DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 108E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

4. TYPE OF ACTION: **7** (L8)

1. Initial — 2. Recertification
3. Termination — 4. CHOW
5. Validation — 6. Complaint
7. On-Site Visit — 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **07/26/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited — 1 TJC
2 AOA — 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **81** (L18)
13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC
B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Thomas Linhoff, DSFM — 07/26/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist — 08/04/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
X 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :

22. ORIGINAL DATE OF PARTICIPATION
04/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30) **00**

VOLUNTARY
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 08/15/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/02/2016
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

CMS Certification Number (CCN): 245221
August 4, 2016

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, MN 55117

Dear Ms. Jensen:

The Minnesota Department of Health assists the Centers for Medicare and Medicaid Services (CMS) by surveying skilled nursing facilities and nursing facilities to determine whether they meet the requirements for participation. To participate as a skilled nursing facility in the Medicare program or as a nursing facility in the Medicaid program, a provider must be in substantial compliance with each of the requirements established by the Secretary of Health and Human Services found in 42 CFR part 483, Subpart B.

Based upon your facility being in substantial compliance, we are recommending to CMS that your facility be recertified for participation in the Medicare and Medicaid program.

Effective July 25, 2016, the above facility is certified for or recommended for:

81 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 81 skilled nursing facility beds.

You should advise our office of any changes in staffing, services, or organization, which might affect your certification status.

If, at the time of your next survey, we find your facility to not be in substantial compliance your Medicare and Medicaid provider agreement may be subject to non-renewal or termination.

Please contact me if you have any questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

cc: Licensing and Certification File

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
August 2, 2016

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, MN 55117

RE: Project Number F5221025 & S5221027

Dear Ms. Jensen:

On March 22, 2016, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 17, 2016. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On April 28, 2016, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 17, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 18, 2016. Based on our revisit and a Federal Monitoring Survey completed May 3, 2016, we have determined that your facility has obtained substantial compliance with, but has not totally corrected, the deficiencies issued pursuant to our survey, completed on March 17, 2016, effective April 25, 2016.

Due to our findings, we recommended the following action to the Centers for Medicare and Medicaid Services (CMS) Region V Office:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective April 25, 2016 be rescinded. (42 CFR 488.417 (b))

Additionally, on May 19, 2016, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 3, 2016.

Also, we notified you in our letter of May 19, 2016, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from August 3, 2016.

This was based on the deficiencies cited by this Department for a standard survey completed on March 17, 2016, and a Federal Monitoring Survey (FMS) completed May 3, 2016 and lack of verification of substantial compliance with the Life Safety Code (LSC) deficiencies at the time of our May 19, 2016 notice. The most serious LSC deficiencies in your facility at the time of the Federal Monitoring Survey were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On July 26, 2016, the Minnesota Department of Public Safety completed a Post Certification Revisit (PCR) to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey completed March 15, 2016, and a Federal Monitoring Survey (FMS) completed on May 3, 2016. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 25, 2016. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on May 3, 2016, as of July 25, 2016.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in our letter of May 19, 2016. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective August 3, 2016, be rescinded. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective August 3, 2016, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective August 3, 2016, is to be rescinded.

In our letter of May 19, 2016, we advised you that, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from August 3, 2016, due to denial of payment for new admissions. Since your facility attained substantial compliance on July 25, 2016, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

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

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245221	A. Building B. Wing	4/28/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix F0279 Reg. # 483.20(d), 483.20(k)(1) LSC	Correction Completed 04/25/2016	ID Prefix F0309 Reg. # 483.25 LSC	Correction Completed 04/25/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 08/02/2016	SIGNATURE OF SURVEYOR 16022	DATE 04/28/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/17/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER (Y1)	MULTIPLE CONSTRUCTION (Y2)	DATE OF REVISIT (Y3)
245221	A. Building 01 - MAIN BUILDING 01 B. Wing	7/26/2016

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix Reg. # NFPA 101 LSC K0052	Correction Completed 04/25/2016	ID Prefix Reg. # NFPA 101 LSC K0144	Correction Completed 04/25/2016	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS) SR/KJ	DATE 08/02/2016	SIGNATURE OF SURVEYOR 12424	DATE 07/26/2016
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON	
3/15/2016	☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER	MULTIPLE CONSTRUCTION	DATE OF REVISIT
245221 Y1	A. Building 01 - MAIN BUILDING 01 B. Wing Y2	7/26/2016 Y3

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0017	07/25/2016	LSC K0018	07/25/2016	LSC K0020	07/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0025	07/25/2016	LSC K0027	07/25/2016	LSC K0038	07/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed
LSC K0052	07/25/2016	LSC K0054	07/25/2016	LSC K0056	07/25/2016
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. # NFPA 101	Completed	Reg. # NFPA 101	Completed	Reg. #	Completed
LSC K0062	07/25/2016	LSC K0069	07/25/2016	LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☐	REVIEWED BY (INITIALS)	DATE	SIGNATURE OF SURVEYOR	DATE
	TL/KJ	08/02/2016	12424	07/26/2016
REVIEWED BY CMS RO ☐	**REVIEWED BY (INITIALS)**	**DATE**	**TITLE**	**DATE**

FOLLOWUP TO SURVEY COMPLETED ON
5/3/2016

☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES — **CENTERS FOR MEDICARE & MEDICAID SERVICES**

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 108E

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**

2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 EAST ROSELAWN AVENUE**
(L5) **MAPLEWOOD, MN** (L6) **55117**

4. TYPE OF ACTION: **2** (L8)
1. Initial 2. Recertification
3. Termination 4. CHOW
5. Validation 6. Complaint
7. On-Site Visit 9. Other
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/17/2016** (L34)

8. ACCREDITATION STATUS: ___ (L10)
0 Unaccredited 1 TJC
2 AOA 3 Other

7. PROVIDER/SUPPLIER CATEGORY **02** (L7)

01 Hospital	05 HHA	09 ESRD	13 PTIP	22 CLIA
02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	
03 SNF/NF/Distinct	07 X-Ray	11 ICF/IID	15 ASC	
04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	

FISCAL YEAR ENDING DATE: (L35)
12/31

11. .LTC PERIOD OF CERTIFICATION
From (a) :
To (b) :

12.Total Facility Beds **81** (L18)

13.Total Certified Beds **81** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
X 1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers:

And/Or Approved Waivers Of The Following Requirements:
___ 2. Technical Personnel
___ 3. 24 Hour RN
___ 4. 7-Day RN (Rural SNF)
___ 5. Life Safety Code
__ 6. Scope of Services Limit
__ 7. Medical Director
__ 8. Patient Room Size
__ 9. Beds/Room

* Code: **A1*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	81			
(L37)	(L38)	(L39)	(L42)	(L43)

15. FACILITY MEETS
1861 (e) (1) or 1861 (j) (1): (L15)

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):

17. SURVEYOR SIGNATURE — Date :
Mary Heim, HPR Social Work Specialist 03/31/2016 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kate JohnsTon, Program Specialist 04/26/2016 (L20)

PART II - TO BE COMPLETED BY HCFA REGIONAL OFFICE OR SINGLE STATE AGENCY

19. DETERMINATION OF ELIGIBILITY
____ 1. Facility is Eligible to Participate
____ 2. Facility is not Eligible
(L21)

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

21. 1. Statement of Financial Solvency (HCFA-2572)
2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
_____

22. ORIGINAL DATE OF PARTICIPATION
04/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

27. ALTERNATIVE SANCTIONS
A. Suspension of Admissions:
(L44)
B. Rescind Suspension Date:
(L45)

26. TERMINATION ACTION: (L30)
VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal
INVOLUNTARY
05-Fail to Meet Health/Safety
06-Fail to Meet Agreement
OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 05/02/2016 Co.

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MDH
Minnesota
Department
of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Electronically delivered
March 22, 2016

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 East Roselawn Avenue
Maplewood, Minnesota 55117

RE: Project Number S5221027

Dear Ms. Jensen:

On March 17, 2016, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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.

This letter provides important information regarding your response to these deficiencies and addresses the following issues:

Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;

Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;

Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

Potential Consequences - the consequences of not attaining substantial compliance 3 and 6 months after the survey date; and

Informal Dispute Resolution - your right to request an informal reconsideration to dispute the attached deficiencies.

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.

DEPARTMENT CONTACT

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

Susanne Reuss, Unit Supervisor
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
P.O. Box 64900
85 East Seventh Place, Suite 220
St. Paul, Minnesota 55164-0900
Telephone: (651) 201-3793
Fax: 651-215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by April 26, 2016, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC must:

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;

- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;

- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;

- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

The state agency may, in lieu of a revisit, determine correction and compliance by accepting the facility's ePoC if the ePoC is reasonable, addresses the problem and provides evidence that the corrective action has occurred.

If an acceptable ePoC is not received within 10 calendar days from the receipt of this letter, we will recommend to the CMS Region V Office that one or more of the following remedies be imposed:

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));

- Per day civil money penalty (42 CFR 488.430 through 488.444).

Failure to submit an acceptable ePoC could also result in the termination of your facility's Medicare and/or Medicaid agreement.

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

The facility's ePoC will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. In order for your allegation of compliance to be acceptable to the Department, the ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, an onsite revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification. A Post Certification Revisit (PCR) will occur after the date you identified that compliance was achieved in your plan of correction.

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.

Original deficiencies not corrected

If your facility has not achieved substantial compliance, we will impose the remedies described above. If the level of noncompliance worsened to a point where a higher category of remedy may be imposed, we will recommend to the CMS Region V Office that those other remedies be imposed.

Original deficiencies not corrected and new deficiencies found during the revisit

If new deficiencies are identified at the time of the revisit, those deficiencies may be disputed through the informal dispute resolution process. However, the remedies specified in this letter will be imposed for original deficiencies not corrected. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed.

Original deficiencies corrected but new deficiencies found during the revisit

If new deficiencies are found at the revisit, the remedies specified in this letter will be imposed. If the deficiencies identified at the revisit require the imposition of a higher category of remedy, we will recommend to the CMS Region V Office that those remedies be imposed. You will be provided the required notice before the imposition of a new remedy or informed if another date will be set for the imposition of these remedies.

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

If substantial compliance with the regulations is not verified by June 17, 2016 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the

result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

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 September 17, 2016 (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.

INFORMAL DISPUTE RESOLUTION

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/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: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

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.

Questions regarding all documents submitted as a response to the Life Safety Code deficiencies (those preceded by a "K" tag), i.e., the plan of correction, request for waivers, should be directed to:

Mr. Tom Linhoff, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
Email: tom.linhoff@state.mn.us
Telephone: (651) 201-7205
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kate JohnsTon, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
85 East Seventh Place, Suite 220
P.O. Box 64900
St. Paul, Minnesota 55164-0900
kate.johnston@state.mn.us
Telephone: (651) 201-3992 Fax: (651) 215-9697

Enclosure
cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	03/17/2016

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

(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 The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic POC, an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279		4/25/16

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

Electronically Signed | 03/31/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	03/17/2016

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F 279	Continued From page 1 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive plan of care regarding hospice care for 1 of 1 resident (R102) reviewed for hospice, and regarding diabetes for 1 of 5 residents (R95) reviewed for unnecessary medications. Findings include: R102 did not have a comprehensive and individualized plan of care for hospice care. Record review revealed a hospice provider's care plan for R102 with a start date of 12/15/15. The record also contained a hospice certification form showing that R102 was recertified for hospice care on 3/14/16, with a terminal diagnosis of Parkinson's disease. The facility's current care plan, dated 2/8/16, contained one Focus related to the resident's condition that read, "The resident has a terminal prognosis R/T Parkinson's disease and dementia," but there was no reference to hospice care in the care plan. The hospice provider's care plan was generic, with only the facts that the resident enjoyed music and had a Methodist affiliation, as individualized details. When interviewed on 3/17/16 at 11:27 a.m. registered nurse (RN)-A, the nurse manager for R102, stated that she was the staff member who generally completed care plans for resident's on R102's unit and she usually includes much more detail related to hospice care in the care plan. She went on to explain that she was not sure why this care plan was not completed, but will work on improving care plan completion in the future.	F 279	F279 483.20 (d), 483.20(k) (1)Develop Comprehensive Care Plans Corrective Action for resident R102, R95 R102 has had an interdisciplinary review and re-development of comprehensive individualized care plan to address integrated hospice care. R95 has had an interdisciplinary review and re-development of comprehensive and individualized care plan to address unstable Diabetes. How to identify other residents with the same issue The facility will perform an interdisciplinary review to identify residents who have hospice care and residents who have Diabetes. Identified residents plan of care will be reviewed and re-developed as needed to include integration of hospice care and individualization and specific needs of care for Diabetes and hospice by the interdisciplinary team. Residents affected will have an interdisciplinary review and development of their care plan upon admission, quarterly, and with change of condition. Recurrence will be prevented by An interdisciplinary individualized care plan will be developed for residents receiving hospice care and residents who have Diabetes upon admission, quarterly and with change of condition. Re-education will be given to all nursing	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	03/17/2016

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

(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 279	Continued From page 2 R95 did not have a comprehensive and individualized plan of care regarding unstable diabetes. Record review for R95 revealed a physician's order, dated 3/7/16, for 18 units of NovoLog insulin to be injected with meals and an order, dated 3/3/16, for 46 units of Lantus insulin to be injected two times a day. The Blood Sugar Summary in the record showed that, since 3/1/16, the resident has had seventeen blood sugar results above 200 and two above 300. The current care plan in the record, dated 5/1/13, contained a Focus that read, "Resident has Diabetes Mellitus.," but the Goals and Interventions entries for this Focus were generic, with no specific details related to this resident and no mention of a pattern of high blood sugars or difficulty with stabilizing the resident's diabetes. When interviewed on 3/17/16, at 9:45 a.m. licensed practical nurse (LPN)-A stated that she often worked on R95's unit and this resident has long had a problem with elevated blood sugars. She explained that the resident did like to snack, liked sweets, and the resident's physician adjusts insulin dosage fairly often to address the elevated blood sugars. The facility's registered dietician (RD) was interviewed on 3/17/16 at 10:06 a.m. and stated that she was aware of the elevated blood sugars. She concurred that the resident did enjoy snacks and sweets, and has a right to her choice of foods for intake. The RD added that she had recently conducted a class for residents that covered healthy food choices and carb counting. R95	F 279	staff, dietary staff, social service staff, and recreational activity staff who complete care plans. Audits will be completed to ensure an interdisciplinary individualized care plan is developed for residents receiving hospice care and for residents who have diabetes as outlined below. These issues will be monitored in the following manner The Director of Nursing and Nurse Managers will audit care plans for residents receiving hospice care and for residents who have Diabetes. Audits will be completed for comprehensive care plan completion weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3 attended this class and asked questions. When interviewed on 3/17/16 at 11:27 a.m. registered nurse (RN)-A, the nurse manager for R95, stated that she was the staff member who generally completed care plans for resident's on R95's unit. She then explained that she found the software program that the facility used for care plan development difficult for adding specific detail about residents, but she will work on improving care plan completion in the future.	F 279		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility failed to develop a comprehensive care plan that addressed hospice care for 1 of 1 resident (R102) who required the provision of necessary care and services for hospice. Findings include: Record review revealed a hospice provider's care plan for R102 with a start date of 12/15/15. The record also contained a hospice certification form showing that R102 was recertified for hospice care on 3/14/16, with a terminal diagnosis of	F 309	F309 483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Corrective Action for resident R102, R102 has had an interdisciplinary review and re-development of individualized comprehensive care plan to address necessary care and services for hospice. How to identify other residents with the same issue The facility will perform an interdisciplinary review to identify residents who receive hospice care. Residents plan of care will	4/25/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 EAST ROSELAWN AVENUE MAPLEWOOD, MN 55117

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F 309	Continued From page 4 Parkinson's disease. The facility's current care plan, dated 2/8/16, contained one Focus related to the resident's condition that read, "The resident has a terminal prognosis R/T Parkinson's disease and dementia," but there was no reference to hospice care in the care plan. The hospice provider's care plan was generic, with only the facts that the resident enjoyed music and had a Methodist affiliation as individualized details. When interviewed on 3/17/16 at 11:27 a.m. registered nurse (RN)-A, the nurse manager for R102, stated that she was the staff member who generally completed care plans for resident's on R102's unit and she usually includes much more detail related to hospice care in the care plan. She went on to explain that she was not sure how this care plan was not completed, but she will work on improving care plan completion in the future.	F 309	be reviewed and re-developed as needed to include necessary care and services for hospice by the interdisciplinary team. Residents affected will have an interdisciplinary review and development of their care plan to include necessary care and services for hospice upon admission, quarterly, and with change of condition. Recurrence will be prevented by An interdisciplinary individualized care plan will be developed for residents receiving necessary care and services for hospice. Re-education will be given to all nursing staff, dietary staff, social service staff, and recreational activity staff. Audits will be completed to ensure an interdisciplinary care plan for necessary care and services is developed for residents on hospice care as outlined below. These issues will be monitored in the following manner The Director of Nursing and Nurse Managers will audit care plans for residents receiving hospice care. Audits will be conducted for comprehensive care plan of necessary care and services for hospice completion weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance committee for further review as needed.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2016**

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

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOU ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPTS OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. BUILDING 1 - 1985, 1993 AND 1996 ADDITIONS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Maplewood was found NOT in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: HEALTHCARE FIRE INSPECTIONS STATE FIRE MARSHAL DIVISION 445 MINNESOTA STREET, SUITE 145 ST. PAUL, MN 55101-5145	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/31/2016

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2016**

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

(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
K 000	Continued From page 1 Or by email to: Angela.Kappenman@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Maplewood Good Samaritan Center is a 2-story building with no basement. The building was constructed at three different times. In 1965 the nursing home was built and was determined to be of Type II(111) construction. In 1967 an addition was constructed to the south of the main building, that was determined to be of Type II(111) construction. In 1997 an addition was constructed to the south and west of the 1967 building that was determined to be of Type II(111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The sleeping rooms	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2016**

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

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K 000	Continued From page 2 in the 1997 addition have single smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code. The facility has a capacity of 96 beds and had a census of 76 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 052 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain the building fire alarm system in accordance with NFPA 101 (00) Chapter 9, Section 9.6 and Chapter 19, Section 19.3.4.1, and NFPA 72 (1999 edition) Sections 7-3.2 and 7-5.2.2 and, Table 7-3.1. This deficient practice could adversely affect 96 of 96 residents. FINDINGS INCLUDE: On 03/01/2016 between 0930 and 1230, while reviewing the facility's fire alarm inspection and testing reports, the Director of Environmental Services failed to produce documentation verifying that the facility's digital alarm communicator transmitter (DACT) was being tested monthly. This finding was confirmed with the Director of Environmental Services (JK).	K 052	K052 1. Monitoring company has been contacted and has agreed to E-mail DACT report on the 1st of each month to Director of Environmental Services. The DES will print off a copy for placement in Life Safety Documentation binder. 2. This item was completed on April 1 2016 3. The correction was made by and will be completed monthly by the DES.	4/25/16

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/15/2016**

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

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K 144 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: Based on review of records and interview, the facility failed to maintain the emergency generator in accordance with the requirements of NFPA 110 - 1999 edition and NFPA 99 - 1999 edition, section 3-4.1.1.2. This deficient practice could affect the safety of all patients, staff and visitors. Findings include: On facility tour between 9:30 AM and 12:30 PM on 03/25/2016, based on review of available documentation it was revealed that there was no documentation for the minimum 5 minute cool down period when testing generator. This deficient practice was verified by the Director of Environmental Services (JK).	K 144	K144 1. Monthly Generator Checklist form has been edited to include 5 minute cool down line to be documented each time the generator is ran. 2. This item was completed on March 17th 2016 3. This correction was made by the Director of Environmental Services and will be completed by the Maintenance Technician monthly.	4/25/16

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Midwest Division of Survey and Certification
Chicago Regional Office
233 North Michigan Avenue, Suite 600
Chicago, IL 60601-5519

CMS Certification Number (CCN): 245221

May 19, 2016
By Certified Mail and Facsimile

Ms. Susan Jensen, Administrator
Good Samaritan Society – Maplewood
550 East Roselawn Avenue
Maplewood, MN 55117

Dear Ms. Jensen:

SUBJECT: FEDERAL MONITORING SURVEY RESULTS
Cycle Start Date: May 3, 2016

FEDERAL MONITORING SURVEY
On May 3, 2016, a surveyor representing this office of the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) at Good Samaritan Society – Maplewood to determine if your facility was in compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs. As the surveyor informed you during the exit conference, the FMS revealed that your facility was not in substantial compliance with the most serious deficiencies at Scope and Severity (S/S) level F, cited as follows:

- K25 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K52 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K54 -- S/S: F -- NFPA 101 -- Life Safety Code Standard
- K62 -- S/S: F -- NFPA 101 -- Life Safety Code Standard

The findings from the FMS are will be posted on the EPOC system.

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 enclosed deficiencies cited at the FMS. To be acceptable, a provider's ePOC must include the following:

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

- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur
- The date that each deficiency will be corrected
- An electronic acknowledgement signature and date by an official facility representative

The POC must be signed and dated by an official facility representative. Please send your POC by fax or email to the following:

Stephen Pelinski, Branch Manager
Fax: (443) 380-6716
Email: Stephen.Pelinski@cms.hhs.gov

Please note, if you choose to email the POC, you must not include any resident personal identifiable information (PII) or personal health information (PHI). Such information may be sent by fax.

If you are unable to send the POC electronically, you may send it to the following address:

Stephen Pelinski, Branch Manager
Centers for Medicare & Medicaid Services
Division of Survey and Certification
233 North Michigan Avenue, Suite 600
Chicago, Illinois 60601-5519

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. However, if substantial compliance is not achieved upon a subsequent visit, we will impose the following remedy against your facility under the authority contained in §1819(h) and §1919(h) of the Social Security Act (the Act):

- Mandatory Denial of Payment for New Medicare and Medicaid Admissions effective August 3, 2016

INFORMAL DISPUTE RESOLUTION

CMS has established an Informal Dispute Resolution (IDR) process to give providers one opportunity to informally refute deficiencies cited at a Federal survey, in accordance with the regulation at 42 CFR § 488.331. To use this process, you must send your written request, identifying the specific deficiencies you are disputing, to Steven Pelinski, Branch Manager, at the Chicago address shown above. The request must set forth in detail your reasons for disputing each deficiency and include copies of all relevant documents supporting your position. A request for IDR will not delay the effective date of any enforcement action, nor can you use it to challenge any other aspect of the survey process, including the following:

- Scope and Severity assessments of deficiencies, except for the deficiencies constituting immediate jeopardy and substandard quality of care;

- Remedies imposed;
- Alleged failure of the surveyor to comply with a requirement of the survey process;
- Alleged inconsistency of the surveyor in citing deficiencies among facilities; and
- Alleged inadequacy or inaccuracy of the IDR process.

You must submit your request for IDR within the same ten (10) calendar day timeframe for submitting your ePOC. You must provide an acceptable ePOC for all cited deficiencies, including those that you dispute. We will advise you in writing of the outcome of the IDR. Should the IDR result in a change to the Statement of Deficiencies, we will send you a revised CMS-2567 reflecting the changes.

An IDR, including any face-to-face meetings, constitutes an informal administrative process that in no way is to be construed as a formal evidentiary hearing. If you wish to be accompanied by counsel for your IDR, then you must indicate that in your written request for informal dispute resolution, so that CMS may also have counsel present.

LIFE SAFETY CODE (LSC) WAIVERS

If you request an annual waiver for a LSC deficiency cited during the FMS, the request must indicate why correcting would impose an unreasonable hardship on the facility; if high cost is the hardship, you must include recent, bona fide cost estimates. In addition, the request must indicate how continued non-correction of the deficiency will not pose a risk to resident safety, based on additional compensating features or other reasons.

Each cited deficiency (other than those which receive annual waivers) must be corrected within a reasonable timeframe. If a reasonable correction date falls beyond your enforcement cycle's three month date, you may request a temporary waiver to allow correction by the reasonable date, and without the noncompliance leading to the imposition of remedies. Include a request for a temporary waiver as part of your POC, indicating the basis for the length of correction time needed, and include a timetable for correction. A temporary waiver may be granted if the POC date extends beyond your enforcement cycle's three month date, and if the correction timeframe is reasonable, in CMS' judgment. Your enforcement cycle's three month date is August 3, 2016.

TERMINATION PROVISION

If your facility has not attained substantial compliance by November 3, 2016, your Medicare and Medicaid participation will be terminated effective with that date. This action is mandated by the Act at §§ 1819(h) and 1919(h) and Federal regulations at 42 CFR § 488.456 and § 489.53.

We are required to provide the general public with notice of an impending termination and will publish a notice in a local newspaper prior to the effective date of termination. If termination goes into effect, you may take steps to come into compliance with the Federal requirements for long term care facilities and reapply to establish your facility's eligibility to participate as a provider of services under Title XVIII of the Act. Should you seek re-entry into the Medicare program, the Federal regulation at 42 CFR § 489.57 will apply.

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 (NATCEP) 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 $5,000; 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. We will notify you if any of these circumstances results in a prohibition at your facility.

CONTACT INFORMATION

If you have any questions regarding the Federal Monitoring LSC survey, please contact Bruce Wexelberg, Safety Engineer at (312) 353-2859. For questions regarding this enforcement case, please contact Tamika J. Brown, Principal Program Representative at (312) 353-1502. Information may also be faxed to (443) 380-6614.

Sincerely,

Tamika J. Brown
Principal Program Representative
Long Term Care Certification
& Enforcement Branch

cc: Minnesota Department of Health
Minnesota Department of Human Services
Office of Ombudsman for Older Minnesotans
Stratis Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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

(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
K 000	INITIAL COMMENTS A Life Safety Code Comparative Federal Monitoring Survey was conducted by the Centers for Medicare & Medicaid Services (CMS) on 5/3/16 following a Minnesota Department of Health Services survey on 3/15/16. At this Comparative Federal Monitoring Survey, Good Samaritan Society - Maplewood was found to be not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR 483.70(a), Life Safety from Fire, and the related National Fire Protection Association (NFPA) standard 101 - 2000 edition. Good Samaritan Society - Maplewood is a two story building that was constructed at three different times. The original building was constructed in 1965 and additions were constructed in 1967 and 1998. The 1965 and 1967 buildings are of Type II (111) construction. The 1998 building is of Type II (000) construction. The building is fully sprinklered and there are supervised smoke detectors located in the corridors and spaces open to the corridors. Resident rooms on the "acute care unit" have hardwired smoke detectors that are connected to the nurse call system only. The building was surveyed as one building of Type II (000). The facility has 81 certified beds. All 81 beds are dually certified for Medicare and Medicaid. At the time of the survey the census was 67.	K 000		
K 017 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Corridors are separated from use areas by walls constructed with at least 1/2 hour fire resistance rating. In fully sprinklered smoke compartments, partitions are only required to resist the passage	K 017		7/25/16

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

Electronically Signed | 05/27/2016

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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K 017	Continued From page 1 of smoke. In non-sprinklered buildings, walls extend to the underside of the floor or roof deck above the ceiling. (Corridor walls may terminate at the underside of ceilings where specifically permitted by Code. Charting and clerical stations, waiting areas, dining rooms, and activity spaces may be open to corridor under certain conditions specified in the Code. Gift shops may be separated from corridors by non-fire rated walls if the gift shop is fully sprinklered.) 19.3.6.1, 19.3.6.2, 19.3.6.4, 19.3.6.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide corridor wall separations in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.1, 19.3.6.2 and 19.3.6.5. This deficient practice could affect approximately 20 of the 67 residents. Findings include: On 5/3/16 at 1:30pm, observation revealed that by the second floor east nurses station there were open grate ceiling tiles and above the ceiling the corridor wall did not extend to the roof deck. This finding was confirmed by the Director of Environmental Services at the time of discovery.	K 017	Tag K017 Corridors are separated from use areas by walls constructed with a least1/2 hour fire resistance rating. A. How corrective action will be accomplished for those residents found to have been affected by the deficient practices- 1. Metro Sheet Metal has be contracted to construct an extension for the return duct so that return air can be taken below the ceiling height and thus eliminating the need for egg crate in the ceiling. B. How will the facility identify other residents having the potential to be affected by the same deficient practices- 1 An inspection of all of the return ducts have been made to insure that no other residents have the potential to be affected by this deficient practice, C. What measures will be put in place, or systemic changes made, to ensure that the deficient practices will not recur- 1. No other changes need to made due to the finite number of returns in the ceilings. D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and	

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 017	Continued From page 2	K 017	will not recur- 1.All return air ducts have been inspected to ensure compliance. E. 1.Return air duct extension install by July 25, 2016	
K 018 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 13/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Clearance between bottom of door and floor covering is not exceeding 1 inch. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Hold open devices that release when the door is pushed or pulled are permitted. Doors shall be provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.2.3.2.1. Roller latches are prohibited by CMS regulations in all health care facilities. 19.3.6.3 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide automatic positive latching corridor doors in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.6.2, 19.3.6.3.1, 19.3.6.3.2 and 19.3.6.3.3. This deficient practice could affect approximately 40 of the 67 residents. Findings include: On 5/3/16 at 2:10pm, observation revealed that the corridor doors to the kitchen had thumb turn	K 018	Tag K-018 Corridor doors will be provided with a means suitable for automatic positive latching A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice - 1. A door handle will be installed on door with latching device B. How will the facility identify other residents having the potential to be affected by the same deficient practices-	7/25/16

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K 018	Continued From page 3 operated dead bolt latching hardware. The corridor door was not automatically positive latching. This finding was confirmed by the Director of Environmental Services at the time of discovery.	K 018	An inspection of all corridor doors was made to ensure the was no other doors in violation of K-018 C. What measures will be put in place, or systemic changes made, to ensure that the deficient practices will not recur- No other doors were found to be in violation of K-018 D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur No other doors were found to be in violation of K-018 E. This corrective action has been put into action on May 7, 2016	
K 020 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. An atrium may be used in accordance with 8.2.5, 8.2.5.6, 19.3.1.1 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide fire rated opening protection on fire rated vertical shafts as required by NFPA 101 - 2000 edition, sections 19.3.1, 19.3.1.1, 8.2.2.2, 8.2.3, 8.2.3.2.4.2 and 8.2.5. This deficient practice could affect approximately 40 of the 67 residents. Findings include: 1. On 5/3/16 at 11:25am, observation revealed that in the beauty shop above the ceiling there was a pipe penetration in the floor above that was not properly fire stopped.	K 020	Tag K-020 Stairways, elevator shafts, light and ventilation shafts, chutes, and other vertical openings between floors are enclosed with construction having a fire resistance rating of at least one hour. A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice 1). Beauty shop penetration will be sheet rocked and sealed using 5/8 inch sheetrock and sealed using 3M fire sealant CP 25WB+. 2). The ceiling will be caulked along the lower level elevator	7/25/16

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K 020	Continued From page 4 2. On 5/3/16 at 11:06am, observation revealed that above the ceiling at the lower level west elevator the top 1/4" of the rated shaft wall was not properly firestopped. 3. On 5/3/16 at 2:17pm, observation revealed that on the second floor the door on the east laundry chute did not have a label indicating that it had a fire resistance rating. These findings were confirmed by the Director of Environmental Services at the time of discovery.	K 020	landing ceiling using 3M fire sealant 25WB. 3) The east laundry chute door will be replaced with a door that has a fire resistance rating. B. Identify other residents having the potential to be affected by the same deficient practice- 1. No other residents can be affected by the deficient practice. 2. No other residents can be affected by the deficient practice. 3 No other residents can be affected by the deficient practice.. C. What measures have been put in place to ensure deficient practice from reoccurring- 1. All ceilings along smoke barrier walls have been inspected for proper sealing. 2. No other measures will be needed due to the finite number of elevators. 3. No other measures will be needed due to the finite number of laundry chutes. D. How will the facility monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur. 1. No further monitoring is required because of the finite number of locations with the potential to be improperly sealed. 2. No other monitoring is required due to the finite number of elevators on site. 3. No other monitoring is required due to the finite number of laundry chutes on site. E. 1. The ceiling in the Beauty Shop will be repaired by July 25, 2016 2. The ceiling by the elevator will be caulked by July 25 2016, 3. The laundry chute door will be replaced by July 25, 2016.	
K 025 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD	K 025		7/25/16

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K 025	Continued From page 5 Smoke barriers shall be constructed to provide at least a one half hour fire resistance rating and constructed in accordance with 8.3. Smoke barriers shall be permitted to terminate at an atrium wall. Windows shall be protected by fire-rated glazing or by wired glass panels and steel frames. 8.3, 19.3.7.3, 19.3.7.5 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to maintain smoke barrier walls in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.7, 19.3.7.1, 19.3.7.3, 8.3.2 and 8.3.6. This deficient practice could affect all 67 residents. Findings include: 1. On 5/3/16 at 11:06am, observation revealed that above the ceiling at the smoke barrier wall in the beauty shop there was a pipe penetration that was not properly firestopped. 2. On 5/3/16 at 12:54pm, observation revealed that above the ceiling at the smoke barrier by room 101 there were penetrations of a bundle of two - three conduits, a duct and a bundle of three -15 cables that were not properly firestopped. 3. On 5/3/16 at 12:56pm, observation revealed that above the ceiling in the first floor dining room there was a 2-1/2" hole in the smoke barrier wall that was not properly firestopped. 4. On 5/3/16 at 1:05pm, observation revealed that above the ceiling at the smoke barrier by room 104 there was a penetration of a flexible metal conduit that was not properly firestopped.	K 025	Tag K025 Smoke barriers are constructed to provide at least ¿ hour fire resistance in accordance with 8.3. A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice □ 1. Beauty shop penetration will be sheet rocked and sealed using 5/8 inch sheetrock and sealed using 3M fire sealant CP 25WB+. 2. The smoke barrier by room 101 will be fire stopped using 3m product CP 25WB+ 3. The 1st floor dining room CP 25WB+wall will be fire stopped using 5/8 inch sheet rock and CP 25WB+. 4 The smoke barrier by room 104 will be fire stopped with the use of 3m product CP 25WB+. 5. Room 102 will be fitted with a fire rated solid core door that is self-closing so to make all of room 102 part of the east smoke compartment. The bathroom will no longer be considered a smoke barrier and the cited wall that does not extend to the deck will need no other changes. 6. The east wall of the East Post-Acute dining room will be fire stopped using a combination of 5/8 inch sheet rock and 3M product CP 25WB+ 7. The west wall of the East Post-Acute dining room will be fire stopped using a	

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K 025	Continued From page 6 5. On 5/3/16 at 1:06pm, observation revealed that above the ceiling at the smoke barrier in the room 102 bathroom the smoke barrier wall was not continuous and stopped 6" below the deck. 6. On 5/3/16 at 1:47pm, observation revealed that above the ceiling at the smoke barrier that was the east wall of the post acute east dining room there were two 3" holes, penetrations of two electrical conduits and a 6" by 12" hole at a pipe penetration that were not properly firestopped. 7. On 5/3/16 at 1:48pm, observation revealed that above the ceiling at the smoke barrier wall at the west wall of the post acute east dining room there was a 6" by 18" section of wall that was missing. 8. On 5/3/16 at 1:52pm, observation revealed that above the ceiling at the smoke barrier wall in the physical therapy gym there was an electrical junction box in the wall with a 1/4" gap around it that was not properly firestopped. 9. On 5/3/16 at 2:08pm, observation revealed that above the ceiling by room Room A-4 there was a cable penetration that was not properly firestopped. 10. On 5/3/16 at 2:27pm, observation revealed that above the ceiling at the smoke barrier at the east wall of the north dining room there was a penetration of a flexible metal conduit that was not properly firestopped. 11. On 5/3/16 at 2:29pm, observation revealed that above the ceiling at the smoke barrier at the west wall of the north dining room there was a penetration of a flexible metal conduit and a 1/4"	K 025	combination of 5/8 inch sheet rock and 3M product CP 25WB+. 8. The junction box in the P.T. gym will be fire stopped using 3M product CP 25WB+. 9. The cable penetration above room A-4 will be fire stopped using 3M product CP 25WB+. 10. The east wall of the North ding room will be fire stopped using a combination of 5/8 inch5/8 inch sheet rock and 3M product CP 25WB+ sheet rock and 3M product CP 25WB+. 11. The west wall of the North dining room will be fire stopped using a combination of 5/8 inch sheet rock and 3M product CP 25WB+. 12. The bundle of wires that penetrate the smoke barrier above the ceiling by room 241 will be fire stopped using 3M product CP 25WB+. B. Identify other residents having the potential to be affected by the same deficient practice- No other resident can be affected by this deficient practice because it affects all of the residents. C. What measures will be put in place, or systemic changes made, to ensure that the deficient practices will not recur- All new construction projects are subject to inspection prior to completion for new penetrations or disturbances of old fire stopping. D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur □ The Environmental Services Director will inspect all new construction projects prior to completion for compliance to Life Safety Codes and will conduct quarterly inspections of all	

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K 025	Continued From page 7 by 20" section of the wall near the top that were not properly firestopped. 12. On 5/3/16 at 2:47pm, observation revealed that above the ceiling at the smoke barrier by room 241 there was a bundle of three cables that were not properly firestopped. These findings were confirmed by the Director of Environmental Services at the time of discovery.	K 025	smoke barriers to check for shrunken disturbed smoke barrier products. E. All fire stopping will be applied to deficient areas no later than July 25, 2016.	
K 027 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Door openings in smoke barriers have at least a 20-minute fire protection rating or are at least 1o-inch thick solid bonded wood core. Non-rated protective plates that do not exceed 48 inches from the bottom of the door are permitted. Horizontal sliding doors comply with 7.2.1.14. Doors are self-closing or automatic closing in accordance with 19.2.2.2.6. Swinging doors are not required to swing with egress and positive latching is not required. 19.3.7.5, 19.3.7.6, 19.3.7.7 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to provide doors in smoke barrier walls that were solid core self-closing doors as required by NFPA 101 - 2000 edition, section 19.3.7, 19.3.7.1, 19.3.7.6, 8.3 and 8.3.4. This deficient practice could affect approximately 20 of the 67 residents. Findings include: On 5/3/16 at 2:25pm, observation revealed that the wall between rooms 14 and 16 was a smoke barrier wall and the door to the bathroom between those rooms was not a self-closing solid core wood door.	K 027	Tag K027 Doors in smoke barrier walls are solid core and self-closing. A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice - 1. A self -closing fire rated door will be installed to the corridor to room 14 as to make room14 part of the smoke compartment with the other resident rooms beyond the hallway fire doors to the east. B. How will the facility identify other residents having the potential to be	7/25/16

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K 027	Continued From page 8 This finding was confirmed by the Director of Environmental Services at the time of discovery.	K 027	affected by this deficient practice- No other residents can be affected by this deficient practice C. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur To ensure that the door closers are working properly and that all smoke seals are being made, the maintenance department will audit and initial after completion the preventive maintenance audits form. D. This corrective action will be completed by July25, 2016.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to provide means of egress that were in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.2.1, 19.2.1, 19.2.3.5, 19.2.2.3, 7.1.5, 7.1.6, 7.1..6.2, 7.1.10.1, 7.2.1.4, 7.2.1.4.1, 7.2.1.4.5,7.2.2, 7.2.1.5.4, 7.2.2.2, 7.2.2.2.4 and 7.7.1. This deficient practice could affect approximately 30 of the 67 residents. Findings include: 1. On 5/3/16 at 1:15pm, observation revealed that the exit door by room 114 stuck on the door frame and required more than 15 pounds force to open. 2. On 5/3/16 at 2:06pm, observation revealed that the exit at the delivery door was locked with a magnetic lock that is released by pushing a	K 038	Tag K038 Exit access is readily accessible at all times A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice □ 1. Exit door by room 114 has been adjusted to not need more than 15 pounds force to open. 2. Exit magnet release button was lowered to below 48inches. 3. Electronics that control exit from North dining area removed from the exit. B. How will the facility identify other residents having the potential to be affected by this deficient practice.- 1. All fire exit doors are checked weekly to be operating properly. 2 Button that controls magnet on delivery exit was lowered to	7/25/16

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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

(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
K 038	Continued From page 9 button located adjacent to the door. However, the releasing button was located 67" above the floor, which was higher than the maximum allowable height of 48". 3. On 5/3/16 at 2:21pm, observation revealed that the exit at the north dining room door was locked with a magnetic lock that is released by pushing a button located adjacent to the door. However, the releasing button was located 71.5" above the floor, which was higher than the maximum allowable height of 48". These findings were confirmed by the Director of Environmental Services at the time of discovery.	K 038	below the 48 inch height. 3. No other residents can be affected by this deficient practice because no other exit door is controlled this way. C. What measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur- 1. Maintenance technician was educated to report any door that does not operate properly. 2. No other measures are required because this is the only door with this style of button. 3. No other measures are required because no other door is controlled this way. D. How will the facility monitor its corrective actions to ensure that the practice is being corrected and will not recur- 1. Weekly preventive maintenance reports are input into the TELS system that monitors all preventive maintenance and life safety inspections. 2. No other monitoring is necessary because this is the only exit with this exit button on it. 3. No other monitoring is required because no other exit is controlled this way. E. This deficiency was corrected on. 1. Corrected on May 12, 2016. 2. Corrected on May 12, 2016. 3. Corrected on May 12, 2016	
K 052 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety shall be, tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved maintenance and testing program complying with applicable requirement of NFPA 70 and 72.	K 052		7/25/16

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE** **MAPLEWOOD, MN 55117**

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K 052	Continued From page 10 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to properly document testing of the fire alarm system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3, 7-3.1, 7-3.2, 7-5.2.2 and Figure 7-5.2.2. This deficient practice could affect all 67 residents. Findings include: On 5/3/16 at 3:01pm, review of the documents titled "Fire Alarm and Emergency Communication System Inspection and Testing Form" dated 1/14/16 revealed that the fire alarm system test and inspection report does not include all of the required information. The report does not list an inventory of all of the fire alarm devices located in the facility and it did not include a list of the initiating devices that were tested and the results of the test. This finding was confirmed by the Facility Administrator and the Director of Environmental Services at the time of discovery.	K 052	Tag K052 A fire alarm system required for life safety shall be tested and maintained in accordance with NFPA 72 National Fire Alarm Code and records kept readily available. A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice - 1. Convergent Technologies ran a sensitivity report which also lists each piece of the system individually and future annual test will have a complete inventory provided with the report. B. How will the facility identify other residents having the potential to be affected by the same deficient practices.- No other resident have the potential of being affected by these deficient practices. C. What measures will be put in place, or systemic changes made, to ensure that the deficient practices will not recur- 1. Vendor has been notified that inventory list must be provided after each annual test. D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur- Director of Environmental Services will inspect annual test results for completeness. E. This was completed on May 18, 2016	
K 054 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those	K 054		7/25/16

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	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE** **MAPLEWOOD, MN 55117**

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K 054	Continued From page 11 activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to ensure that all smoke detectors were tested for sensitivity every two years in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.4 and 9.6 and NFPA 72 - 1999 edition, Sections 7-3.1, 7-3.2, 7-3.2.1 and 7.5.2.2. This deficient practice could affect all 67 residents. Findings include: On 5/3/16 at 10:15am, review of the document titled "Account 5820 Upload on 2/10/14," which the Director of Environmental Services stated was the most recent smoke detectors sensitivity test report, revealed that the smoke detectors in the facility had not been tested for sensitivity within the last two years.	K 054	Tag K054 All required smoke detectors are maintained and inspected in accordance with manufactures specifications. 9.6.1.3 A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice- Vendor will run sensitivity report from the fire panel. B. How the facility will identify other residents having the potential to be affected by the same deficient practice- No other residents can be affected by this deficient practice. C. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur-Sensitivity testing will be done in accordance to manufactures specifications and with a frequency as prescribed by Life safety Code. D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur- A journal for Life Safety Testing will be kept to keep testing from being overlooked when due. E. Sensitivity test was completed by Convergent Technologies on May 18, 2016	
K 056 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Where required by section 19.1.6, Health care	K 056		7/25/16

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 EAST ROSELAWN AVENUE** **MAPLEWOOD, MN 55117**

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K 056	Continued From page 12 facilities shall be protected throughout by an approved, supervised automatic sprinkler system in accordance with section 9.7. Required sprinkler systems are equipped with water flow and tamper switches which are electrically interconnected to the building fire alarm. In Type I and II construction, alternative protection measures shall be permitted to be substituted for sprinkler protection in specific areas where State or local regulations prohibit sprinklers. 19.3.5, 19.3.5.1, NPFA 13 This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to install the sprinkler system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 13 - 1999 edition, Section 5-1.1. This deficient practice could affect approximately 20 of the 67 residents. Findings include: On 5/3/16 at 12:45pm, observation revealed that in the closets in the first floor south unit there was only one sprinkler and the the closet was divided into two sections by a vertical wooden divider. The divider extended to within 3" - 5" of the ceiling. The sprinklers were located between 13" and 19" away from the divider. The water spray from the sprinkler would be obstructed by the divider and the second half of the closet was not protected by sprinkler coverage. This finding was confirmed by the Director of Environmental Services at the time of discovery.	K 056	Tag K056 Where required by section 19.1.6 Healthcare facilities shall be protected throughout by an approved supervised automatic sprinkler system in accordance with section 9.7 A. How corrective action will be accomplished for those residents found to have been affected by the deficient practices- Closet dividers will be cut down to remove the obstruction of the sprinkler spray pattern. B. How the facility will identify other residents having the potential to be affected by the same deficient practice- No other closets are divided like the ones on the first level. C. What measures will be put in place, or systemic changes made, to ensure that the deficient practice will not recur- No other changes need to be made because these are the only closets that are divided. D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur- no other monitoring will need to be made because once they are cut they are completed	

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K 056	Continued From page 13	K 056	E. This will be completed by July 25, 2016	
K 062 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observation and interview the facility failed to maintain the automatic sprinkler system in accordance with NFPA 101 - 2000 edition, Sections 19.3.5 and 9.7 and NFPA 25 - 1998 edition, Sections 2-2, 2-2.1 and 2-3.3. This deficient practice could affect all 67 residents. Findings include: 1. On 5/3/16 at 1:17pm, observation revealed that in room B2-1 a ceiling tile adjacent to the sprinkler was missing. 2. On 5/3/16 at 1:21pm, observation revealed that in room B9 a ceiling tile adjacent to the sprinkler was missing. 3. On 5/3/16 at 1:25pm, observation revealed that there were not two spare sprinklers of each type used in the facility kept on site. 4. On 5/3/16 at 2:11pm, observation revealed that two sprinklers in the kitchen were showing signs of corrosion. These findings were confirmed by the Director of Environmental Services at the time of discovery.	K 062	Tag K062 Required automatic sprinklers systems are continuously maintained in reliable operating condition and are inspected and tested periodically A. How corrective action will be accomplished for those residents found to have been affected by the deficient practice- 1.ceiling tile in room B2-1 has been replaced. 2. Ceiling tile in room B9 has been replaced. 3. An inventory of all sprinkler heads in use was made by General Sprinkler and 2 of each missing head has been ordered to complete the spares. 4. The kitchen sprinkler heads will be replaced. B. How the facility will identify other residents having the potential to be affected by the same deficient practice- 1. No other resident can be affected by this deficient practice. 2. No other resident can be affected by this deficient practice. 3. No other residents can be affected by this deficient practice. 4. No other residents can be affected by this deficient practice. C. What measures will be put into place, or systemic changes made, to ensure that the same deficient practice will not	7/25/16

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K 062	Continued From page 14	K 062	recur-1. A quarterly inspection of obscure locations within the building will be made to check condition of ceiling tiles. 2. A quarterly inspection of obscure locations within the building will be made to check condition of ceiling tiles. 3. Any changes to the sprinkler system will include 2 spares be included. 4. Kitchen sprinkler heads will be inspected bi-annually for corrosion and replaced as needed. D. How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur- 1. Task will be added to the TELS program to be listed and signed off when completed. 2. Task will be added to the TELS program to be listed and signed off when completed. 3. No other monitoring will be required once the spare set is completed. 4. Director of Environmental Services will inspect sprinkler heads in the kitchen bi-annually to check for signs of corrosion. E. 1. Was completed on May 5, 2016 2. Was completed on May 5, 2016 3. Will be completed by General sprinkler by July 25, 2016 4. Will be completed by General Sprinkler by July 25, 2016	
K 069 SS=C	NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 19.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on record review and interview, the facility failed to inspect the kitchen range hood fire extinguishing system in accordance with the requirements of NFPA 101 - 2000 edition, Sections 19.3.2.6 and 9.2.3; NFPA 96 - 1998	K 069	Tag 069 Cooking facilities are protected in accordance with 9.2.3 19.3.2.6 NFPA 96 A. How corrective action will be	7/25/16

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K 069	Continued From page 15 edition, Section 8-2. This deficient practice could affect approximately 30 of the 67 residents. Findings include: On 5/3/16 at 10:29am, review of the documents titled "Nardini Fire Equipment Cooking Hood Fire Suppression System Report" dated 7/7/15 and 2/16/16 revealed that the kitchen range hood system was not inspected at least every six months. This finding was confirmed by the Facility Administrator and the Director of Environmental Services at the time of discovery.	K 069	accomplished for those residents found to have been affected by the deficient practice- Fire hood test vendor will schedule testing one month in advance of the six month date, so that testing is always done no more than six months from the last testing date. B. How the facility will identify other having the potential to be affected by the same deficient practice- No others have the potential of being affect by this deficient practice. C. What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur- General Sprinkler will schedule testing one month prior to the six month date of last test.	