STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	03/05/2020

NAME OF PROVIDER OF SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

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E 0018 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish procedures for tracking staff and patients during an emergency.** Based on interview and document review, the facility failed to develop and implement emergency preparedness policies and procedures that included a system to track residents and both on-duty staff during evacuation in the case of an emergency, this had the potential to effect all 82 residents currently residing the facility as well as staff. Findings include: The facilities Emergency Preparedness Program Plan, revised 2/27/20, did not include a system to track the location of on-duty staff and sheltered residents that would require evacuation during an emergency. The policy under the evacuation section included, At least (1) staff member would accompany residents in each vehicle. Designated staff member to remain behind at evacuation site. Residents would be checked in at the evacuation site and when entering the vehicle using hand written log. Head count total per vehicle and site. The procedure did not indicate how evacuating on-duty staff would be tracked. During interview on 3/2/20, at 1:55 p.m. registered nurse (RN)-B stated the policy and plan did not have a tracking system that would document both on-duty staff and residents being evacuated. RN-B stated that names of residents being evacuated would be recorded on a hand written tablet. During interview on 3/2/20, at 1:58 p.m. director of nursing (DON) confirmed the emergency preparedness policy and procedures did not include a system to track on-duty staff during an evacuation.
E 0024 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish policies and procedures for volunteers.** Based on document review and interview, the facility failed to develop policies and procedures in response to accepting and vetting volunteers that may be assisting in resident evacuation or sheltering in place or in other staffing strategies designed to address surge needs during an emergency. This had the potential to affect all 82 residents currently residing in the facility. Findings include: The facilities Emergency Preparedness Program Plan, revised 2/27/20, failed to include a system to include the integration of State and Federal volunteer health care professionals to address surge needs during an emergency. During interview on 3/2/20, at 1:38 p.m. registered nurse (RN)-B stated the policy and plan did not have a method or procedure that addressed managing volunteers during an emergency. During interview on 3/2/20, at 1:39 p.m. director of nursing (DON) confirmed the emergency preparedness policy and procedures did not have a method or procedure that addressed managing volunteers during an emergency.
E 0026 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish roles under a Waiver declared by secretary.** Based on interview and document review, the facility failed to ensure their emergency preparedness policies and procedures addressed the role of the facility under a waiver declared by the Secretary, in accordance with section 1135 of the Act, (a waiver designed to waive specific regulatory requirements in order to more easily provide needed care in an emergency situation) in the provision of care and treatment at an alternate care site identified by emergency management officials. This had the potential to affect all 82 residents, staff and visitors at the facility. Findings include: The facility policy and procedures for emergency preparedness, revised 2/27/20, failed to address the role of the facility under a 1135 waiver by declared by the Secretary. When interviewed on 3/2/20, at 1:42 p.m. registered nurse (RN)-B stated the facility emergency preparedness plan and procedures did not document facility operations or procedures under a 1135 waiver. When interviewed on 3/2/20, at 1:44 p.m. director of nursing (DON) verified the facility emergency preparedness plan and procedures did not document facility operations or procedures under a 1135 waiver.
E 0032 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Provide primary/alternate means for communication.** Based on interview and document review, the facility failed to ensure policies and procedures addressed alternative means of communication with staff and local emergency management resources in the event of an emergency. In addition, the facility emergency preparedness communication plan did not include both primary and alternative communication means with State and Federal emergency management resources. This had the potential to affect all 82 residents who resided at the facility. Findings include: The facilities Emergency Preparedness Program Plan, revised 2/27/20, failed to identify alterative communication means with local emergency management resources in the Emergency Phone Numbers section of the plan. In addition, the facility emergency preparedness communication plan did not include both primary and alternative communication means with State and Federal emergency management resources. During interview on 3/2/20, at 2:02 p.m. maintenance (M)-A stated the policy and plan did not have a did not include alternative means to contact emergency management resources and stated the facility was not aware of this requirement. During interview on 3/2/20, at 2:04 p.m. director of nursing (DON) confirmed the emergency preparedness policy and procedures did not did not have alternative means of contacting emergency management resources and primary contact information for State and Federal emergency management resources were not in the emergency preparedness communication plan.
E 0037 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Many	**Establish staff and initial training requirements.** Based on document review and interview, the facility failed to conduct annual training of the emergency preparedness plan with staff. This had the potential to affect all 82 residents and staff. Findings include: The facilities Emergency Preparedness Program Plan, revised 2/27/20, identified the most recent Annual Emergency Preparedness Training, as occurring on 12/31/18. During interview on 3/2/20, at 2:10 p.m. registered nurse (RN)-B stated the the last staff emergency preparedness training based on the facility's emergency preparedness plan and annual plan revisions had occurred on 12/31/18. RN-B stated the facility was not aware that this was an annual requirement. During interview on 3/2/20, at 2:12 p.m. director of nursing (DON) confirmed the the facility had not conducted emergency preparedness training based on the facility's emergency preparedness plan and annual plan revisions during the last year.
F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Reasonably accommodate the needs and preferences of each resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review the facility failed to comprehensively assess and develop intervention to accommodate needs and promote independence with the ability to perform hand hygiene and utilize the sink in the resident's bathroom for 4 of 4 residents (R118, R24, R50 and R116) reviewed for accommodation of needs. Findings include: R118 was admitted on [DATE], with a [DIAGNOSES REDACTED]. R118's admission Minimum Data Set ((MDS) dated [DATE] identified intact cognition and was dependent with transfers and locomotion, requiring an assist of 1 person. R118's care plan with revision date of 2/27/20, identified a self care performance deficit related to R118's left knee sprain and resulting weakness. R118's care plan goal was to improve R118's level of function in R118's ability to perform self cares. R118's physical therapy plan of care dated 2/28/20, identified R118's discharge plan was to return home and be independent with self cares. During interview on 3/4/20, at 10:49 a.m. R118 stated that R118 had difficulty reaching the soap dispenser in R118's bathroom due to where it was located on the wall. R118 was observed in R118's wheelchair trying to reach the soap dispenser which was mounted on the wall in the bathroom next to the sink and above the counter. It was observed due to the

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F 0558 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 1) height and the depth of the counter, in a wheelchair, R118 needed to stretch to be able to use the soap dispenser. R118 stated, It would be nice if they could give me a soap dispenser I could move and reach more easily. R118 stated often R118 wanted to become more independent with hand washing and often needed to use the soap and needed to use the call light and wait in order to wash or do self cares. R24 was admitted on [DATE], with a [DIAGNOSES REDACTED]. R24 was wheelchair dependent due a left leg immobilizer which prevented R24 from flexing the left knee. R24's admission MDS dated [DATE], identified R24 had intact cognition and was dependent with transfers and locomotion, requiring an extensive assist of 2 people. R24's care plan with revision date of 2/28/20, identified a self care performance deficit related to weakness and the 2 fractures. R24's care goal was to improve R24's level of function in relation to R24's ability to perform self cares and personal hygiene. R24's physical therapy plan of care dated 2/29/20 identified R24's discharge plan was to return home and be independent with self cares. During interview on 3/4/20, at 1:21 p.m. R24 stated that R24 had difficult reaching the soap dispenser in the bathroom with the identical counter set up, and needed to use the call light to perform hand washing. R24 stated R24 wanted to become more independent and this was made more difficult with not being able to reach the soap dispenser and having to use the call light. R50 was admitted from the hospital on [DATE], with a [DIAGNOSES REDACTED]. R50's care plan with revision date of 2/20/20, identified R50 had a limit with mobility due to weakness and required a wheelchair for locomotion. R50's admission MDS dated [DATE], identified R24 had intact cognition and was dependent with transfers and locomotion, requiring an extensive assist of 1 person. R50's care plan also identified R50 had a self care deficit related to weakness from the [MEDICAL CONDITION] hospitalization and R50's goal was to improve R50's level of function in being able to be independent with personal hygiene. R50's physical therapy plan of care dated 2/20/20, identified R50's discharge plan was to return home and be independent with self cares. During interview on 3/5/20, at 8:35 a.m. R50 stated that with being in a wheelchair the soap dispenser in the bathroom was difficult to reach, stating, I am lucky I am taller and my arms are long but I really have to stretch to get at the soap in the bathroom. R116 was admitted on [DATE], following a hospitalization for right hip dislocation and right hip arthroplasty (surgical repair). R116's admission MDS dated [DATE], identified R116 had intact cognition and was dependent with transfers and locomotion, requiring an extensive assist of 1 person. R116's care plan identified R116 had a self care deficit related to weakness and being wheelchair dependent from the right hip dislocation. R116's care plan goal was to improve R116's level of function in R116's ability to perform self cares. R118's physical therapy plan of care dated 2/28/20, identified R118's discharge plan was to return to R116's assisted living and be independent with self cares. During interview on 3/5/20, at 8:42 a.m. R116 stated the with being in a wheelchair and having a leg immobilizer on, they could not reach the soap dispenser in the bathroom, otherwise could wash hands independently. R116 stated R116 wanted to become more independent in self cares, but because of this, needed to call for assistance to perform hand hygiene. During interview on 3/4/20, at 1:38 p.m. maintenance (M)-A stated the process for if a resident wanted to have a moveable soap dispenser, was for the aide or the nurse to notify maintenance and one could be added to the resident's bathroom. M-A stated they were not aware of any requests being made for moveable soap dispensers or soap dispensers that were easier to reach for residents in wheelchairs. M-A stated this would be something the facility could improve for residents. During interview on 3/5/20, at 8:09 a.m. housekeeper (H)-A stated they were not aware that the soap dispensers in the bathroom were difficult for some residents to reach. During interview on 3/5/20, at 8:25 a.m. H-B stated they were not aware that the soap dispensers in the bathroom were difficult for some residents to reach. During interview on 3/5/20, at 9:12 a.m. nursing assistant (NA)-B stated they had seen where it is difficult for shorter residents who are in wheelchairs to be able to reach the soap dispensers in the bathrooms. Stating, Sometimes it is harder for shorter residents to get at the soap on the back wall. NA-B stated when NA-B sees that NA-B lets therapy know the resident is having difficulty. During interview on 3/5/20, at 9:19 a.m. NA-C stated they had observed that depending on the resident's height, it can be difficult for the resident to reach the soap dispenser in the bathroom. During interview on 3/5/20, at 9:24 a.m. RN-C identified the facility on admission with a resident performs a diagnostic questionnaire with each resident that is used to identify what type of room is required and what accommodations will be needed for the resident in that room. RN-C stated that if any staff members notices room accommodations that need to be made to promote independence, the resident's nurse is notified of the need(s). The nurse then notifies maintenance. During interview on 3/5/20, at 9:58 a.m. RN-D stated admissions does an assessment for each resident. RN-D stated there is not a form that is used and recorded for the assessment. RN-D stated that if a resident has room accommodation needs the process is for physical therapy or occupation therapy to identify the needs and make suggestions. During interview on 3/5/20, at 10:10 a.m. physical therapist (PT)-A stated when a resident is admitted , a room assessment is done and the assessment is ongoing during the coarse of rehabilitation. PT-A stated this assessment includes observing the residents ability to perform self cares in the bathroom. PT-A stated the goal of the assessment and the therapy is to have the resident become as independent as possible with self cares. Soap dispensers should be easily accessible. During interview on 3/5/20, at 10:22 a.m. director of nursing (DON) stated that if a resident required assistance with self cares it would be noted on the MDS and the care plan. DON stated that if the resident required assistance with hand washing or oral care the expectation is for the resident to use the call light. The facility policy Accommodation of Resident Need, dated February 2013, identified under purpose, To ensure resident individual needs and preferences are reasonably accommodated. With under procedure listed, The center should attempt to adapt things such as schedules, call systems and room arrangements to accommodate residents' preferences, desires and unique needs .
F 0571 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Limit the charges against residents' personal funds for items or services for which payment is made under Medicare or Medicaid.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to provide shaving supplies and services covered by payment for his stay for 1 of 1 resident (R28) reviewed for covered services. Findings include: R28's Minimum Data Set (MDS) entry tracking, dated 1/2/20 and discharge MDS 1/27/20, revealed a stay covered by R28's Medicare Benefits. R28's most recent none of the above minimum data set (MDS), dated [DATE], revealed R28 had a stay covered by Medicare benefits from 1/28/20 to 2/11/20. R28's admission minimum data set (MDS), dated [DATE], revealed R28 was cognitively intact, did not reject cares and required limited assist of one staff person for personal hygiene. R28 did not use anticoagulation medications. On 3/2/20, at 7:17 p.m. R28 was observed with a full beard covering entire face and onto the neck. R28 reported he had discussed shaving with staff but had been told he was not allowed to have sharp objects. R28 reported he preferred to be clean shaven. On 3/5/20, at 9:37 a.m. R28 was observed with a full untrimmed beard over most of face and front portion of neck. R28 was in his room visiting with a close family member (F)-A. R28 reported he would prefer to be clean shaven. The facility had not provided him with a razor to use. F-A reported R28 had previously worn a goatee and beard right around his mouth, but not clean shaven or a full beard on entire face and front of neck. F-A reported the facility had asked family to bring in an electric razor. F-A reported family was unable to find or purchase a razor for R28. On 3/5/20, at 9:43 a.m. nursing assistant (NA)-D reported she had not shaved R28 as a razor was not available. NA-D reported the family had been asked to bring in a razor as a razor was not supplied for residents in the post acute unit. There were not razors available for residents on post-acute unit. On 3/5/20, at 9:54 a.m. registered nurse (RN)-F reported she thought R28 preferred a beard, but had not asked him. RN-F checked R28's room and found no razor. RN-F reported the post acute unit did not supply razors and instead asked family to bring razors in for residents. On 3/5/20, at 10:11 a.m. registered nurse and unit manager, RN-G reported the post acute unit asked family to supply razors. RN-G reported if the family did not supply the razor, then the facility should provide one. The Shaving Policy, dated 8/18, directed staff that equipment required, razor of resident choice when not on anti-coagulation therapy. An email attachment, dated 3/6/20, revealed Upon admission to our facility on 1/2/20, (R20) had a full beard. It is our procedure to ask family to bring in any grooming supplies that a resident is accustomed to using. The family admit that they were asked to bring in an electric razor. A policy on supplies covered by the facility and those to be supplied by resident or family was requested but not provided.
F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to ensure 1 of 1 residents (R13) reviewed for dental, was accurately assessed for dental status on the admission Minimum Data Set (MDS) Resident Assessment Instrument (RAI). Findings include: R13's admission MDS, dated [DATE], revealed R13 experienced frequent pain at 8 (with 0 no pain and

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F 0641 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 2) 10 most severe pain) affecting sleep. R13 was not coded as having, Abnormal mouth tissue (ulcers, masses, oral [MEDICAL CONDITION], including under denture or partial if one is worn, or Mouth or facial pain, discomfort or difficulty with chewing. R13 was cognitively intact. R13's [DIAGNOSES REDACTED]. R13's February 2020 Medication Administration Record [REDACTED]. R13 utilized the pain medications at least daily between 2/15/20 and 2/21/20. R13's nursing admission assessment, dated 2/15/20 included a skin observation and pain assessment. R13's skin observation assessment, dated 2/15/20, revealed, partial glossectomy (surgical removal of part of the tongue). R13's pain assessment, dated 2/15/20, revealed pain at an 8 out of 10 (0 being no pain and 10 being severe pain) almost constantly related to, mouth pain due [MEDICAL CONDITION]. R13's progress noted, dated 2/18/20, included, Mouth somewhat sore after supper. R13's progress note, dated 2/19/20, included, Mouth still sore. R13's nurse practitioner visit summary, dated 2/18/20, included, Today she was seen for increased pain left side of her mouth rating it at 9 out of a 10. R20's nutritional assessment, dated 2/20/10, included, Has been eating mainly softer foods recently, r/t (related to) tongue/mouth [MEDICAL CONDITION]. Now s/p (status [REDACTED]. A care area for pain triggered and revealed, She reports having pain mouth s/p glossectomy due to [MEDICAL CONDITION]. On 3/3/20, at 1:48 p.m. R13 was observed in her room dotting her mouth with a tissue. When asked if R13's mouth hurt, R13 stated, Oh boy does it ever. R13 reported her first couple days at the facility, It hurt so bad. On 3/4/20, at 1:14 p.m. the registered nurse and Resident Assessment Instrument (RAI) coordinator, (RN)-E, explained the floor nurses do the dental observation and assessment and she completed the pain assessment with residents. RN-E reported she was responsible for entering the data for the MDS and completing the dental and pain care area assessment. RN-E reported R13's MDS, dated [DATE] was completed. RN-E confirmed R13 did not have coded the presence of, Abnormal mouth tissue (ulcers, masses, oral [MEDICAL CONDITION], including under denture or partial if one is worn, or, Mouth or facial pain, discomfort or difficulty with chewing. RN-E reported she coded R13 had pain presence and felt it was her clinical judgement to code mouth or facial pain or discomfort. RN-E reported she did not code abnormal mouth tissues as R13 had [MEDICAL CONDITION] tissue removed with the glossectomy. RN-E reviewed the MDS manual and reported R13's MDS, dated [DATE], may be inaccurate related to oral/dental status. The CMS'S (Centers for Medicare and Medicaid Services) RAI Version 3.0 Manual; Section L Oral/ Dental Status, dated July 2010, directed staff, This item is intended to record any dental problems present in the 7 day look back period. Coding instructions included : Check L0200 F, Mouth or facial pain, discomfort or difficulty with chewing if the resident reports any pain in the mouth or face, or discomfort with chewing. Coding instructions included: Check L0200 C, abnormal mouth tissue (ulcers, masses, oral [MEDICAL CONDITION]): Select if any ulcer, mass, or oral lesion is noted on any oral surface. The manual further directed staff, Mouth or facial pain coded for this item should also be coded in Section J0100 through J0850.
F 0676 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure 1 of 3 residents (R28)reviewed for activities of daily living was provided assistance to shave according to his preferences. Findings include: R28's admission minimum data set (MDS), dated [DATE], revealed R28 was cognitively intact, did not reject cares and required limited assist of one staff person for personal hygiene. R28 did not use anticoagulation medications. R28's care plan, dated as admission on 1/2/20 with a print date of 3/5/20, directed staff, PERSONAL HYGIENE: Resident requires limited assist of 1 staff. On 3/2/20, at 7:17 p.m. R28 was observed with a full beard covering entire face and onto the neck. R28 reported he had discussed shaving with staff but had been told he was not allowed to have sharp objects. R28 reported he preferred to be clean shaven. Staff had not assisted him to shave either. On 3/03/20, at 1:51 p.m. R28 was observed getting his coat on and still had a full untrimmed beard over entire lower face and most of neck. On 3/4/20, at 7:38 a.m. R28 was observed unshaven with whiskers on most of face and front portion of neck. On 3/4/20, at 11:07 a.m. R28 was observed with a untrimmed beard over most of face and front portion of neck. On 3/5/20, at 9:37 a.m. R28 was observed with a full untrimmed beard over most of face and front portion of neck. R28 was in his room visiting with a close family member (F)-A. R28 reported he would prefer to be clean shaven. The facility had not provided him with a razor to use, nor assisted him with shaving, even though he had asked. F-A reported R28 had previously worn a goatee and beard right around his mouth, but not clean shaven or a full beard on entire face and front of neck. F-A reported the facility had asked family to bring in an electric razor. F-A reported family was unable to find or purchase an electric razor for R28. On 3/5/20, at 9:43 a.m. nursing assistant (NA)-D reported she had not shaved R28, as a razor was not available. NA-D reported the family had been asked to bring in a razor as a razor was not supplied for residents in the post acute unit. On 3/5/20, at 9:54 a.m. R28's registered nurse, (RN)-F reported she thought R28 preferred a beard, but had not asked him. RN-F checked R28's room and found no razor. RN-F reported the post acute unit did not supply razors and instead asked family to bring razors in for residents. On 3/5/20, at 10:11 a.m. R28's registered nurse and unit manager (RN)-G reported the post acute unit asked family to supply razors. RN-G reported if the family did not supply the razor, then the facility should provide one. RN-G reported she expected staff to offer shaving services to residents. The Shaving Policy, dated 8/18, directed staff that equipment required, razor of resident choice when not on anti-coagulation therapy and Encourage resident to shave or assist as needed.
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Provide appropriate treatment and care according to orders, resident's preferences and goals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and document review, the facility failed to properly prepare a resident for scheduled surgery, by allowing resident to eat breakfast on day of surgery, for 1 of 1 residents (R33) who was reviewed for quality of care. Findings include: R33's quarterly Minimum Data Set ((MDS) dated [DATE], identified R33 was cognitively intact and required minimal assist with activities of daily living (ADLs). During observation on 3/4/20, at 1:13 p.m. R33 wheeled to the nurses station and stated, Well that was a waste of time. I was not supposed to eat anything this morning. When interviewed on 3/4/20, at 1:23 p.m. R33 stated, They had to cancel it (cataract surgery). I wasn't supposed to eat or drink and the nurse never said anything. They put the drops in my eyes and everything. I ate breakfast. When interviewed on 3/4/20, at 1:35 p.m. nursing assistant (NA)-A stated NAs received report from the night nurse. The night nurse should tell me anything I need to know. NA-A further verified being aware that R33 was having surgery, but did not know if R33 was supposed to be NPO (nothing by mouth) for eye surgery she had not been told he was not to. When interviewed on 3/4/20, at 1:38 p.m. license practical nurse (LPN)-A stated that NPO status was normally on the Medication Administration Record [REDACTED]. LPN-A further stated that R33 did not know not to eat anything before surgery. It is written on the 24-hour report, but was not verbally communicated during shift report. LPN-A stated that the night nurse typically wrote in communication book throughout the shift and then would report off all items to the day nurse. LPN-A confirmed that R33's NPO status displayed on the MAR for the night shift but did not carry over to the day shift, Whoever enters the order should notify dietary. When interviewed on 3/4/20, at 1:44 p.m. registered nurse (RN)-A stated R33's NPO status was on the MAR but dropped off at 7:00 a.m. RN-A confirmed the nurse that entered the order should have completed a dietary slip and turned it into nutrition. If it was during the night, the nurse should have taped it to the kitchen door. RN-A stated the expectation for morning report off would include any appointment, procedure, changes in medications, new or change in condition and changes in required cares. RN-A further stated, When I have observed the shift to shift report, they are looking at the 24-hour report (communication book), reading it and giving verbal report. When interviewed on 3/4/20, at 1:53 p.m. dietary supervisor (DS) confirmed, nutrition services should receive a diet order sheet when the order is first placed. DS further stated that the kitchen would communicate the diet change to the kitchen aide serving the resident involved. DS checked with the kitchen and confirmed there were no slips for that day and dietary staff was not aware R33 should not be provided breakfast. When interviewed on 3/4/20, at 2:50 p.m. the director of nursing (DON) verified and stated the off-going nurse and the on-coming nurse should review the 24-hour report sheet together along with a verbal hand off. They write things throughout the shift so the next nurse would know. DON further stated the nurse who received the order should enter the order and then either notify dietary by phone or send them a note. They (the nurse receiving the order) should see it all the way through. R33's medication review report indicated R33 was to have, Cataract Procedure: Arrive to 2080 Woodwinds Dr. Woodbury MN at 11:30 AM No food after midnight, Ok for clear liquids only till 7:30 AM day

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0684 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 3) of procedure. OK for all AM pills with sip of water. Continue [MEDICATION NAME]. Bring Photo ID and insurance information. Bring Prednisoine (sic) with to appointment. No valuable. Bath and wash hair the night prior to procedure. R33's MAR indicated [REDACTED]. May have clear liquids till 7:30 AM. Ok for (sic) take all medication AM of procedure with sit (sic) of water. An undated handwritten explanation of the facility's pre-operation process provided by the DON indicated the staff should, follow the orders and instructions that are given to us from the clinic or M.D. (medical doctor). It is different for every operation, procedure or clinic or hospital and also per person (resident). The undated facility policy titled Food and Nutrition Services Diet Order indicated a process for communication of new diet orders. The policy indicated that when staff received a new diet order or a change to an existing order, a Diet Order Notification (GSS #297) should be completed and given to the food and nutrition department. The facility training titled Mandatory Education Related to Resident/Patient Care dated 8/8/16, identified the process for shift report for nursing staff. It is required that the licensed nurse coming on is to receive report from the nurse going off duty. It is also required that the nurse give report to the CNAs (certified nursing assistants) at the beginning of each shift and receive report from the CNAs prior to the end of each shift. Communication and continuity of care is essential for the resident's quality of care, safety and quality of life.
F 0812 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview and document review, the facility failed to ensure hand hygiene during food service was maintained for residents served in the sub acute dining room. This had the potential to impact 15 of 15 residents (R35, R264, R265, R44, R266, R41, R270, R2, R60, R272, R54, R57, R13, R122, and R28) served by the post acute 2 dining room. In addition the facility failed to ensure orange drink supplements were safely stored. This had the potential to impact 5 of 5 residents (R47, R15, R33, R19, and R17) receiving the orange drink supplement on long term care north unit. Findings include: Dining service on the post acute unit 2 was observed on 3/2/20, from 5:00 p.m. to 6:00 p.m. Cook-A was observed with bare hands touching name cards, rolled up a sheet of wax paper in a crumple then used it to grab rolls out of a bag and serve to residents. Cook-A touched her face and glasses then continued to serve without washing hands, using a crumpled up piece of wax paper and touching the inside of the roll bag then taking sandwiches out of a serving tin and serve to residents. Cook-A touched her face and glasses and continued to serve residents sandwiches without washing her hands. Cook-A touched the garbage bin while throwing out food on a plate and continued to served food without washing hands. On 3/5/20, at 1:15 p.m. the dietary manager (DM) reported staff should wash hands after touching their mouth and face, before serving food and should not touch food with bare hands. On 3/5/20, from 1:15 p.m. to 2:16 p.m. the kitchen and kitchenettes were toured. Three thawed orange nutritional supplements were found in the long term care north kitchenette with no date or indication of a thaw date. Instructions on the carton directed staff the orange drink supplement was safe for fourteen days after thawing. Cook-B reported she was not aware when the orange drink supplement was placed in the refrigerator or when it was no longer able to be safely served. Cook-B reported she would go by the expiration date on the orange drink supplement, but was unable to find an expiration date. A box of 50 thawed orange drink was found in the main kitchen. No deliver or thaw date was found on the box. The registered dietitian (RD)-A reported the orange drink supplement were safe for 14 days after thawing. RD-A was not aware of when the box of orange drink supplement was delivered or thawed. RD-A reported the facility did not have a system to date orange drink supplement when thawed. A list provided by the facility, dated 3/5/20, revealed the following residents routinely received orange drink supplement on long term care north: R47, R15, R33, R19, and R17. A list provided by the facility, dated 3/5/20, revealed the following residents were served out of the post acute dining room [ROOM NUMBER]: R35, R264, R265, R44, R266, R41, R270, R2, R60, R272, R54, R57, R13, R122, and R28. The Medical Nutritional Supplement policy, last revised 9/2017, directed staff, Medical Nutrition Supplements will be: a. Prepared under sanitary conditions, b. labeled, dated and include resident's name when appropriate, c. covered during transport, d. served chilled for improved acceptance, e. handled according to manufacture recommendations for proper handling and storage. The Hand Washing and Glove Use policy, last revised 7/2018, directed staff, When to wash hands .b. After touching any contaminated object (face, hair, body or clothing; garbage or dirty utensils, dirty dishes, phone, linen or money.