Electronically delivered
December 10, 2021

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

RE: CCN: 245593
Cycle Start Date: November 23, 2021

Dear Administrator:

On November 23, 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 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" 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 February 23, 2022 (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 May 23, 2022 (six months after the identification of noncompliance) your provider agreement will be terminated. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

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

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
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
	245593	A. BUILDING _____ B. WING _____	C 11/23/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ST JAMES	1000 SOUTH SECOND STREET ST JAMES, MN 56081

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS On 11/22/21 and 11/23/21, a standard abbreviated survey was conducted at your facility. Your facility was found to be NOT in compliance with the requirements of 42 CFR 483, Subpart B, Requirements for Long Term Care Facilities. The following complaint was found to be SUBSTANTIATED: H5593035C (MN78588), with a deficiency cited at F677. H5593033C (MN78641 and MN78650), H5593034C (MN78586) and H5593037C (MN78694), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Departments acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained.	F 000		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §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	F 677		12/24/21

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

Electronically Signed | 12/17/2021

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 677	Continued From page 1 by: Based on observation, interview and document reviewed, the facility failed to provide activities of daily living (ADL), specifically personal hygiene of regular bathing for 1 of 3 residents (R4) who were dependent upon staff for personal cares. Findings include: R4's Face Sheet printed 11/23/21, indicated he was admitted to the facility on 8/19/21. R4's primary admitting diagnoses dated 8/19/21, include cognitive communication disorder (difficulty in verbally communicating), Myasthenia Gravis (neurological disease-causing weakness of limbs and problems with speaking), collapsed lumbar vertebra, and urinary incontinence. R4's Care Plan last revision dated 9/28/21, directed that R4 had frequent incontinence of bowel related to impaired mobility and required assistance with transfers and toileting; had a communication problem related to Myasthenia Gravis and a hearing deficit; has an alteration in neurological status related to Myasthenia Gravis evidenced by severe muscle weakness; had alteration in activity involvement related to unclear speech evidenced by staff having difficulty understanding R4's requests; has shortness of breath related to Myasthenia Gravis evidenced by decreased energy, fatigue, and musculoskeletal impairment; and had an ADL self-care performance deficit related to Myasthenia Gravis and requires limited assist of one staff with bathing/showering. R4's Medicare 5-Day Minimum Data Set (MDS) dated 8/26/21, documented R4 scored 13 of 15	F 677	F677 ADL Care Provided for Dependent Residents Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. Resident R4's care plan was reviewed and his preferences for bathing reflected two times per week. Resident R4 was given a bath on 11/21/2021. All residents were reviewed to ensure bathing and documentation is in place. Education was provided to all CNAs working at Good Samaritan Society – St. James by the DNS on 12/15/2021. CNA's were re-educated on how to chart bathing tasks in POC, which is part of PCC. Education also included that all charting is to be completed prior to leaving the shift for the day. The bath schedule was reviewed and updated to level the work	

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F 677	Continued From page 2 on the brief interview of mental status assessment indicating R4 as cognitively intact and required extensive assistance with toileting and personal hygiene. The facility Section #1 Bath Schedule copied 11/23/21, had R4 scheduled for a whirlpool bath during the Sunday evening shift and Wednesday during the day shift. Directions at the bottom of the schedule directed, "do not change without talking to the case manager." The facility Documentation Survey Report for October and November 2021, printed on 11/23/21, documented R4 was to receive fifteen whirlpool baths during 10/01/21 - 11/23/21 but received four: 10/03/21 - no bath 10/06/21 - no bath 10/10/21 - no bath 10/13/21 - no bath 10/17/21 - no bath 10/20/21 - whirlpool bath 10/24/21 - no bath 10/27/21 - no bath 10/31/21 - no bath 11/03/21 - whirlpool bath 11/07/21 - no bath 11/10/21 - no bath 11/12/21 - whirlpool bath (directed by director of nursing (DON)) 11/14/21 - no bath 11/21/21 - whirlpool bath On 10/11/12, nurse practitioner (NP)-A documented in the medical appointment summary reporting the family sent a message to her that R4 smelled of urine and was concerned the facility was not providing peri-care.	F 677	load between each shift and hallway according to resident's preferences. The C NA schedule has been adjusted to increase C NA hours during peak times to ensure bathing is completed according to the resident's care planned preferences for bathing times. Audits will be conducted to ensure bathing is done per the care planned approaches. These audits will be done for R4 and 3 other random residents weekly X 4 then monthly X 2. Results will be taken to the monthly Quality committee for further recommendations.	

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F 677	Continued From page 3	F 677		

Additionally, the family indicated they washed R4's wheelchair seat cushion three times due to the cushion smelling of urine. NA-A documented that she made the facility aware of the concerns.

During an interview on 11/23/21, at 10:18 a.m. R4 was unable to speak in sentences and he could only indicate yes/no to questions. R4 stated no that he was not getting regular baths; stated yes that he liked whirlpool baths; stated yes, he wants to have the two whirlpool baths per week as was set-up during his admission; stated yes, it makes him feel sad and not clean when he does not get a bath for extended amounts of time; and stated yes that he has asked staff to give him a whirlpool bath, but they did not follow up on his request.

During an interview on 11/23/21, 10:47 a.m. power of attorney (POA) stated R4 had informed her that he was not getting his whirlpool baths. POA reported this to DON on 11/12/21, and DON went to staff and directed them to immediately bath R4.

During an interview on 11/23/21, at 9:35 a.m. nursing assistant (NA)-A stated NA's should be doing the baths, but not all NA's are completing them. Instead, staff are doing bed baths or hand washing the resident. NA-A stated there just isn't enough time with the number of NA staff on duty.

During an interview on 11/23/21, at 12:08 p.m. registered nurse (RN)-A stated nursing assistants are to follow the bath schedule and complete baths. RN-A further stated, the facility is short staff and using a lot of agency staff, that do not seem to follow through with their bathing assignments.

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F 677	Continued From page 4 During an interview on 11/23/21, at 12:16 p.m. DON stated R4's baths are not getting done and is disappointed with staff for not completing them. DON stated after a family meeting on 11/12/21, she went to staff and directed to complete R4's whirlpool bath immediately. DON stated the facility has had staffing challenges but that is no excuse for not providing resident baths. During an interview on 11/23/21, at 12:55 p.m. NA-B stated some NA staff, especially agency NA staff, are not completing the baths and/or not documenting that they completed the bath. NA-B stated, the facility is short staffed, but especially NA's. During an interview on 11/23/21, at 12:59 p.m. RN-B stated the last few months have been tough with having enough staff on duty. RN-B further stated, there have been mistakes and considerable tension between staff. The facility Care Plan, last reviewed/revised 9/17/21, directed that residents will receive and be provided the necessary care that meet emotional and physical professional standards of care.	F 677		

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
December 10, 2021

Administrator
Good Samaritan Society - St James
1000 South Second Street
St James, MN 56081

Re: State Nursing Home Licensing Orders
Event ID: W4D211

Dear Administrator:

The above facility was surveyed on November 22, 2021 through November 23, 2021 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule and/or statute of the Minnesota Department of Health.

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

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

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

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

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

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

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

Please feel free to call me with any questions.

Melissa Poepping, Health Program Representative Senior
Program Assurance | Licensing and Certification
Minnesota Department of Health
P.O. Box 64900
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
	00697	A. BUILDING: _____ B. WING _____	C 11/23/2021

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On 11/22/21 and 11/23/21, a complaint survey was conducted at your facility by a surveyor from the Minnesota Department of Health (MDH). Your facility was found NOT in compliance with the MN State Licensure. Please indicate in your electronic plan of correction you have reviewed these orders and identify the date when they will be completed.	2 000		

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2 000	Continued From page 1 The following complaint was found to be SUBSTANTIATED: H5593035C (MN78588), with a licensing order issued at S840. H5593033C (MN78641 and MN78650), H5593034C (MN78586) and H5593037C (MN78694), however, NO deficiencies were cited due to actions implemented by the facility prior to survey. Minnesota Department of Health is documenting the State Licensing Correction Orders using Federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far-left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by," Following the surveyor's findings are the Suggested Method of Correction and Time Period for Correction. You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib14_1.html The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word	2 000		

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2 000	Continued From page 2 "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. PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.	2 000		
2 840	MN Rule 4658.0520 Subp. 2 B Adequate and Proper Nursing Care; Clean skin Subp. 2. Criteria for determining adequate and proper care. The criteria for determining adequate and proper care include: B. Clean skin and freedom from offensive odors. A bathing plan must be part of each resident's plan of care. A resident whose condition requires that the resident remain in bed must be given a complete bath at least every other day and more often as indicated. An incontinent resident must be checked at least every two hours, and must receive perineal care following each episode of incontinence. [144A.04 Subd. 11. Incontinent residents. Notwithstanding Minnesota Rules, part 4658.0520, an incontinent resident must be checked according to a specific time interval written in the resident's care plan. The resident's attending physician must authorize in writing any interval longer than two hours unless the resident,	2 840		12/24/21

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 840	Continued From page 3 if competent, or a family member or legally appointed conservator, guardian, or health care agent of a resident who is not competent, agrees in writing to waive physician involvement in determining this interval, and this waiver is documented in the resident's care plan.] Clean linens or clothing must be provided promptly each time the bed or clothing is soiled. Perineal care includes the washing and drying of the perineal area. Pads or diapers must be used to keep the bed dry and for the resident's comfort. Special attention must be given to the skin to prevent irritation. Rubber, plastic, or other types of protectors must be kept clean, be completely covered, and not come in direct contact with the resident. Soiled linen and clothing must be removed immediately from resident areas to prevent odors. This MN Requirement is not met as evidenced by: Based on observation, interview and document reviewed, the facility failed to provide activities of daily living (ADL), specifically personal hygiene of regular bathing for 1 of 3 residents (R4) who were dependent upon staff for personal cares. Findings include: R4's Face Sheet printed 11/23/21, indicated he was admitted to the facility on 8/19/21. R4's primary admitting diagnoses dated 8/19/21, include cognitive communication disorder (difficulty in verbally communicating), Myasthenia Gravis (neurological disease-causing weakness of limbs and problems with speaking), collapsed	2 840	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: _____ B. WING _____	C 11/23/2021

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2 840	Continued From page 4 lumbar vertebra, and urinary incontinence. R4's Care Plan last revision dated 9/28/21, directed that R4 had frequent incontinence of bowel related to impaired mobility and required assistance with transfers and toileting; had a communication problem related to Myasthenia Gravis and a hearing deficit; has an alteration in neurological status related to Myasthenia Gravis evidenced by severe muscle weakness; had alteration in activity involvement related to unclear speech evidenced by staff having difficulty understanding R4's requests; has shortness of breath related to Myasthenia Gravis evidenced by decreased energy, fatigue, and musculoskeletal impairment; and had an ADL self-care performance deficit related to Myasthenia Gravis and requires limited assist of one staff with bathing/showering. R4's Medicare 5-Day Minimum Data Set (MDS) dated 8/26/21, documented R4 scored 13 of 15 on the brief interview of mental status assessment indicating R4 as cognitively intact and required extensive assistance with toileting and personal hygiene. The facility Section #1 Bath Schedule copied 11/23/21, had R4 scheduled for a whirlpool bath during the Sunday evening shift and Wednesday during the day shift. Directions at the bottom of the schedule directed, "do not change without talking to the case manager." The facility Documentation Survey Report for October and November 2021, printed on 11/23/21, documented R4 was to receive fifteen whirlpool baths during 10/01/21 - 11/23/21 but received four: 10/03/21 - no bath	2 840		

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2 840	Continued From page 5 10/06/21 - no bath 10/10/21 - no bath 10/13/21 - no bath 10/17/21 - no bath 10/20/21 - whirlpool bath 10/24/21 - no bath 10/27/21 - no bath 10/31/21 - no bath 11/03/21 - whirlpool bath 11/07/21 - no bath 11/10/21 - no bath 11/12/21 - whirlpool bath (directed by director of nursing (DON)) 11/14/21 - no bath 11/21/21 - whirlpool bath On 10/11/12, nurse practitioner (NP)-A documented in the medical appointment summary reporting the family sent a message to her that R4 smelled of urine and was concerned the facility was not providing peri-care. Additionally, the family indicated they washed R4's wheelchair seat cushion three times due to the cushion smelling of urine. NA-A documented that she made the facility aware of the concerns. During an interview on 11/23/21, at 10:18 a.m. R4 was unable to speak in sentences and he could only indicate yes/no to questions. R4 stated no that he was not getting regular baths; stated yes that he liked whirlpool baths; stated yes, he wants to have the two whirlpool baths per week as was set-up during his admission; stated yes, it makes him feel sad and not clean when he does not get a bath for extended amounts of time; and stated yes that he has asked staff to give him a whirlpool bath, but they did not follow up on his request. During an interview on 11/23/21, 10:47 a.m. power of attorney (POA) stated R4 had informed	2 840		

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2 840	Continued From page 6	2 840		

her that he was not getting his whirlpool baths. POA reported this to DON on 11/12/21, and DON went to staff and directed them to immediately bath R4.

During an interview on 11/23/21, at 9:35 a.m. nursing assistant (NA)-A stated NA's should be doing the baths, but not all NA's are completing them. Instead, staff are doing bed baths or hand washing the resident. NA-A stated there just isn't enough time with the number of NA staff on duty.

During an interview on 11/23/21, at 12:08 p.m. registered nurse (RN)-A stated nursing assistants are to follow the bath schedule and complete baths. RN-A further stated, the facility is short staff and using a lot of agency staff, that do not seem to follow through with their bathing assignments.

During an interview on 11/23/21, at 12:16 p.m. DON stated R4's baths are not getting done and is disappointed with staff for not completing them. DON stated after a family meeting on 11/12/21, she went to staff and directed to complete R4's whirlpool bath immediately. DON stated the facility has had staffing challenges but that is no excuse for not providing resident baths.

During an interview on 11/23/21, at 12:55 p.m. NA-B stated some NA staff, especially agency NA staff, are not completing the baths and/or not documenting that they completed the bath. NA-B stated, the facility is short staffed, but especially NA's.

During an interview on 11/23/21, at 12:59 p.m. RN-B stated the last few months have been tough with having enough staff on duty. RN-B further stated, there have been mistakes and

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2 840	Continued From page 7 considerable tension between staff. The facility Care Plan, last reviewed/revised 9/17/21, directed that residents will receive and be provided the necessary care that meet emotional and physical professional standards of care. SUGGESTED METHOD OF CORRECTION: The director of nursing and/or designee could educate responsible staff to provide care to residents' dependant on facility staff, based on residents' care planned needs and request. The DON or designee could conduct audits of dependent resident cares to ensure their personal hygiene needs are met consistently. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 840		