STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245149	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN AMBASSADOR	8100 MEDICINE LAKE ROAD NEW HOPE, MN 55427

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to develop and implement a baseline care plan that included interventions for positioning to decrease pain and [MEDICAL CONDITION] for 1 of 1 residents (R266) reviewed for baseline care planning. Findings include: R266's face sheet indicated R266 was admitted to the facility on [DATE], was cognitively intact and needed limited assistance with activities of daily living (ADL's). R266 had medical [DIAGNOSES REDACTED]. R266's care plan dated [DATE]20, indicated R266 has an ADL self care performance deficit related [MEDICAL CONDITION] left [MEDICAL CONDITION], weakness, deconditioned evidenced by inability to perform transfers without mechanical lift and has decreased ability to participate with self cares, had a potential impairment to skin integrity related [MEDICAL CONDITION] by left sided weakness, had chronic pain/discomfort related to weakness, required extensive assist of 1 staff with all repositioning, 2 staff present for transfers, had a limited physical mobility related [MEDICAL CONDITION] left [MEDICAL CONDITION], weakness, deconditioned evidenced by WC is primary mode of locomotion at baseline, unable to ambulate, is receiving physical therapy and occupational therapy. The care plan interventions lacked evidence of a positioning device for R266's left arm. R266's progress note dated [DATE], at 12:42 p.m. licensed practical nurse, (LPN)-A documented R266 was grimacing and holding her left hand, that R266 stated her fingers hurt. The progress note identified that LPN-A massaged R266's fingers and hand with a muscle rub, and put R266's left arm up on a pillow. The note further indicated joints were puffy looking and that R266 stated that was helpful. R266 progress note dated [DATE], at 10:02 a.m. indicated LPN-A massaged R266's left shoulder, hand and wrist and left knee with muscle rub before breakfast and put R266's hand up on a pillow. No further notes identified of a positioning device use for R266's left hand. During observation on [DATE], at 10:32 a.m. R266 was sitting in wheelchair (WC) with left arm on lap and left hand resting in her lap. left hand and fingers were [MEDICAL CONDITION] (swelling). No positioning device noted. During observation on [DATE], at 8:02 a.m. R266 was in the dining room in WC. R266's left hand was in lap with noticeable [MEDICAL CONDITION] in hand and fingers. No positioning device noted. During observation on [DATE], at 12:48 p.m. R266 was in WC, eating lunch. R266's left arm and hand were [MEDICAL CONDITION]. No positioning device noted. During interview on [DATE], at 1:15 p.m. nursing assistant (NA)-B stated R266's care sheet lacked documentation for positioning devices used on R266's left arm. During observation on [DATE], at 8:17 a.m. R266 was sitting in WC in dining room eating breakfast. R266's left hand was resting on leg and was noted to have [MEDICAL CONDITION] in hands and fingers. R266 left hand did not have a positioning device in place. During observation on [DATE], at 9:15 a.m. R266 was working with occupational therapy. (OT)-A was assisting R266 with balance bars. OT-A then had R266 sit down in WC R266's left hand and fingers were [MEDICAL CONDITION] and R266 was not wearing a positioning device. During interview on [DATE], at 9:23 a.m. OT-A stated on admission OT-A reviewed the medical record, and completed an assessment with the focus on functional goals. OT-A stated R266 had an order for [REDACTED]. OT-A stated she had not discussed the use of a pillow or other device with R266 that could be used to support R266's left arm. Further, OT-A stated she would provide education on the plan of care, the goals of therapy and the frequency of therapy. During interview on [DATE], at 9:43 a.m. R266 stated she had a lot of pain in her left arm and hand and when R266 was in bed the staff put a pillow under R266's left arm and hand and that helped with the pain. Further, R266 stated the staff every once in awhile put a pillow under R266's left arm and hand when in the WC. Additionally, added she liked to be in her WC for most of the day and liked having a pillow under her left hand because it feels lots better. During interview on [DATE], at 10:05 a.m. LPN-A stated R266 did have a swollen left hand and fingers and that LPN-A used muscle rub and had spoken to therapy and ordered a sling for R266. LPN-A stated R266's left arm is positioned with the use of a pillow. During observation on [DATE], at 10:44 a.m. R266 was in the WC in her room with R266's left arm/hand positioned on a pillow. During interview on [DATE], at 11:26 a.m. nursing assistant (NA)-A stated LPN-A just recently requested NA-A find a tray in R266's room and that NA-A positioned R266's left arm on the tray and it was painful for R266. NA-A further stated NA-A then placed a pillow under R266's left arm which was per LPN-A's request. A policy titled Mobility Support and Positioning dated 10/2013, with a revision date of 12/2019, indicated the purpose of the policy was to position those residents unable to position/reposition independently on a manner which prevents formation of contractures, provides comfort and maintains skin integrity and to provide proper body alignment for residents in wheelchairs. The section of this policy titled positioning of the affected side: upper extremity: Resident's arm is supported with a surface such as pillow, or hemi tray. Resident's wrist and hand are properly positioned in a functional position (wrist is in neutral and fingers are slightly flexed with thumb at side). Shoulders are level (not elevated or depressed). Elbow of affected arm is slightly forward of the shoulder. The forearm rests perpendicular to the back of the wheelchair. During an interview on [DATE], at 2:29 p.m. the director of nursing (DON) stated if the resident had dependant [MEDICAL CONDITION] the staff should be elevating or supporting the arm to decrease swelling. Further, the DON stated the expectation was the resident's affected extremity should be supported with a pillow or another device to help with positioning and to reduce the swelling.
F 0688 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and document review, the facility failed to implement restorative therapy to maintain or prevent physical decline after discharge from physical therapy and prior to discharge from the facility for resident (R214) reviewed for restorative services. Findings include: R214's minimum data set (MDS) indicated a BIMS score (brief interview for cognitive mental status) was 13, which indicated cognition was intact, and R214 required limited to extensive assistance with all activities of daily living (ADL's). R214's [DIAGNOSES REDACTED]. R214's progress note dated 12/31/19, indicated a care conference was held and discharge plans were discussed. R214 was to be discharged from physical therapy on 1/3/20, and discharged home on[DATE]. R214's family member (FM)-A expressed concerns for discharge and wished to appeal. Further, the note indicated R214 would remain in the facility until the appeal process was completed. R214's Notice of Medicare Non-coverage indicated services would end 1/3/20, and was signed by FM-A on 12/31/19. R214's BFCC-QIO (Beneficiary and Family Centered Care-Quality Improvement Organizations) Determination letter dated 1/2/2020, indicated Livanta LLC was authorized by Medicare to review the services received by R214 and determined that R214 no longer required skilled nursing facility services. Further, it directed to contact MAXIMUS Federal Services, Inc if FM-A disagreed with this determination. A letter addressed to R214 dated 1/8/2020, indicated an Expedited Appeal Request had been completed and the decision was unfavorable. Occupational Therapy (OT) Patient Instructions dated 1/3/2020, indicated R214 was discharging home with 24/7

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

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

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) supervision and assistance from caregivers. OT recommended long term care however, family declined the recommendation. Further, OT note indicated R214 required use of extended tub bench for all bathing transfers with assist of 1 for self-cares and a HEP (home exercise program) was provided in visual aid format with instructions for caregivers. Physical Therapy (PT) discharge instructions dated 1/3/2020, indicated R214 was discharging facility to home and recommended a four wheeled walker for short distance ambulation and a wheelchair for longer distance mobility. Patient was given HEP for lower extremity strengthening exercises. Therapist recommends home care PT. PT orders dated 1/10/20, indicated R214 start a restorative exercise program offering options for strengthening exercises. R214's care plan indicated restorative therapy was initiated on 1/14/20 and canceled on 1/14/20. During an interview on 3/4/20, at 3:07 p.m. FM-A stated R214 did not receive restorative therapy after discharge from physical therapy (PT) and prior to discharge home. During an interview on 3/5/20, at 1:56 p.m. social worker (SW)-A indicated R214's discharge plans had changed due to the appeal to Medicare coverage of skilled services. Further, SW-A stated typically PT would have known prior to discharge from Medicare PT the status of a resident's plan to go home or stay in the facility. However, R214's plan was changed when FM-A requested an appeal on behalf of R214 and she remain in the facility until the appeal was completed. Further, SW-A confirmed the record lacked evidence of communication with therapy related to change in discharge plans. SW-A stated we should have recognized before the 10th (1/10/20) that R214 was not receiving restorative therapy. During an interview on 3/5/20, at 2:07 p.m. registered nurse (RN)-A stated restorative therapy would have been set up prior to discharge from PT unless PT thought R214 was discharging home. Further, RN-A stated she was not aware why there was no communication with therapy between 1/3/20 and 1/10/20 in regards to restorative therapy for R214. During an interview on 3/5/2020, at 3:17 p.m. director of nursing (DON) stated there should have been communication with PT that R214's discharge plans had changed. A facility policy on discharge planning revised 9/17, indicated the resident and resident representative be involved in the development of the discharge plan.
F 0695 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide safe and appropriate respiratory care for a resident when needed.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure [MED]gen therapy was provided as ordered for 1 of 1 residents (R47) reviewed for respiratory care. Findings include: R47's quarterly Minimum Data Set ((MDS) dated [DATE], identified R47 as moderately cognitively impaired. R47 required extensive staff assistance with transfers, dressing, and personal hygiene. R47 had shortness of breath with exertion and received [MED]gen. A provider note, dated [DATE], identified R47 as [MED]gen dependent. The note indicated R47 gets short of breath when off [MED]gen and [MED]gen saturations are good when R47 is on 2 liters/per/min (LPM) of [MED]gen. R47's Order Summary Report, printed 3/5/20, included an order initiated on 9/23/19 for Oxygen 2 LPM scheduled every shift for [MEDICAL CONDITION] (below normal [MED]gen in blood). During observation and interview with R47 on 3/3/20, at 3:02 p.m. R47 was sitting in a wheelchair in his room. R47 had an [MED]gen nasal cannula in his nose. The nasal cannula tubing was attached to an [MED]gen tank secured to the back of R47's wheelchair. R47 stated he is always on [MED]gen which is set at 2 (LPM). R47 did not appear to be laboring with breathing and had even respirations; however, R47 stated it feels like I'm fighting for a breath. The [MED]gen tank was observed to be set at 0 (off). On 3/3/20, at 3:04 p.m. registered nurse RN-(D) and registered nurse (RN)-E were informed of R47 complaints of shortness of breath and that R47's [MED]gen tank was observed to be turned off. RN-E immediately went to R47's room. RN-E stated R47 was to receive [MED]gen at 2 LPM continuously, but R47's [MED]gen tank was turned off. RN-E turned R47's [MED]gen tank to 2 LPM. RN-E asked R47 if he was short of breath. R47 stated yeah, I'm breathing harder. R47 denied dizziness. RN-E checked R47's [MED]gen saturation level at the surveyor's request. R47's [MED]gen saturation level was normal at 99% on 2 LPM of [MED]gen. RN-E stated he had just started his shift and RN-D had worked with R47 during the day. On 3/3/20, at 3:10 p.m. RN-D stated she had filled R47's tank at 12:30 p.m. RN-D stated at that time R47's [MED]gen tank was on and set at 2 LPM. RN-D stated she did not know how the [MED]gen tank got turned off. RN-D added the nursing assistants do not adjust the flow rate on the [MED]gen tanks. During an interview on 3/5/20, at 2:46 p.m. the director of nursing (DON) stated residents who have orders for continuous [MED]gen are to receive [MED]gen as ordered unless it is the resident's preference not to use [MED]gen. The facility's policy Oxygen Administration dated 1/20, directed Oxygen administration carried out only with a medical provider order. A licensed nurse or other employee trained according to state regulations in the use of [MED]gen will be on duty and is responsible for the proper administration of [MED]gen to the resident.
F 0732 **Level of harm** - Potential for minimal harm **Residents Affected** - Many	**Post nurse staffing information every day.** Based on interview and document review, the facility failed to ensure the required nurse staffing information was posted daily. This had the potential to affect all 77 residents residing in the facility and/or their visitors who may wish to view this information. Findings include: When reviewing the facility's daily nursing hour postings for 3/2/20-3/5/20, the daily postings were noted to be displayed on the wall at eye level on 3/2/20, 3/3/20, and 3/4/20. However, on 3/5/20 the posting was not updated. When interviewed on 3/5/20, at 12:11 p. m. director of nursing (DON) stated the posting had not been updated for the day. Further, DON indicated the staff person in charge of posting had called in for the day. It was DON's responsibility to make sure it was updated and it had been an oversight.
F 0761 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure medication was labeled with the current physician orders [REDACTED]. Findings include: R60's Order Recap Report, printed on 3/5/20 revealed the following route order changes. -A 2/7/20 order for [MED] 5 mg by mouth two times a day changed to 5 mg via pe[DEVICE] 2 times a day on 2/20/20. -A 2/7/20 order for folic acid 1 mg by mouth daily changed to 1 mg via pe[DEVICE] daily on 2/20/20. -A 2/7/20 order for [MEDICATION NAME] 20 mg by mouth daily changed to 20 mg via peg tube daily on 2/20/20. -A 2/7/20 order for [MEDICATION NAME] 25 mg by mouth 2 times a day changed to 25 mg via pe[DEVICE] on 2/20/20. During observations of a medication administration pass on 3/5/20, at 8:28 a.m., registered nurse (RN)-F stated R60 receives some medication via a pe[DEVICE] and some medication orally. RN-F stated she would administer the medication R60 receives via the pe[DEVICE] now and R60's oral medication later, as R60 was sleeping. -RN-F removed a bubble pack of [MED] 5 mg tablets from R60's medication cupboard. The [MED] label directed to administer 1 tablet by mouth twice daily. RN-A placed 1 tablet in a medication cup. -RN-F removed a bubble pack of folic acid 1 mg tablets from R60's medication cupboard. The folic acid label directed to administer 10mg by mouth daily. RN-F placed the medication in a separate medication cup. -RN-F removed a bubble pack of [MEDICATION NAME] 20 mg tablets from R60's medication cupboard. The [MEDICATION NAME] label directed to administer 20 mg by mouth daily. RN-F placed the medication in a separate medication cup. -RN-F removed a bubble pack of [MEDICATION NAME] 25 mg tablets from R60's medication cupboard. The [MEDICATION NAME] label directed to administer 25 mg by mouth twice daily. RN-F placed the medication in a separate medication cup. RN-F crushed each medication separately and stated all the medication will be administered via R60's pe[DEVICE]. When asked about the medication labels identifying to administer medication by mouth, RN-F reviewed R60's medication orders and stated R60's [MED], Folic acid, [MEDICATION NAME] and [MEDICATION NAME] are ordered to be administered via R60's pe[DEVICE]. RN-F stated a change of direction sticker to refer to the chart should have been placed on the medication when the medication route direction changed, but this was not done. During an interview on 3/5/20, at 8:28 a.m. the director of nursing (DON) stated when a physician changes the direction of a medication, staff are to place a change of direction sticker on the medication label and refer to the resident's orders for directions. The facility's policy Acquisition, Receiving, Dispensing and Storage of Medications, dated 12/19, directed All medication are packaged in accordance with the location dispensing system and state pharmacy rules. these medications must be labeled according to state pharmacy regulations. Cautionary and accessory instructions, as well as expiration date, will be included. New labels will be applied by the pharmacist or the pharmacist's agent as needed. The policy lacked directions related to change of direction stickers.
F 0880 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide and implement an infection prevention and control program.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**

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F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 2) Based on observation, interview, and document review, the facility failed to ensure proper gloving and hand hygiene was implemented during incontinent cares for 1 of 1 residents (R4) reviewed. Findings include: R4's annual Minimum Data Set ((MDS) dated [DATE], indicated R4 was cognitively intact. R4 required extensive assistance with bed mobility, personal hygiene and with toileting. R4 was always incontinent of bowel and bladder. R4's Care Plan dated [DATE] directed staff to check and change R4 every 2 hours, assist with changing incontinent brief, and assist with cleansing. During observations of morning cares on 3/4/20, at 7:07 a.m. nursing assistant (NA)-C filled up a basin with soap and water, gloved, and brought the basin of water to R4's bedside. NA-C removed the blanket covering R4. NA-C looked at R4's incontinent brief and stated R4 was very wet. NA-C unfastened the brief and put a washcloth in the soapy water basin. NA-C cleaned R4's perineal area with the washcloth and used another towel to dry the area. NA-C cued and assisted R4 to roll to his right side. Stool was observed on R4's buttocks. NA-C removed the soiled incontinent brief. NA-C did not removed her gloves or perform hand hygiene. With the same gloved hands, NA-C put a new towel in the soapy water and washed R4's back. NA-C then used the soapy towel to clean the stool from R4's buttocks. NA-C dried R4's back and buttocks with a new dry towel. NA-C, did not remove her gloves and perform hand hygiene. With the same gloved hands, NA-C pulled down R4's clean shirt, placed a lift sling under R4, placed and secured a new incontinent brief on R4, and pulled up R4's pants. NA-C then removed her gloves, dumped the soapy water filled basin into the toilet and washed her hands with soap and water. During an interview on 3/4/20, at 7:37 a.m. NA-C stated gloves are to be removed and hands washed after performing perineal care. NA-C stated she did not do this and did not know why she did not. During an interview on 3/5/20, at 2:46 p.m. the director of nursing (DON) stated staff are to remove gloves after providing perineal care where urine and stool are present, wash hands and glove again before continuing with cares. The facility's policy Hand Washing and Glove Use dated 7/18, directed hands are washed thoroughly before putting gloves on and after taking gloves off. The use of gloves does not eliminate the need for proper hand washing or good hygiene. Gloves are to be worn when contact with bodily fluid is expected. Gloves are changed after coming in contact with body fluids. Staff are to wash hands before and after using gloves.