DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

December 2, 2019

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

Re: Reinspection Results
Event ID: 6RSQ12

Dear Administrator:

On November 21, 2019 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on October 17, 2019. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Electronically Submitted

November 5, 2019

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

RE: CCN: 245593
Cycle Start Date: October 15, 2019

Dear Administrator:

On October 15, 2019, an extended survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

Your facility was not in substantial compliance with the participation requirements and the conditions in your facility constituted both substandard quality of care and immediate jeopardy to resident health or safety. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constituted past non-compliance immediate jeopardy (Level J). Past non-compliance does not require a plan of correction (POC).

Also, the extended survey found isolated deficiencies that constituted actual harm that was not immediate jeopardy (Level G) whereby corrections are required. The Statement of Deficiencies (CMS-2567) is being electronically delivered.

REMOVAL OF IMMEDIATE JEOPARDY

On June 11, 2019, the situation of immediate jeopardy to potential health and safety cited at F678 was removed.

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 listed below to the CMS Region V Office for imposition: The CMS Region V Office concurs and is imposing the following remedy and has authorized this Department to notify you of the imposition:

• Discretionary Denial of Payment for new Medicare and/or Medicaid Admissions, Federal regulations at 42 CFR § 488.417(a), effective January 3, 2020.

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).

The CMS Region V Office will notify your Medicare Administrative Contractor (MAC) that the denial of payment for new admissions is effective January 3, 2020 (42 CFR 488.417 (b)). They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective January 3, 2020 (42 CFR 488.417 (b)).

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.

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.

Therefore, your agency is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Programs or Competency Evaluation Programs for two years effective October 15, 2019. This prohibition is not subject to appeal. Under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

SUBSTANDARD QUALITY OF CARE

Your facility's deficiencies with with one or more of the following: §483.10, Residents Rights, §483.12, Freedom from Abuse, Neglect, and Exploitation, §483.15, Quality of Life and §483.25, Quality of Care, 483.40 Behavioral Health Services, §483.45 Pharmacy Services, §483.70 Administration, or §483.80

Infection control has been determined to constitute substandard quality of care as defined at §488.301. Sections 1819(g)(5)(C) and 1919(g)(5)(C) of the Social Security Act and 42 CFR 488.325(h) require that the attending physician of each resident who was found to have received substandard quality of care, as well as the State board responsible for licensing the facility's administrator, be notified of the substandard quality of care. If you have not already provided the following information, you are required to provide to this agency within ten working days of your receipt of this letter the name and address of the attending physician of each resident found to have received substandard quality of care.

Please note that, in accordance with 42 CFR 488.325(g), your failure to provide this information timely will result in termination of participation in the Medicare and/or Medicaid program(s) or imposition of alternative remedies.

Federal law, as specified in the Act at Sections 1819(f)(2)(B) and 1919(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care. Therefore, Good Samaritan Society - St James is prohibited from offering or conducting a Nurse Assistant Training / Competency Evaluation Programs (NATCEP) or Competency Evaluation Programs for two years effective October 15, 2019. This prohibition remains in effect for the specified period even though substantial compliance is attained. Under Public Law 105-15 (H. R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

ELECTRONIC PLAN OF CORRECTION (ePOC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable plan of correction (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:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

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 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 April 15, 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 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.

APPEAL RIGHTS DENIAL OF PAYMENT

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.

APPEAL RIGHTS NURSE AIDE TRAINING PROHIBITION

Pursuant to the Federal regulations at 42 CFR Sections 498.3(b)(13)(2) and 498.3(b)(15), a finding of substandard quality of care that leads to the loss of approval by a Skilled Nursing Facility (SNF) of its NATCEP is an initial determination. In accordance with 42 CFR part 489 a provider dissatisfied with an initial determination is entitled to an appeal. If you disagree with the findings of substandard quality of

care which resulted in the conduct of an extended survey and the subsequent loss of approval to conduct or be a site for a NATCEP, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40, et. Seq.

A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services (formerly Health Care Financing Administration) at 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

A request for a hearing should identify the specific issues and the 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. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

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 plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04_8.html

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245593	A. BUILDING _____ B. WING _____	C 10/17/2019

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 10/15-10/17/19, an abbreviated survey was completed at your facility to conduct a complaint investigation. Your facility was found not to be in compliance with 42 CFR Part 483, Requirements for Long Term Care Facilities. The following complaint was found to be substantiated: H5593023C at an immediate jeopardy (IJ) identified at F678. The IJ began on 10/8/19 when the facility failed to initiate cardio pulmonary resuscitation (CPR) for a resident who had previously requested to receive CPR. The immediate jeopardy was removed 10/11/19 when the faciltiy had implemented appropriate corrective action to prevent the situation from recurring. The complaint H5593023C was also substantiated at F689. In addition, an extended survey was completed 10/16 and 10/17/19 as a result of the past non-compliance IJ identified at F678. While the facility receives a CMS 2567 documenting the findings, past non-compliance does not require a plan of correction.	F 000	Past noncompliance: no plan of correction required.	
F 678 SS=J	Cardio-Pulmonary Resuscitation (CPR) CFR(s): 483.24(a)(3) §483.24(a)(3) Personnel provide basic life support, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders and the resident's advance directives. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the	F 678	Past noncompliance: no plan of	11/14/19

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

Electronically Signed | 11/14/2019

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F 678	Continued From page 1 facility failed to implement their policy to initiate cardio-pulmonary resuscitation (CPR) for 1 of 2 residents (R1) who had requested to be a full code status, meaning the resident wanted life-saving interventions implemented. Although noncompliance was present at the time of the event, the facility had implemented appropriate corrective action prior to the survey, resulting in a finding of past-noncompliance Immediate Jeopardy (IJ). The IJ began on 10/8/19, when the facility failed to ensure CPR was provided for R1 who sustained a fall, experienced shortness of breath, and continued to deteriorate until respirations and heart stopped. The administrator was notified of the past non-compliance, immediate jeopardy on 10/16/17. The immediate jeopardy was removed, and the deficient practice corrected on 10/11/19, prior to the start of the survey and was therefore past non-compliance. Findings include: The American Heart Association's 2015 guidelines for cardio-pulmonary resuscitation indicated while the general rule is to provide emergency treatment to a victim of cardiac arrest (lack of pulse), there were a few exceptions where withholding CPR would be considered appropriate: -Situations where attempts to perform CPR would place the rescuer at risk of serious injury or mortal peril. -"Obvious clinical signs of irreversible death (e.g., rigor mortis [stiffening of muscles], dependent lividity [pooling of blood in the lowest lying part of the body due to gravity], decapitation [separation of the head from the body], transection [cut	F 678	correction required.	

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F 678	Continued From page 2	F 678		

across body causing body separation], decomposition [decay of the body]."
-a valid advanced directive, Provider Orders for Life-Sustaining Treatment (POLST), or order indicating do not attempt resuscitation

R1's face sheet dated 10/9/19, indicated R1 had been admitted to the facility 10/8/19, with diagnosis including essential hypertension (high blood pressure), urinary tract infection and dementia.

An "After Visit Summary" (AVS) from the local clinic dated 10/8/19, indicated R1 had been hospitalized 10/4 through 10/8/19, for treatment of sepsis (an infection in the blood). The AVS further indicated full code status was discussed and R1 was verified to be full code.

R1's admission physician orders dated 10/8/19, stated "PLEASE specify ADVANCED DIRECTIVES". However, there was no documentation of R1's code status.

R1's medication record dated 10/8/19, identified R1's advanced directive as 'full code status'.

A progress note dated 10/8/19 at 1:05 p.m. included: "NA (nursing assistant) was walking resident back from the dining room, and had her stop in the tub room so she could get her weight. NA went to get resident's wc (wheelchair) and brought it tub room and found resident had just fallen."

A post fall "Fall Scene Huddle Worksheet" dated 10/8/19, at 1:05 p.m., indicated R1 fell unwitnessed in the shower/tub room and was found on the floor. Staff action indicated NA-A

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F 678	Continued From page 3	F 678		

was walking resident back from dining room and had her stop at tub room so she could weigh her. The documentation indicated NA-A had gone back to R1's room to grab R1's wheelchair. The time NA-A was gone was estimated at less than a minute. Documentation indicated R1 had then been found on her right side with her head next to the tub, with a laceration on the side of forehead and right temple.

An incident report dated 10/8/19, at 1:03 p.m., indicated a NA was walking R1 back from dining room, had her stop at the tub room so she could get her weight, then went to get R1's wheelchair. R1 was found on the floor in the tub room. Immediate action taken was assist of three and a lift to transfer resident from floor to her wheelchair. R1 had 2 lacerations to right side of head/temple. Bleeding was controlled at this point. Pupils were slightly dilated at first but then became fixed and enlarged. R1 appeared to be short of breath and had an oximetry (proportion of oxygenated hemoglobin in the blood) reading of 85% on room air. R1 was brought back to her room and transferred to bed and within a few minutes, she had expired.

A "Certificate of Removal" form dated 8/10/19, indicated R1's date of death as 10/8/19, at 1:25 p.m..

During interview on 10/15/19 at 2:12 p.m., NA-A indicated she was assisting R1 from dining room to her room when R1 began complaining of shortness of breath. NA-A indicated she left R1 by the tub room to retrieve R1's wheelchair so she could get her weight. NA-A then indicated she walked of out R1's room and saw R1 turn and go into the tub room then heard a loud bang.

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F 678	Continued From page 4	F 678		

NA-A indicated she found R1 on the floor next to the tub, was responding to her questions but bleeding from somewhere on her head . NA-A indicated licensed practical nurse (LPN)-A, and LPN-B responded to the room and assisted with using the lift to place R1 in her wheelchair. NA-A then indicated R1 stated she felt sick to her stomach, and was slurring her words and was transferred to her room but during transport R1 went unresponsive and had gasping respirations. NA-A indicated registered nurse (RN)-A informed all three staff members present, R1 was a full code at which time LPN-B left to call 911. R1 was then transferred to her bed unresponsive with no respirations. NA-A indicated CPR was not done at any time. NA-A stated "I don't know why CPR was not performed" and indicated she was sorry.

During interview on 10/15/19, at 2:56 p.m., LPN-A indicated approximately 1:00 p.m., she heard a noise and heard NA-A calling for help as she went into the tub room. LPN-A indicated she walked into the room and found R1 laying on the floor bleeding from her head. LPN-A indicated R1 appeared short of breath and upset from her fall, but was responding to questions so was transferred to her wheelchair. LPN-A indicated she completed vital signs and neurological checks that included R1's right pupil which dilated slightly with the left pupil responding a little more than that. LPN-A indicated she asked for RN-A to come assess R1 but by the time RN-A arrived R1's pupils were larger, not responding to light, less responsive and short of breath having difficulty speaking. LPN-A indicated R1 was holding her head as she was transferred to her room. Upon transfer to her bed, LPN-A indicated RN-A informed them R1 was a full code status. LPN-A then indicated after transfer to the bed, R1

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took a few gasping breaths, then stopped breathing. LPN-A indicated CPR was never started and stated "it never crossed my mind to start CPR."

During interview on 10/15/19, at 3:25 p.m., RN-A indicated she was asked to assess the neurological status of R1 because her pupils weren't reacting so she told LPN-B to call 911 because she knew R1 was a full code resuscitation. RN-A indicated when she arrived in the tub room, R1 had a significant head injury but R1 was responsive and stating she felt nauseated. RN-A indicated she thought at this point she informed staff present R1 was a full code status. RN-A indicated she then left the room to ensure LPN-B had contacted 911 then returned to R1's room and assisted staff to put R1 into the bed. RN-A indicated by this time, R1 was no longer responsive. RN-A informed staff present again, R1 was a full code but indicated no one started CPR. RN-A indicated the ambulance had arrived, but LPN-B told them it was too late so the ambulance left. RN-B indicated if a resident is full code CPR should be done.

During interview on 10/16/19, at 10:19 a.m., LPN-B indicated she was charge nurse on 10/8/19 when LPN-A asked for help. LPN-B indicated R1 was on the floor , talking, short of breath but denied any pain at this time. LPN-B indicated she assisted with lifting R1 off the floor into her wheelchair when R1 began stating she had to throw up and her stomach was very upset. LPN-B indicated she checked R1's pupils twice because she saw no dilation in either eye. LPN-B indicated LPN-A was attempting to get a blood pressure but none was registering. LPN-B

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F 678	Continued From page 6	F 678		

indicated within approximately 2 minutes R1 had slurred speech, was very pale and her pupils were fully dilated. LPN-B indicated she was instructed by RN-A to contact 911 so she left the room. While contacting 911 and the hospital, LPN-B indicated RN-A informed her R1 was a full code. LPN-B indicated upon returning to the room, LPN-A shook her head no and said she is gone. LPN-B indicated she notified RN-A via radio and the director of nurses (DON), interim DON, and RN-A of the death after a fall who immediately responded to the room. LPN-B indicated RN-A at this time informed the DON and interim DON that R1 was a full code status. LPN-B indicated someone asked why CPR had not been performed, which is when "it clicked that none of us had performed CPR." LPN-B indicated it was at this time the ambulance arrived and she informed them R1 "did not make it." LPN-B stated "I don't know why CPR wasn't started but it happened so quickly it didn't even enter my thought process at all."

During interview on 10/16/19, at 11:20 a.m., the DON indicated she was notified a resident had fallen and was deteriorating at approximately 1:30 p.m. on 10/8/19. The DON indicated R1 was in her bed and had no respirations when she arrived. The DON indicated she wasn't thinking the resident was a full code, but once she did, no one could tell her the exact time R1's respirations ceased and believed it was to late to start CPR. The DON stated "in hindsight CPR should have been started." The DON further indicated LPN-A and LPN-B were both suspended for approximately two days and it was believed the root cause was lack of communication and and code blue process.

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	245593	A. BUILDING _____ B. WING _____	C 10/17/2019

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

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F 678	Continued From page 7	F 678		

During interview on 10/16/19, at 11:45 p.m., the interim DON indicated she was alerted at approximately 1:25 p.m. that R1 was not doing very well and she was aware the resident was a full code. Upon arrival to the room, the interim DON indicated LPN-A came out of room and stated she is dead. The interim DON indicated she was not aware of the timeline and how long R1 had been without respirations so CPR was not initiated. The interim DON indicated CPR should have been initiated immediately by staff members present, but during their root cause interview, all staff involved indicated starting CPR never entered their thought process.

During interview on 10/16/19, at 12:10 p.m., the administrator indicated she was notified R1 had a fall and staff report was she was deteriorating. The administrator stated by the time she arrived at R1's room, the resident was deceased. The administrator indicated expectations are for CPR to be started immediately on a full code status resident.

A policy titled "Advance Care Planning and Advance Directives" last revised 4/6/19 included:
Definitions:
- CPR: Any medical intervention use to restore circulatory and/or respiratory function that has ceased.
- Do not Resuscitate (DNR): An advance directive, end of life decision in which a physician and resident or their surrogates agree not to use cardiopulmonary resuscitation when the heart stops. In accordance with local or state agreements, DNR's are usually signed physician's orders that are used across the healthcare continuum.
If cardiac arrest occur, CPR will be initiated

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F 678	Continued From page 8 unless: - A valid DNR order is in place - Obvious signs of clinical death are present, or - Initiating CPR could cause injury or peril to the rescuer The past non-compliance immediate jeopardy began on 10/8/19. The IJ was removed and the deficient practice corrected by 10/11/19, after the facility implemented a systemic plan that included: a root cause analysis, corrective action provided to the licensed nurses involved, and each resident's chart was reviewed to verify code status. In addition, facility policies were reviewed for adequacy. Staff education was implemented to ensure all licensed staff understood the facility's policies for CPR, the advanced directive books were updated daily and drills were established for staff to verify appropriate response. Verification of corrective action was confirmed by interview with a variety of nursing staff, interview with the administrator, review of progress notes, and documentation of staff training. In addition, facility policies were reviewed and audits were initiated.	F 678		
F 689 SS=G	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced	F 689		11/14/19

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F 689	Continued From page 9 by: Based on observation, interview and document review, the facility failed to provide adequate supervision and assistance to reduce the risk of accident hazards for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm when R1 was left alone in the hallway, walked independently into a tubroom, fell, hit her head sustaining symptoms of head injury, and sustained a head laceration. Findings include: R1's face sheet dated 10/8/19, identified admission date to the facility as 10/8/19, with diagnosis including: hypertension (high blood pressure), urinary tract infection and dementia. No care plan or Minimum Data Set assessment data had been started as resident had just been admitted to the facility at approximately 11:05 a.m.. A discharge summary dated 10/8/19, at 9:09 a.m., by medical doctor (MD)-A, indicated R1 was hospitalized 10/4/19 through 10/8/19 for sepsis (potentially life-threatening condition caused by the body's response to an infection) and a urinary tract infection. A physical therapy inpatient evaluation/treatment assessment dated 10/5/19, at 11:11 a.m., indicated a steady gait pattern with use of front wheeled walker in hallway and who is able to ambulate without assuasive device in her room, with contact guard (physical therapist needs to merely have one or two hands on the body but provides no other assistance to perform the functional task. The contact is made to help steady the body or help with balance.) assist and	F 689	1) For resident R-1, has been discharged from the facility. The facility is not able to go back to make corrections for this resident. 2) For all other residents to ensure that each resident receives adequate supervision and assistive devices to prevent accidents. The facility will assure that for all new admissions the staff have received communication as to the level of supervision and assistance each resident requires. The facility will complete an assessment upon admission to determine the level of assistance and supervision. Upon admissions all new admissions will be assisted with mobility and transfers until assessment is completed. This information will be verbally communicated to staff, will be written on nurse to nurse shift report and will be updated on the “Preadmission data collection form” and placed in the communication book. Care plan will be developed and updated to reflect level of care and assistive devices or equipment needed. Implementation/In-services: 3) Education and training will be provided by the DNS and staff development on November 19th 2019. Education will include GSS policy and procedure for assessment with mobilization, transfers and assistive devices needed and level of care each resident requires. Education will include review of ADL level of care scoring. The nursing staff has been assigned the ADL scoring module in learning center for	

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F 689	Continued From page 10 supervision. Without assistive device, patient reaches for walls and furniture. Recommend use of gait belt with in room ambulation and transfers. An admit data collection sheet dated 10/8/19, at 11:05 a.m., indicated R1 was admitted skilled therapy, monitoring for high blood pressure and complications from sepsis. Fall risk factors included anti-hypertensive medication and moderately impaired cognitive status with poor memory, disorientation and forgets to use equipment such as call light, assistive device. A progress note dated 10/8/19 at 1:05 p.m. included: "NA (nursing assistant) was walking resident back from the dining room, and had her stop in the tub room so she could get her weight. NA went to get resident's wc (wheelchair) and brought it tub room and found resident had just fallen." A "Fall Scene Huddle Worksheet" dated 10/8/19, at 1:05 p.m., indicated R1 fell unwitnessed in the shower/tub room and was found on the floor. Staff action indicated NA-A was walking resident back from dining room and had her stop at tub room so she could weigh her. The documentation indicated NA-A had gone back to R1's room to grab R1's wheelchair. The time NA-A was gone was estimated at less than a minute. Documentation indicated R1 had then been found on her right side with her head next to the tub, with a laceration on the side of forehead and right temple. During interview 10/15/19 at 2:12 p.m., NA-A stated she'd assisted R1 from the dining room back towards her room. NA-A stated it had taken a "few" attempts to stand R1, and R1 had	F 689	added education and training. All staff will have this completed by October 15th 4) AUDITS will be completed weekly x 4 weeks and monthly x 2 months on all new admissions to include assessment was completed upon admission to determine the level of care and assistance resident requires. Appropriate assistive device or equipment has been provided for the resident and determined by the assessment. Shift to shift or Nurse to nurse communication has been completed and the GSS form 945 data is completed and available for all staff to refer to. Audit findings will be reported monthly to the QAPI committee for further recommendations.	

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F 689	Continued From page 11	F 689		

seemed a little short of breath. NA-A stated she had asked R1 if she needed her walker and R1 had refused. NA-A stated there had been no gait belt on R1 at the time, but stated she was wearing a radio. NA-A then stated R1 appeared steady on her feet so she asked R1 to stay by the tub room and went to R1's room to retrieve R1's wheelchair. NA-A stated as she'd come out of R1's room, she saw R1 round the corner into the tub room then heard a bang. NA-A then stated she'd found R1 on the floor next to the tub bleeding from her head, so she'd grabbed a towel and applied pressure, and yelled for help. NA-A stated R1 had been alert and complaining of nausea at that time.

During interview on 10/15/19, at 2:56 p.m., licensed practice nurse (LPN)-A stated she'd observed NA-A and R1 walk by the nurses' desk side by side with no walker. LPN-A stated she did not believe R1 had a gait belt on, and a gait belt should have been usual practice. LPN-A stated at approximately 1:00 p.m. she'd heard a loud noise and had heard NA-A yell for help. LPN-A stated she'd proceeded to the tub room and found LPN-A stated R1 was laying on her right side with her head near the tub, blood was present on the floor and NA-A was holding pressure to R1's head. LPN-A stated R1 had an abrasion on the right side of her temple and below it was a skin tear. LPN-A stated R1 had appeared short of breath but was alert and talking. LPN-A also said R1's pulse oximeter (measures oxygen in the blood) was 85% and she was not able to obtain a blood pressure. LPN-A said she'd checked R1's pupils, and the right pupil was dilated slightly the left pupil a little more than the right. LPN-A stated within a minute or so, R1's pupils got larger and were not

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F 689	Continued From page 12	F 689		

responding to light and R1 was less responsive. LPN-A stated R1 was transferred back to her room and became less responsive with gasping breaths. LPN-A stated the staff had used a lift to move R1 to her bed where her respirations ceased. LPN-A said the entire event was approximately 10 minutes.

During interview on 10/15/19, at 3:25 p.m., registered nurse (RN)-A stated she had completed R1's admission evaluation and had identified R1 was alert, feeling fine but wasn't oriented, which was normal for R1. RN-A stated she was asked by an unknown staff member to go to the tub room to assess R1's neuro status after a fall. RN-A said, "Upon arrival I knew the head injury was pretty serious." RN-A said she'd asked LPN-B to call an ambulance. RN-A stated she'd stayed with R1 who was talking, but had complained of nausea, until R1 was transferred back to her room. RN-A could not recall if a walker or gait belt were present.

During interview on 10/16/19, at 10:19 a.m., LPN-B stated she was the charge nurse on the day of the event and was asked to help after R1 fell. LPN-B stated R1 was on the floor when she'd arrived and was still talking but was short of breath. LPN-B stated R1 had a large laceration on the top of the right side of her head, a cut above her eyebrow and she could feel a large laceration posterior and slightly higher than R1's right ear. LPN-B stated she hadn't seen a walker in the room nor a gait belt on R1. LPN-B stated within approximately two minutes of her arrival, R1 had become pale and her pupils were dilated and not responding to light. LPN-B said she was directed by RN-A to call 911 and left the room. LPN-B further stated R1 had been a limited assist

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F 689	Continued From page 13 of one, and was supposed to have been walked with stand by assist and supervision. LPN-B stated generally a resident should not be left alone to retrieve something, and staff should have radio' d for help instead. During interview 10/16/19 at 11:20 a.m., the director of nurses (DON) stated she'd been notified at approximately 1:30 p.m. on 10/8/19, R1 had a fall and was deteriorating. The DON stated by the time she'd arrived, the resident had no respirations. The DON confirmed R1 should not have been left in the hallway unattended. The facility's 5/16/17 policy Fall Prevention and Management, included: The risk of falling for residents in long-term care locations substantially increases due to decreased mobility, frailty, muscle weakness, gait disturbance and disease progression....It is our obligation to provide the safest environment possible for the residents trusted to our care.	F 689		

Electronically Delivered

November 6, 2019

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

Re: State Nursing Home Licensing Orders - Complaint Number H5593023C

Dear Administrator:

A complaint investigation was completed on October 15, 2019. At the time of the investigation, the surveyor assessed compliance with Minnesota Department of Health Nursing Home Rules. The surveyor from the Minnesota Department of Health noted one or more violations of these rules. These state licensing orders are issued in accordance with Minnesota Statute section 144.653 and/or Minnesota Statute Section 144A.10. If, upon reinspection, it is found that the violations 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 of the Minnesota Department of Health.

To assist in complying with the licensing 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 violation. 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 violation within the established time frame is required. The “suggested method of correction” is for your information and assistance only.

The State licensing orders are delineated on the Minnesota Department of Health order form. The Minnesota Department of Health is documenting the state licensing 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 after the statement, "This Rule is not met as evidenced by." Following surveyor's 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.

When all licensing orders are corrected, the form should be signed and returned electronically to:

Elizabeth Silkey, Unit Supervisor
Mankato District Office
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
12 Civic Center Plaza, Suite #2105
Mankato, MN 56001
Email: elizabeth.silkey@state.mn.us
Phone: 651-201-3784
Fax: (507) 344-2723

You may request a hearing on any assessments that result from non-compliance with these licensing orders by providing a written request 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00697	A. BUILDING: _____ B. WING _____	C 10/17/2019

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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 10/15-10/17/19, an abbreviated survey was completed at your facility to conduct a complaint investigation and to determine compliance with State licensure requirements. The following correction order is issued. Complaint H5593023C was found to be	2 000		

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2 000	Continued From page 1 substantiated. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled " ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors 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 http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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	2 000		

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2 000	Continued From page 2 IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES	2 000		
2 830	MN Rule 4658.0520 Subp. 1 Adequate and Proper Nursing Care; General Subpart 1. Care in general. A resident must receive nursing care and treatment, personal and custodial care, and supervision based on individual needs and preferences as identified in the comprehensive resident assessment and plan of care as described in parts 4658.0400 and 4658.0405. A nursing home resident must be out of bed as much as possible unless there is a written order from the attending physician that the resident must remain in bed or the resident prefers to remain in bed. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide adequate supervision and assistance to reduce the risk of accident hazards for 1 of 3 residents (R1) reviewed for accidents. This resulted in actual harm when R1 was left alone in the hallway, walked independently into a tubroom fell, hit her head sustaining symptoms of head injury, and sustained a head laceration. Findings include: R1's face sheet dated 10/8/19, identified admission date to the facility as 10/8/19, with diagnosis including: hypertension (high blood	2 830	corrected	11/14/19

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2 830	Continued From page 3	2 830		

pressure), urinary tract infection and dementia. No care plan or Minimum Data Set assessment data had been started as resident had just been admitted to the facility at approximately 11:05 a.m..

A discharge summary dated 10/8/19, at 9:09 a.m., by medical doctor (MD)-A, indicated R1 was hospitalized 10/4/19 through 10/8/19 for sepsis (potentially life-threatening condition caused by the body's response to an infection) and a urinary tract infection.

A physical therapy inpatient evaluation/treatment assessment dated 10/5/19, at 11:11 a.m., indicated a steady gait pattern with use of front wheeled walker in hallway and who is able to ambulate without assuasive device in her room, with contact guard (physical therapist needs to merely have one or two hands on the body but provides no other assistance to perform the functional task. The contact is made to help steady the body or help with balance.) assist and supervision. Without assistive device, patient reaches for walls and furniture. Recommend use of gait belt with in room ambulation and transfers.

An admit data collection sheet dated 10/8/19, at 11:05 a.m., indicated R1 was admitted skilled therapy, monitoring for high blood pressure and complications from sepsis. Fall risk factors included anti-hypertensive medication and moderately impaired cognitive status with poor memory, disorientation and forgets to use equipment such as call light, assistive device.

A progress note dated 10/8/19 at 1:05 p.m. included: "NA (nursing assistant) was walking resident back from the dining room, and had her stop in the tub room so she could get her weight.

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 10/17/2019

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) COMPLETE DATE
2 830	Continued From page 4 NA went to get resident's wc (wheelchair) and brought it tub room and found resident had just fallen." A "Fall Scene Huddle Worksheet" dated 10/8/19, at 1:05 p.m., indicated R1 fell unwitnessed in the shower/tub room and was found on the floor. Staff action indicated NA-A was walking resident back from dining room and had her stop at tub room so she could weigh her. The documentation indicated NA-A had gone back to R1's room to grab R1's wheelchair. The time NA-A was gone was estimated at less than a minute. Documentation indicated R1 had then been found on her right side with her head next to the tub, with a laceration on the side of forehead and right temple. During interview 10/15/19 at 2:12 p.m., NA-A stated she'd assisted R1 from the dining room back towards her room. NA-A stated it had taken a "few" attempts to stand R1, and R1 had seemed a little short of breath. NA-A stated she had asked R1 if she needed her walker and R1 had refused. NA-A stated there had been no gait belt on R1 at the time, but stated she was wearing a radio. NA-A then stated R1 appeared steady on her feet so she asked R1 to stay by the tub room and went to R1's room to retrieve R1's wheelchair. NA-A stated as she'd come out of R1's room, she saw R1 round the corner into the tub room then heard a bang. NA-A then stated she'd found R1 on the floor next to the tub bleeding from her head, so she'd grabbed a towel and applied pressure, and yelled for help. NA-A stated R1 had been alert and complaining of nausea at that time. During interview on 10/15/19, at 2:56 p.m., licensed practice nurse (LPN)-A stated she'd	2 830		

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2 830	Continued From page 5	2 830		

observed NA-A and R1 walk by the nurses' desk side by side with no walker. LPN-A stated she did not believe R1 had a gait belt on, and a gait belt should have been usual practice. LPN-A stated at approximately 1:00 p.m. she'd heard a loud noise and had heard NA-A yell for help. LPN-A stated she'd proceeded to the tub room and found LPN-A stated R1 was laying on her right side with her head near the tub, blood was present on the floor and NA-A was holding pressure to R1's head. LPN-A stated R1 had an abrasion on the right side of her temple and below it was a skin tear. LPN-A stated R1 had appeared short of breath but was alert and talking. LPN-A also said R1's pulse oximeter (measures oxygen in the blood) was 85% and she was not able to obtain a blood pressure. LPN-A said she'd checked R1's pupils, and the right pupil was dilated slightly the left pupil a little more than the right. LPN-A stated within a minute or so, R1's pupils got larger and were not responding to light and R1 was less responsive. LPN-A stated R1 was transferred back to her room and became less responsive with gasping breaths. LPN-A stated the staff had used a lift to move R1 to her bed where her respirations ceased. LPN-A said the entire event was approximately 10 minutes.

During interview on 10/15/19, at 3:25 p.m., registered nurse (RN)-A stated she had completed R1's admission evaluation and had identified R1 was alert, feeling fine but wasn't oriented, which was normal for R1. RN-A stated she was asked by an unknown staff member to go to the tub room to assess R1's neuro status after a fall. RN-A said, "Upon arrival I knew the head injury was pretty serious." RN-A said she'd asked LPN-B to call an ambulance. RN-A stated she'd stayed with R1 who was talking, but had

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2 830	Continued From page 6	2 830		

complained of nausea, until R1 was transferred back to her room. RN-A could not recall if a walker or gait belt were present.

During interview on 10/16/19, at 10:19 a.m., LPN-B stated she was the charge nurse on the day of the event and was asked to help after R1 fell. LPN-B stated R1 was on the floor when she'd arrived and was still talking but was short of breath. LPN-B stated R1 had a large laceration on the top of the right side of her head, a cut above her eyebrow and she could feel a large laceration posterior and slightly higher than R1's right ear. LPN-B stated she hadn't seen a walker in the room nor a gait belt on R1. LPN-B stated within approximately two minutes of her arrival, R1 had become pale and her pupils were dilated and not responding to light. LPN-B said she was directed by RN-A to call 911 and left the room. LPN-B further stated R1 had been a limited assist of one, and was supposed to have been walked with stand by assist and supervision. LPN-B stated generally a resident should not be left alone to retrieve something, and staff should have radio' d for help instead.

During interview 10/16/19 at 11:20 a.m., the director of nurses (DON) stated she'd been notified at approximately 1:30 p.m. on 10/8/19, R1 had a fall and was deteriorating. The DON stated by the time she'd arrived, the resident had no respirations. The DON confirmed R1 should not have been left in the hallway unattended.

The facility's 5/16/17 policy Fall Prevention and Management, included: The risk of falling for residents in long-term care locations substantially increases due to decreased mobility, frailty, muscle weakness, gait disturbance and disease progression....It is our obligation to provide the

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2 830	Continued From page 7 safest environment possible for the residents trusted to our care. SUGGESTED METHOD OF CORRECTION: The director of nursing or designee, could review/revise policies and procedures related to falls, accidents and resident supervision to assure proper assessment and interventioins are being implemented. They could re-educate staff on the policies and procedures. A system for evaluating and monitoring consistent implementation of these policies could be developed, with the results of these audits being brought to the facility's Quality Assurance Committee for review. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 830		