to serving the plate to</p>	2 965		

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2 965	<p>Continued From page 5</p> <p>the resident to ensure they receive the correct diet. Further, NA-C stated R3 required pureed food and was not aware of any incidents of R3 choking or not receiving the correct diet.</p> <p>On 2/7/24 at 3:06 p.m., NA-B stated each resident's diet was listed on their care plan or on their dietary card. However, NA-B stated if staff were assisting a resident at the table and did not assist with serving the plate or if the staff was new, staff would not be aware of the resident's diet order as the staff who delivers the plate to the resident would be expected to verify the plate with the diet order prior to serving the plate and takes the dietary card back to the kitchen. Further, NA-B stated she was unsure what had exactly happened on 2/6/24, but stated the dietary aids did not do their double check to verify it was the correct resident and correct diet prior to serving when R3 was served a regular diet meal instead of pureed. NA-B stated there have not been any incidents of R3 choking that she was aware of.</p> <p>On 2/7/24, DA-A stated each resident had their own dietary card which staff would be expected to verify the plate with the dietary card to ensure they match prior to delivering the plate to the resident. Further, DA-A stated on the evening of 2/6/24, was chaotic and confirmed he did not complete the double check to verify the diet order and the plate matched prior to serving R3 her meal.</p> <p>On 2/7/24 at 3:29 p.m., DON stated the cook was expected to verify resident's diet order when dishing up their plate, then hand the plate and dietary card to another staff member who will look at the dietary card and plate and verify the correct diet and deliver the plate to the resident. DON</p>	2 965		
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2 965	<p>Continued From page 6</p> <p>stated she was aware R3 did not receive pureed diet and has since re-educated all staff on the facility process for verifying diets.</p> <p>Review of facility policy titled Diet Orders- Food and Nutrition revised 5/3/23, revealed a diet card is a communication tool that informs employees of resident diet information and preferences. The policy lacked staff direction of meal delivery process to ensure resident's receive correct diet per physician orders.</p> <p>SUGGESTED METHOD OF CORRECTION: The administrator, registered dietician, or designee should ensure diet orders are followed. The facility should review and/or update or create policies and procedures, and educate staff on specific requirements or interventions related to nutrition. The administrator, registered dietician, or designee should perform audits for a measurable amount of time as determined by the Quality Assurance Performance Improvement (QAPI) committee to ensure food items given, offered, or consumed by residents are implemented as identified or ordered. The facility should report those findings to QAPI for further recommendations and determine the need for further monitoring or compliance.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	2 965		
21810	<p>MN St. Statute 144.651 Subd. 6 Patients & Residents of HC Fac.Bill of Rights</p> <p>Subd. 6. Appropriate health care. Patients and residents shall have the right to appropriate medical and personal care based on individual needs. Appropriate care for residents means</p>	21810		3/6/24

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21810	<p>Continued From page 7</p> <p>care designed to enable residents to achieve their highest level of physical and mental functioning. This right is limited where the service is not reimbursable by public or private resources.</p> <p>This MN Requirement is not met as evidenced by: Based on observation, interview, and record review, the facility failed to accommodate the needs for 1 of 1 residents (R1) who required a two-handled cup for drinking liquids.</p> <p>Findings include:</p> <p>R1's admission Minimal Data Set (MDS) dated 1/3/24, indicated R1 had diagnoses of quadriplegia, fracture of neck and dysphagia.</p> <p>R1's care plan revised on 1/5/24, directed staff to place table over bed lined up with paper on the wall, in front of R1 but not over his hands. R1 requires moderately thick water to be on the table in a double handled cup with a lid.</p> <p>On 2/6/24 at 4:51 p.m., R1 was observed laying in his bed which was along the wall, bed side table was noted to be in the middle of the room and had a one handled water pitcher on it. There was a bright orange sign posted on the wall, on R1's right side, that directed staff to place bedside table lined up with the paper and moderately thick water to be placed on the table in a double handle cup with a lid. There was also a plastic disposable cup with thickened water placed on R1's nightstand. R1 confirmed he was not able to reach either cup of water without having to call for staff assistance.</p>	21810	Corrected.	
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21810	<p>Continued From page 8</p> <p>On 2/6/24 at 5:06 p.m., nursing assistant (NA)-A and NA-B enter R1's room to assist R1 and upon exiting R1's room NA-B offered R1 a drink from the plastic disposable cup however, R1 declined. After exiting the room, NA-B was asked about the sign posted to R1's wall, however NA-B was unaware of the sign. NA-B stated she had never seen R1 have a double handled cup and was unaware he required one. NA-B stated usually R1 had a one handled mug and a disposable plastic cup with thickened water in his room. NA-B continued to walk down the hallway and did not return to R1's room with a two handled cup of thickened water and did not move R1's bedside table to be within reach of R1. At 5:56 p.m., R1 continued to be in his room, bed side table remained in the middle of his room with a one handled pitcher on it and out of reach for R1.</p> <p>On 2/7/24 at 2:21 p.m., NA-C stated R1 required moderately thick liquids with a double handled cup and staff were directed to ensure bed side table within front of R1 within reach.</p> <p>On 2/7/24 at 3:40 p.m., licensed practical nurse (LPN)-A stated R1 required thickened liquids in a two handled cup due to limited movement in his arms.</p> <p>On 2/8/24 at 10:06 a.m., registered nurse (RN)-A stated R1 was admitted to the facility following an accident which resulted in a neck fracture and now was unable to move legs and had some movement of arms. R1 required thickened liquids in a two handled cup so he would be able to independently take a drink when desired.</p> <p>On 2/8/24 at 1:15 p.m., director of nursing (DON) stated R1 required total assistance by staff for activities of daily living (ADLs). Further, DON</p>	21810		
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21810	<p>Continued From page 9</p> <p>stated R1 required thickened liquids in a two handled cup as the handles were easier for R1 to grab onto with his limited mobility of arms and hands.</p> <p>Review of facility policy titled Care Plan revise 11/1/23, revealed each resident would have individualized, person-centered, comprehensive plan of care that would include measurable goals directed toward achieving and maintaining the resident's optimal medical, nursing, physical, functional, spiritual, emotional, psychosocial, and educational needs.</p> <p>SUGGESTED METHODS OF CORRECTION: The director of nursing (DON) or designee could develop, review, and /or revise policies and procedures to ensure all residents have their water within reach for dependent residents. The DON or designee could educate all appropriate staff. The DON or designee could develop monitoring systems to ensure ongoing compliance and report those results to the quality assurance committee.</p> <p>TIME PERIOD FOR CORRECTION: Twenty-one (21) days.</p>	21810		