DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
January 6, 2020

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: CCN: 245234
Cycle Start Date: September 13, 2019

Dear Administrator:

On October 3, 2019, we notified you a remedy was imposed. On October 23, 2019 the Minnesota Department(s) of Health completed a revisit to verify that your facility had achieved and maintained compliance. We have determined that your facility has achieved substantial compliance as of October 9, 2019.

As authorized by CMS the remedy of:

- Discretionary denial of payment for new Medicare and Medicaid admissions effective December 2, 2019 did not go into effect. (42 CFR 488.417 (b))

In our letter of October 3, 2019, in accordance with Federal law, as specified in the Act at § 1819(f)(2)(B)(iii)(I)(b) and § 1919(f)(2)(B)(iii)(I)(b), we notified you that your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 2, 2019 due to denial of payment for new admissions. Since your facility attained substantial compliance on October 9, 2019, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded. However, this does not apply to or affect any previously imposed NATCEP loss.

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

January 6, 2020

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: Enclosed Reinspection Results - Event ID RO2G12

Dear Administrator:

On October 23, 2019 survey staff of the Minnesota Department of Health completed a reinspection of your facility. At this time these correction orders were found corrected and are listed on the attached Revisit Report Form.

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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

Enclosure(s)

cc: Licensing and Certification File

Electronically delivered
October 3, 2019

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

RE: 245234
Cycle Start Date: September 13, 2019

Dear Administrator:

On September 13, 2019, survey was completed at your facility by the Minnesota Department(s) of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G), as evidenced by the electronically delivered CMS-2567, whereby significant corrections are required.

REMEDIES

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

- Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective December 2, 2019.

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective December 2, 2019. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective December 2, 2019.

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

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

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

NURSE AIDE TRAINING PROHIBITION

Please note that Federal law, as specified in the Act at §§ 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs and nurse aide competency evaluation programs offered by, or in, a facility which, within the previous two years, has operated under a § 1819(b)(4)(C)(ii)(II) or § 1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse); has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care; has been assessed a total civil money penalty of not less than $10,483; has been subject to a denial of payment, the appointment of a temporary manager or termination; or, in the case of an emergency, has been closed and/or had its residents transferred to other facilities.

If you have not achieved substantial compliance by December 2, 2019, the remedy of denial of payment for new admissions will go into effect and this provision will apply to your facility. Therefore, Good Samaritan Society - Waconia And Westview Acre will be prohibited from offering or conducting a Nurse Aide Training and/or Competency Evaluation Program (NATCEP) for two years from December 2, 2019. You will receive further information regarding this from the State agency. This prohibition is not subject to appeal. Further, this prohibition remains in effect for the specified period even though selected remedies may be rescinded at a later date if your facility attains substantial compliance. However, under Public Law 105-15, you may contact the State agency and request a waiver of this prohibition if certain criteria are met.

ELECTRONIC PLAN OF CORRECTION (ePOC)

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

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

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

- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Metro C Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by March 13, 2020 (six months after the

identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at § 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR § 488.412 and § 488.456.

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

APPEAL RIGHTS

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

Tamika.Brown@cms.hhs.gov

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

Department of Health & Human Services
Departmental Appeals Board, MS 6132
Director, Civil Remedies Division
330 Independence Avenue, S.W.
Cohen Building – Room G-644
Washington, D.C. 20201
(202) 565-9462

A request for a hearing should identify the specific issues, findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. At an appeal hearing, you may be represented by counsel at your own expense. If you have any questions regarding this matter, please contact Tamika Brown, Principal Program Representative by phone at (312) 353-1502 or by e-mail at Tamika.Brown@cms.hhs.gov.

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

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

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

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

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

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

Feel free to contact me if you have questions.

Sincerely,

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 9/11/19 through 9/13/19, an unannounced abbreviated survey was completed at your facility to conduct a complaint investigation. Good Samritan Society - Waconia And Westview Acre was not in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was substantiated: H#5234018C under G690. 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 validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 690 SS=G	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must	F 690		10/9/19

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

Electronically Signed | 10/09/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 1 ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interviews and document review, the facility failed to complete a comprehensive bladder assessment for 1 of 2 residents (R1) admitted with an indwelling Foley catheter and failed to ensure medical necessity for the continued use of an indwelling Foley catheter. This practice resulted in actual harm to R1 who displayed complications of bleeding from head of penis, leakage and penile swelling resulting in a partial circumcision. Further R1 had multiple visits to the emergency department and multiple diagnoses of urinary tract infections (UTI)s and was placed on antibiotics with each visit to the emergency department.	F 690	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 insubstantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 2 Findings include: R1's 14 day Minimum Data Set assessment dated 9/13/19, indicated he was severely cognitively impaired and required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS indicated R1 had an indwelling Foley catheter and was occasionally incontinent of bowel. R1's care plan dated 7/30/19, identified the use of an indwelling Foley catheter and directed staff to monitor /record/report to health care provider signs and symptoms of UTI, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine in color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills and altered mental status. The care plan further directed catheter care every shift, good perineal cares- especially penis and foreskin cares every shift and as needed, and to report unusual observations/conditions to the nurse. Recent catheter trauma, foreskin care. Review of R1's hospital Interagency Transfer Form - Notes dated 7/13/19, identified sepsis due to bacteremia. The notes indicated urinary retention potentially contributing to delirium. Review of facility Progress Notes, hospital notes and clinic visit notes indicated the following: 7/16/19, R1 was hospitalized due to confusion and delirium had an indwelling Foley catheter in place. No skin issues except a skin tear on his back. 7/26/19, A lump was discovered on the underside	F 690	compliance in accordance with section 7305 of the State Operations Manual. F690 Resident R1 no longer resides in this facility. All current residents with an indwelling Foley catheter records were reviewed to verify that the facility had completed a comprehensive bladder assessment and that there was documented medical necessity for continued use of the indwelling Foley catheter. This was completed on October 7, 2019 by DNS. The admission, annual and significant change workflow process was reviewed and modified by the DNS to highlight process for increased directions to evaluating and care planning nurses to verify that a resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. This was completed by the DNS on 10-08-2019. Education of all nurse managers and admissions nurses regarding this modified process and re-education on regulations and current facility policy regarding Foley catheters was completed by DNS on 10-09-2019. DNS or designee will conduct audits of all current residents and new admissions of residents who enter the facility with an indwelling catheter or subsequently receives an indwelling catheter be assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary. This will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 3 of R1's penis. Staff continue to monitor. 7/30/19, Lump on penis is small and small amount of firmness to lump. 7/30/10, R1's daughter stated his water pill made his condition decline because he wouldn't eat or drink due to concern of going to the bathroom and the catheter had lessened this worry for him and helped him to sleep at night. 8/1/19, R1 found during the night pulling on his catheter. Catheter draining with some blood noted in urine. 8/2/19, R1's Foley catheter to be replaced in hopes of improving flow of fluids. 8/2/19, Catheter changed due to blood in urine. 8/3/19, R1 complained of pain in his penis, possibly due to pulling his catheter out on night shift. On 8/5/19, a clinic visit note indicated R1 indicated R1 was seen in the clinic by his physician for a follow up visit. The note indicated "Has had a catheter placed at the request of family as well noting he has always been very upset about his inability to maintain continence and this was problem for him getting up repeatedly in the middle of the night. Family does understand the potential risk of complications including infection of this going forward." The note further indicated there had been discussion about the indwelling catheter which had resolved his anxiousness and increased urgency to urinate allowing him to participate more effectively in therapy, and there had been discussion	F 690	be completed weekly x 4 and then monthly x 3. Results of the audits will be monitored at the QAPI meetings monthly and follow-up provided as deemed appropriate.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 4	F 690		

associated with the increased risk of infection. The notes indicated the patient had verified awareness of these issues as well. The clinic note from the medical provider included, "I discussed the possibility of transitioning to a condom catheter after a few weeks and using tamsulosin (a medication used to treat the symptoms of benign prostatic hyperplasia (BPH), enlarged prostate) prior to its discontinuation."

8/6/19, R1 currently with Foley catheter which family agreed to use due to previous incontinence and repeated attempts to get up to void. Physican stated R1 verbalized previous bladder infections and his concerns about it.

8/8/19, Facsimile was sent to clinic regarding R1's penile area. Staff documented an abnormal condition on underside of penis, where a lump was noted.

8/9/19, Lump on the underside of R1's penis increasing in size and now growing up the sides of the penis.

8/9/19, Writer looked at R1's penis and the foreskin was swollen and pulled away from the tip. Old catheter was removed and foreskin retracted "somewhat" and new catheter placed. Slight pain during treatment.

8/9/19, Note indicated, remove catheter, compress glands at tip of penis. May take time but foreskin should then retract. May send to emergency room (ER) if no improvement.

8/10/19, ER called with update, stated importance of fully retracting foreskin and cleansing area then be sure to pull back over. Also stated some skin

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 5	F 690		

tearing. Noted R1 was sent to ER after physican order, attempted to loosen foreskin first. This was accomplished previous evening, then worsened in the morning so was sent to ER.

8/10/19, R1 Pariphimosis (condition in which foreskin has retracted and cannot be returned to original condition) persisting. Foreskin pulled over per physican order last night, returned today.

8/10/19, R1 returned from ER, wife stated the swollen foreskin was due to not being pulled back after cleaning. Writer spoke to wife about R1 pulling on his catheter but wife stated that was not what caused it.

Emergency Department (ED) note: On 8/10/19, R1 had diagnosis for Pariphimosis. R1 presented for evaluation of penile swelling. R1 had a Foley catheter in place that was changed yesterday. Since then foreskin has been retracted and swelling. R1 came to the ED for penile swelling and discomfort. Foreskin was reduced back over the glans, however had difficulty maintaining a reduced position due to swelling. Ice pack placed with scrotal elevation. Physician spent quite a bit of time applying pressure to reduce edema and was getting some success. But the physician was noticing the glans penis would still protrude and the problem did not completely go away. There was no urinary difficult at baseline. Discharge instructions were return if worse or new symptoms - especially increased swelling or pain of the penis or foreskin. It is extremely important to fully reduce the foreskin when it is retracted for hygiene cares. It is ok to put some topical Bacitracin ointment on abraded areas of the foreskin as it heals. Foreskin was reduced back over the glans, however had difficulty

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 6 maintain a reduced position due to swelling. Ice pack placed with scrotal elevation. ED note 8/11/19. R1 was seen in the ED for Pariphimosis and UTI. R1 was just seen 24 hours ago with Pariphimosis. R1 came back for recurrent Pariphimosis. A daughter noted that she had been checking on R1 throughout the evening and at 8 PM she noted that the foreskin was again retracted and stuck around the base of the glans. R1 denied pain, however over the last several hours the daughter noted some purulent discharge the indwelling Foley catheter at the meatus as well as inside the tube of the catheter bag. The physican attempted manual reduction of the Pariphimosis without success. A urology consulted and he would perform a dorsal slit. The urologist came in to see the resident and performed a dorsal slit. The urologist noted that the urethral discharge was normal especially with recent manipulation due to Pariphimosis reduction about 24 hours ago. The urologist recommended that R1 be prophylaxis with Keflex to prevent skin infection related to dorsal slit, keep wound clean and dry. Apply Bacitracin to wound 2 times a day and change dressing as needed. The urine analysis with greater than 200 white blood cells, 8-30 red blood cells, packed bacteria, and positive nitrates. Concerning for UTI, but may also be due to colonization with chronic indwelling Foley. A urine culture was pending. Placed on Ceftin tablets 250 mg (milligrams) one tab by mouth twice a day for 7 days. 8/12/19, Circumcision site care completed per orders with intact sutures. Catheter intact and draining within normal limits.	F 690		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 7	F 690		

8/13/19, Family concerned R1 was going to pull out his catheter and wanted it removed. Family planing to speak to nurse practitioner (NP).

On 8/14/19, a clinic visit noted indicated R1 was seen in the clinic by his NP for follow up on circumcision as well as to address other family concerns. Last week resident developed Pariphimosis after multiple attempts to put foreskin back he ended up requiring dorsal slit.

8/14/19, R1's incision cleaned and Bacitracin applied per order, mild swelling noted. Received new order for Ceftin and start Macrobid.

On 8/19/19, clinic visit note indicated R1 had a follow up appointment with his physician in the clinic. R1 had a UTI and subsequently a staph infection in the urine and was switched to a different antibiotic.

8/19/19, Family reported concern about distended appearance of resident bladder. When leg bag was switched over to the night bag, urine started flowing consistently and writer scanned resident's bladder and found at most 49 milliliters (ml) of urine residual.

8/23/19, Writer washed R1's peri-area with warm soapy water and assessed. Writer applied Bacitracin where sutures were. Writer noted scant amount of green discharge on residnet penis and brief. Writer noted some leaking of urine around Foley, checked all tubing and tightened. Passed on to the evening nurse to monitor for urine leaking around catheter, if so it may need to be replaced with a new one.

8/23/19, Family called wanting to check and see if

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 8	F 690		

catheter started flowing normally again, or what other interventions were required. Family continued to talk about how she was concerned staff needed to change it every two weeks instead of once a week. Writer encouraged family to keep it at once a month and try other options like flushing the catheter line to prevent sediment build up as a way to reduce chance of urinary tract infections.

8/23/19, R1 had episodes of agitation this evening on and off. Family was here most of the shift. At the beginning of the shift, family alerted writer to fact that catheter was leaking. On inspection urine was coming out of the tip of his penis around his catheter. R1 was also complaining of pain at the tip of his penis. Staff changed catheter and R1 tolerated catheter change ok but blood was coming out of the tip of his penis. R1 was very sensitive when tip was touched. Fluids were pushed this evening. Some small clots were seen in catheter tubing and urine was brown tinged. Once R1 started to increase fluids urine began to clear. Stitches were cleaned this evening. Some small clots were seen in cath tubing and urine was brown tinged. Once resident started to increase fluids, urine began to clear. Catheter appeared to be flowing without complications. Stitches were cleaned this evening and Bacitracin applied.

8/24/19, R1 was restless in the beginning of the night shift, and after several attempts to have him fall asleep, Nursing assistants (NA) moved him to recliner. R1 got slightly combative and swung at NA. Writer caught resident pulling at catheter through the shift and writer would tell him to stop and get his hands away from catheter. Around 5:00 a.m. NA came to tell writer that resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 9	F 690		

brief had blood on it. Writer assessed R1's brief, catheter and penis. The on call physican said to put nystatin on penis and to attempt to keep resident from pulling at catheter, and to monitor for clots in catheter.

8/24/19, R1's family member was very concerned about blood in urine. Family took resident to ER. Received call from ER that they will be admitting resident with Hyponatremia and ascites.

8/30/19, R1 was brought back from ER to facility by family via tunnel and escorted to his room via wheelchair. R1 was confused and was having hallucinations when writer was in room. R1 would take off his blanket and try to reach to ceiling to grab something. R1 had indwelling Foley catheter for comfort, per family. Resident urine is clear yellow and catheter was patent. R1 was being treated with Cipro for possible UTI.

8/31/19, R1 had been tugging at his catheter and grabbing towards ceiling.

8/31/19, R1 confused and agitated, pulling at catheter, wringing hands. Resident was hallucinating, stated that the walls were on fire.

9/3/19, R1 required one on one supervision this shift. R1 was agitated and restless and continuously tried to get out of his geri (geriatric) chair.

9/4/19, Foley urine output was 1200 cc's (cubic centimeters). No expression of discomfort/pain observed. Penal swelling present, treatment done.

9/7/19, R1's incontinent pad was wet, catheter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 10	F 690		

presumably bypassing, had 400 ml out at around 1:30 p.m. and was emptied prior at around 7:00 a.m.

9/8/19, R1's catheter was bypassing urine into pad, R1 continually pulled catheter.

9/9/19, R1 alert, confused during this shift, hallucinating (has been quite normal for his baseline) however, family was worried and wanted a urinalysis (UA) and urine culture (UC) done, order was given. The family transferred resident to the toilet and called this writer to inspect a new protrusion on his sacrum they had not seen before, it was about the size of a fist, no redness, warmth, or pain noted. This writer informed family she would update NP regarding this new lump. After family got him up from the toilet, they told writer they were going to ER to have it looked at. Resident's family took him to ER via tunnel at approximately 6:00 p.m. and R1 arrived back at facility around 8:00 p.m. with new orders for Cipro.

9/11/19, R1's Foley catheter was discontinued by the nurse practitioner and was successfully removed, 300 cc of clear, yellow urine was noted. R1 received penile care this shift as ordered, wound looks healed.

9/12/19, R1 voided well, had wet brief at 0000, 0200, and 0400 rounds. Post void residual (PVR): 0 ml.

Multiple observations were made on 9/11/19, through 9/13/19 of R1 in the facility being attended by the family 24/7. R1 was able to feed himself during morning observations 9/12/19, without family present in the dining room. R1 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	333 FIFTH STREET WEST WACONIA, MN 55387

(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 690	Continued From page 11	F 690		

not able to coherently answer simple questions while eating. R1 had a Foley catheter that was draining amber urine. During morning observations on 9/12/19, a family member and NA had just finished showering R1. R1 was noted not to be in pain or restless.

Registered Nurse (RN)- A was interviewed on 9/13/19, at 11:50 a.m and confirmed R1 was admitted from hospital on 7/16/19, with a blood infection, to second floor where she was the nurse manager. The nurse manager verified that the staff had not attempted to have the catheter assessed for medical necessity or potential removal.

The NP was interviewed on 9/13/19 at 11:30 a.m., and confirmed that the multiple ER visits, partial circumcision, and UTIs may not have happened if the resident's Foley catheter had been appropriately assessed and removed. The NP further stated R1's family insisted on R1 having the catheter. In addition, the NP stated one of the resident's daughters had requested the Foley catheter remain in place when R1 went on hospice. The NP confirmed R1 lacked a medical diagnosis for the continued use of the Foley catheter and acknowledged having written an order to have the Foley catheter removed on 9/11/19.

The facility's Policy and Procedure for catheters, revised 1/18, included: "A resident is not be be catheterized unless the clinical condition demonstrates that catheterization is necessary and is not to be used solely for nurse/physician convenience. Catheters will be inserted only with a physician's order. Guidelines for Attempted Catheter Removal. The SOM (State Operations

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245234	A. BUILDING _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND WESTVIEW ACRE	**333 FIFTH STREET WEST WACONIA, MN 55387**

(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 690	Continued From page 12 Manual) F-Tag indicates that indwelling catheters must be medically necessary for the resident. The medical record must have documentation of attempts to remove indwelling catheters and the results of the attempts. It is recommended that removal be attempted at least two or three times during his/her stay before it can be determined that it is unsuccessful. "	F 690		

Electronically delivered
October 3, 2019

Administrator
Good Samaritan Society - Waconia And Westview Acre
333 Fifth Street West
Waconia, MN 55387

Re: State Nursing Home Licensing Orders
CCN: 245234
Cycle Start Date: September 13, 2019

Dear Administrator:

The above facility was surveyed on September 11, 2019 through September 13, 2019 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:

Susanne Reuss, Unit Supervisor
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susanne.reuss@state.mn.us
Phone: (651) 201-3793
Fax: (651) 215-9697

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.

Alison Helm

Alison Helm, Enforcement Specialist
Licensing and Certification
Minnesota Department of Health
P.O. Box 64970
Saint Paul, Minnesota 55164-0970
Phone: 651-201-4206
Email: alison.helm@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	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 9/11/19 through 9/13/19, an unannounced abbreviated survey was completed to investigate complaint #H5234018C. As a result the following correction orders are issued. Because you are enrolled in ePOC, your signature is not required at the bottom of the first	2 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
2 000	Continued From page 1 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 validate that substantial compliance with the regulations has been attained in accordance with your verification.	2 000		
2 910	MN Rule 4658.0525 Subp. 5 A.B Rehab - Incontinence Subp. 5. Incontinence. A nursing home must have a continuous program of bowel and bladder management to reduce incontinence and the unnecessary use of catheters. Based on the comprehensive resident assessment, a nursing home must ensure that: A. a resident who enters a nursing home without an indwelling catheter is not catheterized unless the resident's clinical condition indicates that catheterization was necessary; and B. a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This MN Requirement is not met as evidenced by: Based on observation, interviews and document review, the facility failed to complete a comprehensive bladder assessment for 1 of 2 residents (R1) admitted with an indwelling Foley catheter and failed to ensure medical necessity for the continued use of an indwelling Foley	2 910	corrected	10/9/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 2	2 910		

catheter. This practice resulted in actual harm to R1 who displayed complications of bleeding from head of penis, leakage and penile swelling resulting in a partial circumcision. Further R1 had multiple visits to the emergency department and multiple diagnoses of urinary tract infections (UTI)s and was placed on antibiotics with each visit to the emergency department.

Findings include:

R1's 14 day Minimum Data Set assessment dated 9/13/19, indicated he was severely cognitively impaired and required extensive assistance from two staff for bed mobility, transfers and toileting. The MDS indicated R1 had an indwelling Foley catheter and was occasionally incontinent of bowel.

R1's care plan dated 7/30/19, identified the use of an indwelling Foley catheter and directed staff to monitor /record/report to health care provider signs and symptoms of UTI, pain, burning, blood tinged urine, cloudiness, no output, deepening of urine in color, increased pulse, increased temp, urinary frequency, foul smelling urine, fever, chills and altered mental status. The care plan further directed catheter care every shift, good perineal cares- especially penis and foreskin cares every shift and as needed, and to report unusual observations/conditions to the nurse. Recent catheter trauma, foreskin care.

Review of R1's hospital Interagency Transfer Form - Notes dated 7/13/19, identified sepsis due to bacteremia. The notes indicated urinary retention potentially contributing to delirium.

Review of facility Progress Notes, hospital notes and clinic visit notes indicated the following:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 3 7/16/19, R1 was hospitalized due to confusion and delirium had an indwelling Foley catheter in place. No skin issues except a skin tear on his back. 7/26/19, A lump was discovered on the underside of R1's penis. Staff continue to monitor. 7/30/19, Lump on penis is small and small amount of firmness to lump. 7/30/10, R1's daughter stated his water pill made his condition decline because he wouldn't eat or drink due to concern of going to the bathroom and the catheter had lessened this worry for him and helped him to sleep at night. 8/1/19, R1 found during the night pulling on his catheter. Catheter draining with some blood noted in urine. 8/2/19, R1's Foley catheter to be replaced in hopes of improving flow of fluids. 8/2/19, Catheter changed due to blood in urine. 8/3/19, R1 complained of pain in his penis, possibly due to pulling his catheter out on night shift. On 8/5/19, a clinic visit note indicated R1 indicated R1 was seen in the clinic by his physician for a follow up visit. The note indicated "Has had a catheter placed at the request of family as well noting he has always been very upset about his inability to maintain continence and this was problem for him getting up repeatedly in the middle of the night. Family does understand the potential risk of complications	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 4	2 910		

including infection of this going forward." The note further indicated there had been discussion about the indwelling catheter which had resolved his anxiousness and increased urgency to urinate allowing him to participate more effectively in therapy, and there had been discussion associated with the increased risk of infection. The notes indicated the patient had verified awareness of these issues as well. The clinic note from the medical provider included, "I discussed the possibility of transitioning to a condom catheter after a few weeks and using tamsulosin (a medication used to treat the symptoms of benign prostatic hyperplasia (BPH), enlarged prostate) prior to its discontinuation."

8/6/19, R1 currently with Foley catheter which family agreed to use due to previous incontinence and repeated attempts to get up to void. Physican stated R1 verbalized previous bladder infections and his concerns about it.

8/8/19, Facsimile was sent to clinic regarding R1's penile area. Staff documented an abnormal condition on underside of penis, where a lump was noted.

8/9/19, Lump on the underside of R1's penis increasing in size and now growing up the sides of the penis.

8/9/19, Writer looked at R1's penis and the foreskin was swollen and pulled away from the tip. Old catheter was removed and foreskin retracted "somewhat" and new catheter placed. Slight pain during treatment.

8/9/19, Note indicated, remove catheter, compress glands at tip of penis. May take time but foreskin should then retract. May send to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 5 emergency room (ER) if no improvement. 8/10/19, ER called with update, stated importance of fully retracting foreskin and cleansing area then be sure to pull back over. Also stated some skin tearing. Noted R1 was sent to ER after physican order, attempted to loosen foreskin first. This was accomplished previous evening, then worsened in the morning so was sent to ER. 8/10/19, R1 Pariphimosis (condition in which foreskin has retracted and cannot be returned to original condition) persisting. Foreskin pulled over per physican order last night, returned today. 8/10/19, R1 returned from ER, wife stated the swollen foreskin was due to not being pulled back after cleaning. Writer spoke to wife about R1 pulling on his catheter but wife stated that was not what caused it. Emergency Department (ED) note: On 8/10/19, R1 had diagnosis for Pariphimosis. R1 presented for evaluation of penile swelling. R1 had a Foley catheter in place that was changed yesterday. Since then foreskin has been retracted and swelling. R1 came to the ED for penile swelling and discomfort. Foreskin was reduced back over the glans, however had difficulty maintaining a reduced position due to swelling. Ice pack placed with scrotal elevation. Physician spent quite a bit of time applying pressure to reduce edema and was getting some success. But the physician was noticing the glans penis would still protrude and the problem did not completely go away. There was no urinary difficult at baseline. Discharge instructions were return if worse or new symptoms - especially increased swelling or pain of the penis or foreskin. It is extremely important to fully reduce the foreskin when it is	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 6 retracted for hygiene cares. It is ok to put some topical Bacitracin ointment on abraded areas of the foreskin as it heals. Foreskin was reduced back over the glans, however had difficulty maintain a reduced position due to swelling. Ice pack placed with scrotal elevation. ED note 8/11/19. R1 was seen in the ED for Pariphimosis and UTI. R1 was just seen 24 hours ago with Pariphimosis. R1 came back for recurrent Pariphimosis. A daughter noted that she had been checking on R1 throughout the evening and at 8 PM she noted that the foreskin was again retracted and stuck around the base of the glans. R1 denied pain, however over the last several hours the daughter noted some purulent discharge the indwelling Foley catheter at the meatus as well as inside the tube of the catheter bag. The physican attempted manual reduction of the Pariphimosis without success. A urology consulted and he would perform a dorsal slit. The urologist came in to see the resident and performed a dorsal slit. The urologist noted that the urethral discharge was normal especially with recent manipulation due to Pariphimosis reduction about 24 hours ago. The urologist recommended that R1 be prophylaxis with Keflex to prevent skin infection related to dorsal slit, keep wound clean and dry. Apply Bacitracin to wound 2 times a day and change dressing as needed. The urine analysis with greater than 200 white blood cells, 8-30 red blood cells, packed bacteria, and positive nitrates. Concerning for UTI, but may also be due to colonization with chronic indwelling Foley. A urine culture was pending. Placed on Ceftin tablets 250 mg (milligrams) one tab by mouth twice a day for 7 days. 8/12/19, Circumcision site care completed per	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 7 orders with intact sutures. Catheter intact and draining within normal limits. 8/13/19, Family concerned R1 was going to pull out his catheter and wanted it removed. Family planing to speak to nurse practitioner (NP). On 8/14/19, a clinic visit noted indicated R1 was seen in the clinic by his NP for follow up on circumcision as well as to address other family concerns. Last week resident developed Pariphimosis after multiple attempts to put foreskin back he ended up requiring dorsal slit. 8/14/19, R1's incision cleaned and Bacitracin applied per order, mild swelling noted. Received new order for Ceftin and start Macrobid. On 8/19/19, clinic visit note indicated R1 had a follow up appointment with his physician in the clinic. R1 had a UTI and subsequently a staph infection in the urine and was switched to a different antibiotic. 8/19/19, Family reported concern about distended appearance of resident bladder. When leg bag was switched over to the night bag, urine started flowing consistently and writer scanned resident's bladder and found at most 49 milliliters (ml) of urine residual. 8/23/19, Writer washed R1's peri-area with warm soapy water and assessed. Writer applied Bacitracin where sutures were. Writer noted scant amount of green discharge on residnet penis and brief. Writer noted some leaking of urine around Foley, checked all tubing and tightened. Passed on to the evening nurse to monitor for urine leaking around catheter, if so it may need to be replaced with a new one.	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 8 8/23/19, Family called wanting to check and see if catheter started flowing normally again, or what other interventions were required. Family continued to talk about how she was concerned staff needed to change it every two weeks instead of once a week. Writer encouraged family to keep it at once a month and try other options like flushing the catheter line to prevent sediment build up as a way to reduce chance of urinary tract infections. 8/23/19, R1 had episodes of agitation this evening on and off. Family was here most of the shift. At the beginning of the shift, family alerted writer to fact that catheter was leaking. On inspection urine was coming out of the tip of his penis around his catheter. R1 was also complaining of pain at the tip of his penis. Staff changed catheter and R1 tolerated catheter change ok but blood was coming out of the tip of his penis. R1 was very sensitive when tip was touched. Fluids were pushed this evening. Some small clots were seen in catheter tubing and urine was brown tinged. Once R1 started to increase fluids urine began to clear. Stitches were cleaned this evening. Some small clots were seen in cath tubing and urine was brown tinged. Once resident started to increase fluids, urine began to clear. Catheter appeared to be flowing without complications. Stitches were cleaned this evening and Bacitracin applied. 8/24/19, R1 was restless in the beginning of the night shift, and after several attempts to have him fall asleep, Nursing assistants (NA) moved him to recliner. R1 got slightly combative and swung at NA. Writer caught resident pulling at catheter through the shift and writer would tell him to stop and get his hands away from catheter. Around	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 9 5:00 a.m. NA came to tell writer that resident's brief had blood on it. Writer assessed R1's brief, catheter and penis. The on call physican said to put nystatin on penis and to attempt to keep resident from pulling at catheter, and to monitor for clots in catheter. 8/24/19, R1's family member was very concerned about blood in urine. Family took resident to ER. Received call from ER that they will be admitting resident with Hyponatremia and ascites. 8/30/19, R1 was brought back from ER to facility by family via tunnel and escorted to his room via wheelchair. R1 was confused and was having hallucinations when writer was in room. R1 would take off his blanket and try to reach to ceiling to grab something. R1 had indwelling Foley catheter for comfort, per family. Resident urine is clear yellow and catheter was patent. R1 was being treated with Cipro for possible UTI. 8/31/19, R1 had been tugging at his catheter and grabbing towards ceiling. 8/31/19, R1 confused and agitated, pulling at catheter, wringing hands. Resident was hallucinating, stated that the walls were on fire. 9/3/19, R1 required one on one supervision this shift. R1 was agitated and restless and continuously tried to get out of his geri (geriatric) chair. 9/4/19, Foley urine output was 1200 cc's (cubic centimeters). No expression of discomfort/pain observed. Penal swelling present, treatment done. 9/7/19, R1's incontinent pad was wet, catheter	2 910		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 10	2 910		

presumably bypassing, had 400 ml out at around 1:30 p.m. and was emptied prior at around 7:00 a.m.

9/8/19, R1's catheter was bypassing urine into pad, R1 continually pulled catheter.

9/9/19, R1 alert, confused during this shift, hallucinating (has been quite normal for his baseline) however, family was worried and wanted a urinalysis (UA) and urine culture (UC) done, order was given. The family transferred resident to the toilet and called this writer to inspect a new protrusion on his sacrum they had not seen before, it was about the size of a fist, no redness, warmth, or pain noted. This writer informed family she would update NP regarding this new lump. After family got him up from the toilet, they told writer they were going to ER to have it looked at. Resident's family took him to ER via tunnel at approximately 6:00 p.m. and R1 arrived back at facility around 8:00 p.m. with new orders for Cipro.

9/11/19, R1's Foley catheter was discontinued by the nurse practitioner and was successfully removed, 300 cc of clear, yellow urine was noted. R1 received penile care this shift as ordered, wound looks healed.

9/12/19, R1 voided well, had wet brief at 0000, 0200, and 0400 rounds. Post void residual (PVR): 0 ml.

Multiple observations were made on 9/11/19, through 9/13/19 of R1 in the facility being attended by the family 24/7. R1 was able to feed himself during morning observations 9/12/19, without family present in the dining room. R1 was not able to coherently answer simple questions

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 11	2 910		

while eating. R1 had a Foley catheter that was draining amber urine. During morning observations on 9/12/19, a family member and NA had just finished showering R1. R1 was noted not to be in pain or restless.

Registered Nurse (RN)- A was interviewed on 9/13/19, at 11:50 a.m and confirmed R1 was admitted from hospital on 7/16/19, with a blood infection, to second floor where she was the nurse manager. The nurse manager verified that the staff had not attempted to have the catheter assessed for medical necessity or potential removal.

The NP was interviewed on 9/13/19 at 11:30 a.m., and confirmed that the multiple ER visits, partial circumcision, and UTIs may not have happened if the resident's Foley catheter had been appropriately assessed and removed. The NP further stated R1's family insisted on R1 having the catheter. In addition, the NP stated one of the resident's daughters had requested the Foley catheter remain in place when R1 went on hospice. The NP confirmed R1 lacked a medical diagnosis for the continued use of the Foley catheter and acknowledged having written an order to have the Foley catheter removed on 9/11/19.

The facility's Policy and Procedure for catheters, revised 1/18, included: "A resident is not be be catheterized unless the clinical condition demonstrates that catheterization is necessary and is not to be used solely for nurse/physician convenience. Catheters will be inserted only with a physician's order. Guidelines for Attempted Catheter Removal. The SOM (State Operations Manual) F-Tag indicates that indwelling catheters must be medically necessary for the resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00924	A. BUILDING: _____ B. WING _____	C 09/13/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - WACONIA AND	333 FIFTH STREET WEST WACONIA, MN 55387

(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
2 910	Continued From page 12 The medical record must have documentation of attempts to remove indwelling catheters and the results of the attempts. It is recommended that removal be attempted at least two or three times during his/her stay before it can be determined that it is unsuccessful. " SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review all physician orders to assure completion of ordered referrals are completed to prevent ordered referrals are provided. The director of nursing or designee, could conduct random audits of physician orders to ensure appropriate care and services are implemented. TIME PERIOD FOR CORRECTION: Twenty-one (21) days	2 910		