CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 16W7

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I	- TO BE COMP	LETED BY T	THE STAT	TE SURVEY AGENCY	Facility ID: 00967		
MEDICARE/MEDICAID PROVIDER 1 (L1) 245317 2.STATE VENDOR OR MEDICAID NO. (L2) 692515400	NO.	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - CO. (L4) 1201 17TH STREET NE (L5) AUSTIN, MN			MFORCARE (L6) 55912	4. TYPE OF ACTION: 7 (L8) 1. Initial 2. Recertification 3. Termination 4. CHOW 5. Validation 6. Complaint		
5. EFFECTIVE DATE CHANGE OF OWN (L9)	NERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEGO	ORY 09 ESRD	<u>O2</u> (L7) 13 PTIP 22 CLIA	7. On-Site Visit 9. Other 8. Full Survey After Complaint		
6. DATE OF SURVEY 08/07/201: 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) — (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE	FISCAL YEAR ENDING DATE: (L35) 12/31		
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	45 (L18) 45 (L17)	Complian1 B. Not in Con		gram	And/Or Approved Waivers Of T 2. Technical Personnel3. 24 Hour RN4. 7-Day RN (Rural SN5. Life Safety Code * Code: A*	6. Scope of Services Limit 7. Medical Director		
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF 45 (L37) (L38)	19 SNF (L39)	ICF (L42)	IID (L43)		15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1):	(L15)		
	eview of the facease refer to the	cility's plan of co e CMS 2567B.	orrection, to v Effective July	erify that	, the facility is certified for 18. STATE SURVEY AGENCY	rogram Specialist 12/20/2013		
PA	RT II - TO BE	COMPLETED	BY HCFA R	` ′	L OFFICE OR SINGLE ST	CATE AGENCY		
DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Par 2. Facility is not Eligible			MPLIANCE WITH GHTS ACT:	I CIVIL	Statement of Financial Solvency (HCFA-2572) Ownership/Control Interest Disclosure Stmt (HCFA-1513) Both of the Above :			
22. ORIGINAL DATE OF PARTICIPATION 06/01/1986 (L24)	23. LTC AGREEM BEGINNING (L41)		4. LTC AGREEN ENDING DA'		26. TERMINATION ACTION: VOLUNTARY 01-Merger, Closure 02-Dissatisfaction W/ Reimbursem	05-Fail to Meet Health/Safety		
25. LTC EXTENSION DATE: (L27)	27. ALTERNATI	of Admissions:	(L44)		03-Risk of Involuntary Termination 04-Other Reason for Withdrawal	OTHER 07-Provider Status Change 00-Active		
28. TERMINATION DATE:	29 (L28)	. INTERMEDIARY/0		(L31)	30. REMARKS			
31. RO RECEIPT OF CMS-1539	32 (L32)	. DETERMINATION (08/08/2013	OF APPROVAL D	DATE (L33)	DETERMINATION APPR	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 24-5317

December 20, 2013

Ms. Sara Rupkalvis, Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, Minnesota 55912

Dear Ms. Rupkalvis:

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 23, 2013, the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 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,

Colleen B. Leach, Program Specialist

Colleen Feach

Program Assurance Unit, Licensing and Certification Program

Division of Compliance Monitoring

Minnesota Department of Health

P.O. Box 64900, St. Paul, MN 55164-0900

Telephone #: (651)201-4117 Fax #: (651)215-9697

cc: Licensing and Certification File



Protecting, Maintaining and Improving the Health of Minnesotans

August 22, 2013

Ms. Sara Rupkalvis, Administrator Good Samaritan Society - Comforcare 1201 17th Street Northeast Austin, Minnesota 55912

RE: Project Number S5317024

Dear Ms. Rupkalvis:

On June 25, 2013, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on June 13, 2013. This survey found the most serious deficiencies 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 August 7, 2013, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 17, 2013 the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on June 13, 2013. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of July 23, 2013. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on June 13, 2013, effective July 23, 2013 and therefore remedies outlined in our letter to you dated June 25, 2013, will not be imposed.

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.

Enclosed is a copy of the Post Certification Revisit Form, (CMS-2567B) from this visit.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4118 Fax: (651) 215-9697

Email: mark.meath@state.mn.us

Enclosure 5317r13.rtf

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245317	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 8/7/2013
Name of Facility			Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - COMFORCARE			1201 17TH STREET NE AUSTIN, MN 55912	

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).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4)	Item		(Y5)	Date
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	F0156	07/23/2013	ID Prefix	F0164	07/23/2013		ID Prefix	F0431		07/23/2013
Reg. #	483.10(b)(5) - (10), 483.10((b)(1)	Reg. #	483.10(e), 483.75(l)(4)			Reg. #	483.60(b), (d), (e)	
LSC		_	LSC		_		LSC			_
						+-				
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix	F0441	07/23/2013	ID Prefix	F0492	07/23/2013		ID Prefix			
Rea.#	483.65		Rea. #	483.75(b)			Reg. #			
•		_			_		_			_
					_	+-				
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #				Reg. #			
LSC		_	LSC							_
		_			_	+-				_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg.#		_	Reg. #		_		Reg. #			
LSC		_	LSC		_		•			_
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		•	ID Prefix				ID Prefix			
Reg.#		_	Reg. #				Reg. #			_
LSC		_	LSC		_					_
		_			_					
Reviewed By	Reviewed	Ву	Date:	Signature of Surv	reyor:	•			Date:	
State Agenc	y MM/GPI	Ŋ	08/22/20	13 1	0160				08/07	/2013
Reviewed By	, — Reviewed	Ву	Date:	Signature of Surv	reyor:				Date:	
CMS RO										
Followup to	Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of				1			
6/13/2013				=			to the Facility?	YES	NO	
			1							

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245317	(Y2) Multiple Construction A. Building B. Wing 02 - BUIL	T IN 2007	(Y3) Date of Revisit 7/17/2013
Name of Facility		Street Address, City, State, Zip Code	
GOOD SAMARITAN SOCIETY - COMFORO	CARE	1201 17TH STREET NE AUSTIN. MN 55912	

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).

(Y4) Item	(Y	5) Date	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5) I	Date
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		06/14/2013	ID Prefix		-		ID Prefix			_
Reg. #	NFPA 101		Reg. #				Reg. #			
LSC	K0025		LSC				LSC			_
		Correction			Correction					Correction
ID D. G.		Completed	ID Doofee		Completed		ID D. f.			Completed
ID Prefix		<u> </u>	ID Prefix		-		ID Prefix			_
Reg. #		_	Reg. #				Reg. #			_
LSC		_	LSC _				LSC			
					0 "					0 "
		Correction			Correction					Correction
ID Prefix		Completed	ID Prefix		Completed		ID Prefix			Completed
Reg. #			Reg. #		-		Reg. #			_
LSC										_
			_							
		Correction			Correction					Correction
		Completed			Completed					Completed
ID Prefix		_	ID Prefix				ID Prefix			_
Reg. #			Reg. #				Reg. #			
LSC		_	LSC		•		LSC			- -
		Correction			Correction					Correction
ID Drofiv		Completed	ID Drofiv		Completed		ID Drofiv			Completed
		_								_
Reg. #			Reg. #				Reg. #			_
LSC		_	LSC				LSC			_
Reviewed By	Reviewe	d By	Date:	Signature of Surve	yor:				Date:	
State Agency	MM/PS	3	08/22/2013		2582	22			07/17	7/2013
Reviewed By	Reviewe	d By	Date:	Signature of Surve	yor:				Date:	
CMS RO										
Followup to	Survey Completed on:			Check for any	Uncorrected	Deficie	encies. Was	a Summary of		
	6/13/2013							to the Facility?	YES	NO



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5285

August 23, 2013

Ms. Roxanne Gosson, Administrator Mapleton Community Home 301 Troendle Street Mapleton, Minnesota 56065

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5362021

Dear Ms. Gosson:

The above facility was surveyed on August 5, 2013 through August 8, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is only a suggestion and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 12 Civic Center Plaza, #2105 Mankato Minnesota 56001. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Kathryn Serie at (507) 537-7158.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4118 Fax: (651) 215-9697

Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

5362s13lic.rtf



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 5285

August 23, 2013

Ms. Roxanne Gosson, Administrator Mapleton Community Home 301 Troendle Street Mapleton, Minnesota 56065

RE: Project Number S5362021

Dear Ms. Gosson:

On August 9, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

Kathryn Serie Minnesota Department of Health 12 Civic Center Plaza, Suite #2105 Mankato, Minnesota 56001

Telephone: (507) 537-7158

Fax: (507) 344-2716

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 September 17, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by September 17, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 November 8, 2013 (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 February 8, 2014 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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:

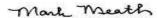
Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,



Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring P.O. Box 64900

St. Paul, Minnesota 55164-0900

Telephone: (651) 201-4118 Fax: (651) 215-9697

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File

5362s13.rtf

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: 16W7

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

	PART	I - TO BE COMP	PLETED BY T	HE STAT	E SURVEY	AGENCY		Facility ID: 00967
MEDICARE/MEDICAID PROVIDER (L1) 245317 2.STATE VENDOR OR MEDICAID NO (L2) 692515400		3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - COME (L4) 1201 17TH STREET NE (L5) AUSTIN, MN			FORCARE (L6) 55912		4. TYPE OF ACTION 1. Initial 3. Termination 5. Validation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF O' (L9)	WNERSHIP	7. PROVIDER/SUP	PLIER CATEGOR' 05 HHA	Y 09 ESRD	02 (I	L7) 22 CLIA	7. On-Site Visit 8. Full Survey After	9. Other Complaint
6. DATE OF SURVEY 06 /18. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	(L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF 15 ASC 16 HOSPICE		FISCAL YEAR ENDIN	IG DATE: (L35)
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	45 (L18) 45 (L17)	X B. Not in Comp	ce With quirements Based On: cceptable POC	1	2. To 3. 24 4. 7-	echnical Personnel 4 Hour RN -Day RN (Rural SNF) ife Safety Code B*	e Following Requirements:	ector
18 SNF 18/19 SNF 45 (L37) (L38)		ICF (L42)	IID (L43)			or 1861 (j) (1):	(L15)	
16. STATE SURVEY AGENCY REMA At the time of the June 13, 2103 st both health and life safety code alc	andard survey the facil	ity was not in substan an of correction. Pos	itial compliance w		ow.	•		
17. SURVEYOR SIGNATURE Michelle McFarland	, HFE NEII	Date : 0	07/16/2013	(L19)		urvey agency aleath, Progr	am Specialist	Date: 08/05/2013 (L20)
	PART II - TO I	BE COMPLETED	D BY HCFA RE	. ,	OFFICE OI	R SINGLE STAT	TE AGENCY	(L20)
DETERMINATION OF ELIGIBILI*	articipate		PLIANCE WITH C	TVIL	2		nal Solvency (HCFA-2572) nterest Disclosure Stmt (HC	FA-1513)
22. ORIGINAL DATE OF PARTICIPATION 06/01/1986	23. LTC AGREEMI BEGINNING I		4. LTC AGREEME ENDING DATI		26. TERMIN VOLUNTARY 01-Merger, Clo	_		(L30) NTARY Meet Health/Safety
(L24) 25. LTC EXTENSION DATE: (L27)	(L41) 27. ALTERNATIV A. Suspension of B. Rescind Susp	of Admissions:	(L25) (L44) (L45)		03-Risk of Invo	tion W/ Reimbursement oluntary Termination on for Withdrawal	nt 06-Fail to <u>OTHER</u>	Meet Agreement er Status Change
28. TERMINATION DATE:	29	. INTERMEDIARY/CA			30. REMARK	S		
	(L28)	00170		(L31)	Posted	8/8/2013 N	ΙL	
31. RO RECEIPT OF CMS-1539	32	DETERMINATION C	OF APPROVAL DA	TE				

(L33)

DETERMINATION APPROVAL

(L32)



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2654

June 25, 2013

Ms. Sara Rupkalvis, Administrator Good Samaritan Society - Comforcare 1201 17th Street Ne Austin, MN 55912

RE: Project Number S5317024

Dear Ms. Rupkalvis:

On June 13, 2013, 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 widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), 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:

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

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

<u>Remedies</u> - 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;

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

<u>Informal Dispute Resolution</u> - 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:

Gary Nederhoff Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506

Telephone: (507) 206-2731 Fax: (507) 206-2711

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 July 23, 2013, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by July 23, 2013 the following remedy will be imposed:

• Per instance civil money penalties. (42 CFR 488.430 through 488.444)

PLAN OF CORRECTION (PoC)

A PoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your PoC 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,
- Include signature of provider and date.

If an acceptable PoC 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 PoC 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 PoC 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 PoC 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 PoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt 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. 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 PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

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 September 13, 2013 (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 December 13, 2013 (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 Division of Compliance Monitoring P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting a PoC 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_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. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division 444 Cedar Street, Suite 145 St. Paul, Minnesota 55101-5145

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4118 Fax: (651) 215-9697

Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5317s13.rtf

	& MEDICAID SERVICES	,	1111 15		/I APPROV <u>). 0938-03</u>
STATEMENT OF DEFICIENCIES IND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION 2013 IG MN Dapt of Health Rochester	(X3) DA	TE SURVEY MPLETED
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NAME OF PROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00	13/2013
GOOD SAMARITAN SOCIETY			1201 17TH STREET NE AUSTIN, MN 55912		850
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO- DEFICIENCY)	DRF	(X5) COMPLETIO DATE
as your allegation of Department's accept bottom of the first page be used as verification. Upon receipt of an accept revisit of your facility requiations has been your verification. 483.10(b)(5) - (10), 48 RIGHTS, RULES, SERTHE facility must inform and in writing in a langunderstands of his or he regulations governing the facility must also provide notice (if any) of the Sta §1919(e)(6) of the Act. made prior to or upon a resident's stay. Receipt any amendments to it, rewriting. The facility must inform	correction (POC) will serve compliance upon the ance. Your signature at the ge of the CMS-2567 form will n of compliance. ceptable POC an on-site may be conducted to al compliance with the attained in accordance with 3.10(b)(1) NOTICE OF RVICES, CHARGES In the resident both orally uage that the resident er rights and all rules and esident conduct and he stay in the facility. The let the resident with the atte developed under Such notification must be dmission and during the confused of such information, and must be acknowledged in each resident who is efits, in writing, at the time ing facility or, when the for Medicaid of the are included in nursing a State plan and for ot be charged; those that the facility offers at may be charged.	4	Preparation and execution this response and plan of correction does not constant an admission or agreement the provider of the truth the facts alleged or conclusions set forth in the statement of deficiencies. plan of correction is prepand/or executed solely because it is required by the provisions of federal and solely because it is required by the provisions of federal and solely allegation that the center is not in substantial compliant with federal requirements participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 730 of the State Operations Manual	fitute ent by of the trace the trace of trace of trace of trace of the trace of t	

uny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing 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 rogram participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/25/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (X3) DATE SURVEY **IDENTIFICATION NUMBER:** A. BUILDING COMPLETED Gapt of Health Rochester 245317 B. WING 06/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - COMFORCARE 1201 17TH STREET NE **AUSTIN. MN 55912** SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DEFICIENCY F 156 Continued From page 1 F 156 F 156 inform each resident when changes are made to the items and services specified in paragraphs (5) (i)(A) and (B) of this section. Resident 15's Medicare coverage ended on 1/11/13 and she discharged The facility must inform each resident before, or from facility on 1/12/13. A notice of at the time of admission, and periodically during non-coverage was signed, and the resident's stay, of services available in the according to CMS Bulletin S&C-09facility and of charges for those services. including any charges for services not covered 20 this is the only notice the resident under Medicare or by the facility's per diem rate. needs to receive. R15 did not need to receive the Skilled Nursing The facility must furnish a written description of Facility Advanced beneficiary notice legal rights which includes: or denial letter according to the A description of the manner of protecting personal funds, under paragraph (c) of this Bulletin on attachment 1. section: Resident 47's Medicare coverage A description of the requirements and procedures ended on 5/13/13 and she discharged for establishing eligibility for Medicaid, including from facility on 5/14/13. A notice of the right to request an assessment under section 1924(c) which determines the extent of a couple's non-coverage was signed and non-exempt resources at the time of institutionalization and attributes to the community according to CMS Bulletin S&C-09spouse an equitable share of resources which 20 this is the only notice the resident cannot be considered available for payment needs to receive. R47 did not need toward the cost of the institutionalized spouse's

medical care in his or her process of spending

A posting of names, addresses, and telephone

advocacy network, and the Medicaid fraud control unit; and a statement that the resident may file a complaint with the State survey and certification agency concerning resident abuse, neglect, and

numbers of all pertinent State client advocacy groups such as the State survey and certification agency, the State licensure office, the State ombudsman program, the protection and

down to Medicaid eligibility levels.

to receive the Skilled Nursing

Bulletin on attachment 1

Facility Advanced beneficiary notice or denial letter according to the

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

PRINTED: 06/25/2013 FORM APPROVED 91

CENTERS FOR MEDICARE	& MEDICAID SERVICES		e	FOF	RM APPROV
TATEMENT OF DEFICIENCIES ND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI	LTIPLE CONSTRUCTION 5 2013		O. 0938-03 ATE SURVEY
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1	045047		Rochester .	1	
AME OF PROVIDER OR SUPPLIER	245317	B. WING		01	6/13/2013
			STREET ADDRESS, CITY, STATE, ZIP CODE		0/10/2013
OOD SAMARITAN SOCIETY -	COMFORCARE		1201 17TH STREET NE		
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES		AUSTIN, MN 55912		
MERIX I LEACH DEFICIENCY &	AUST BE PRECEDED BY FULL DENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	III D. D.	(X5) COMPLETION DATE
The facility must information, and physician responsible for written information, and applicants for admission information about how to Medicare and Medicard	sident property in the liance with the advance is. n each resident of the vay of contacting the for his or her care. nently display in the facility provide to residents and n oral and written	F 15		scharged A signed and &C-09- resident need	
This REQUIREMENT is by: Based on interview, and facility failed to provide the non-coverage notices for R47, and R70) reviewed version Medicare. Findings include: R15, R47, and R70 did not Nursing Facility Advanced one of five denial letters, we resident of the right to have to Medicare for review when determined Medicare no lor services.	document review, the e appropriate Medicare 3 of 4 residents (R15, who were discharged receive the Skilled Beneficiary Notice or hich would inform the the claim submitted in the facility had		All resident have the potential affect by this practice. Non connotices are issued according to CMS Bulletin S&C-09-20. No residents have been identified to affected at this time. We review each notice of noncoverage at the Medicare Meetin weekly. An audit will be done monthly X months by Social Services Director designee. Audit results will be presented to Quality Committee in further recommendations	rerage the be ig	3/13

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

JUL 15 2019

PRINTED: 06/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION Health G		(X3) DATE SURVEY COMPLETED	
	245317	B. WING _		l ni	6/13/2013	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIET			REET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912		713/2013	
PREFIX (EACH DEFICIENC	PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			RRECTION I SHOULD BE APPROPRIATE	COMPLETION DATE	
R15 received Notice only. Document revinotices were provided time, social worker in Part A, Medicare see R15 had been disched During interview at the verified no other liable. R47 was not given the Advanced Beneficiar informed R47 of the insubmitted to Medicare. R47 received Notice only. Document revied notices were provided time, social worker standard Part A, Medicare served discharged from facility at that time, social worker standard from facility at that time, social worker standard from the provide R70 had not been given. R70 had not been given facility Advanced Beneficter that informed R70 bill submitted to Medicare improvement Organizary an immediate appeal of stop Medicare.	e right to have the bill are for a decision. The of Medicare Non-Coverage ew revealed no other liability ed. During interview at that stated R15 was on Medicare vices ended on 1/11/13, and arged from facility on 1/12/13. In time, social worker lity notices were given. The Skilled Nursing Facility of Notice or denial letter that light to have the bill er for a decision. The Medicare Non-Coverage were verticated no other liability. During interview at that lated R47 was on Medicare loes ended on 5/13/13, and the Skilled Nursing efficiary Notice or denial of the right to have the late for a decision and diductice of Medicare locluded the Quality liter information to request liter in the region information to request	F 156				

JUL 15 2013 DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/25/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245317 06/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE **PREFIX** REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE **DEFICIENCY**) F 156 Continued From page 4 F 156 R70 was on Medicare Part A, went off Medicare, and was discharged from the facility. During interview at that time, social worker verified the facility lacked evidence that liability notices were provided. Document review of the facility face sheet revealed R70 was discharged from the facility on 1/16/13. During interview on 6/13/13, at 4:00 p.m., the social worker stated the facility provided Notice of Medicare Non-Coverage when the facility determined residents no longer qualified for Medicare coverage. Social worker stated the facility expected the resident or responsible person to contact the Quality Improvement Organization to request an immediate appeal of the facility decision to stop Medicare. She stated the facility did not provide any other liability notices. Review of the facility Medicare Part A Non-Coverage Notifications policy dated 4/10 revealed, "When a resident is moved from the Medicare-certified section before 100 days have been used because skilled care (as defined by Medicare) is no longer necessary, the beneficiary must receive a written non-coverage notice. The center fulfills this requirement by issuing the SNF Determination on Continued Stay (GSS 926) at least one day prior to the last covered Medicare day." "If you believe that a beneficiary requires on a non-covered level of care beginning with admission or at some point thereafter, give the beneficiary proper notice to that effect. If the beneficiary disagrees and asks you to submit a demand bill to the MAC, you may not require. request or accept deposit or other payment from the beneficiary for the services until the MAC

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/25/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING COMPLETED 245317 B. WING 06/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE **GOOD SAMARITAN SOCIETY - COMFORCARE** AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 156 Continued From page 5 F 156 makes the initial determination that the services are not covered by Medicare." F 164 483.10(e), 483.75(I)(4) PERSONAL F 164 PRIVACY/CONFIDENTIALITY OF RECORDS SS=D F 164 Re-education was provided to The resident has the right to personal privacy and all Nurses/TMA's regarding confidentiality of his or her personal and clinical Personal Privacy and records. Confidentiality of Records through a packet on Personal privacy includes accommodations, 7/10/2013. Processes will be medical treatment, written and telephone reviewed again at July communications, personal care, visits, and Nurse's meeting on meetings of family and resident groups, but this 7/25/2013 and TMA meeting does not require the facility to provide a private 7/18/2013. room for each resident. Audits for Privacy during treatments and Except as provided in paragraph (e)(3) of this Confidentiality of MAR section, the resident may approve or refuse the (medication administration release of personal and clinical records to any record) will be conducted by individual outside the facility. DNS or designee weekly X4 and monthly X3. The resident's right to refuse release of personal Audit results will be and clinical records does not apply when the presented to Quality resident is transferred to another health care Committee for further institution; or record release is required by law. recommendations. The facility must keep confidential all information contained in the resident's records, regardless of the form or storage methods, except when release is required by transfer to another healthcare institution; law; third party payment contract; or the resident. This REQUIREMENT is not met as evidenced

Based on observation, interview and document review, the facility failed to ensure privacy during

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

PRINTED: 06/25/2013 FORM APPROVED OMB NO. 0938-0391

		NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING			
1	GOOD S	PROVIDER OR SUPPLIER	- COMFORCARE		TREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912		/13/2013
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOLLI D BE	(X5) COMPLETION DATE
	p w to ro tra ex re: M/(N. 1:4	treatments and confi for 1 of 2 residents (I for privacy. Findings include: R2 diagnoses include (stroke), hemiparesis The quarterly Minimur 3/19/13 revealed R2 h mpairment, was non- extensive to total assis iving. Ouring a random obse me, the medication and vas noted to be opened by shelf of a cart locate bom in the facility's Locate own in the facility is Locate own in the facility is Locate own in the facility is Located to the control of R2 outes, schedules and the	dentiality of medical records R2) reviewed in the sample and cerebrovascular accident and aphasia. In Data Set (MDS) dated and a mild cognitive verbal and required stance for activities of daily revation on 6/10/13 at 1:37 dministration record (MAR) and unattended, on the ed outside of R2's resident dge unit. The opened MAR 2's medications, doses, treatments. At 1:40 p.m., (TMA)-A was noted to com, assisting another ay, traveling past the open sitor and nursing assistant alk past the open MAR. At attical nurse (LPN)-A exited closed the MAR. R2's	F 164	DEFICIENCY)		
89	Dur on one with R2	6/10/13 at 6:45 p.m., dications to R2 via a q nout providing privacy ' s room during this tr	ninistration observation		,		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/25/2013 FORM APPROVED CENTERS FOR MEDICARE & MEDICAID SERVICES OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: MN Dept of Health A. BUILDING COMPLETED Rochester 245317 B. WING 06/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL (X5) COMPLETION PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY) F 164 Continued From page 7 F 164 located almost directly in front of the hallway door. LPN-B stood to the side of the recliner. while she checked for placement of the g-tube and then administered the medications. At 7:10 p.m., two unidentified facility employees were noted to walk past the opened door and R2's family member (Family-A) entered and remained in the room for a visit. At 7:12 p.m., another resident was noted to walk past R2's room while the administration of his medications continued. During interview on 6/10/13 at 7:40 p.m., LPN-B reported she was unaware she had left R2's room door open throughout administration of his medications. During interview on 6/13/13 at 11:59 a.m., director of nursing (DON) verified that medication administration via a g-tube was a private treatment. DON indicated that LPN-B typically did close the door of resident rooms during treatments and this occasion "was an oversight." DON verified it was her expectation that resident room doors be closed during procedures and treatments. DON also verified it was her expectation that a MAR be closed or covered with a plastic divider when unattended by a nurse, to ensure confidentiality of resident medical records. The facility's Confidentiality of Protected Health information policy revised 4/05 read, "The [facility] will protect the resident's/client's right to personal privacy and confidentiality of his or her personal records." F 431 483.60(b), (d), (e) DRUG RECORDS, F 431 SS=E LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of

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

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MU A. BUILI		(X3) D/	(X3) DATE SURVEY COMPLETED	
NAME OF	PROVIDER OR SUPPLIER	245317	B. WING		06	6/13/2013	
	SAMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912	DE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL BC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETION DATE	
Il fa ii a li fa lo co ha li fa lo co Co co ab pa qui be	a licensed pharmacis of records of receipt controlled drugs in staccurate reconciliation records are in order a controlled drugs is more conciled. Drugs and biologicals abeled in accordance professional principles appropriate accessory instructions, and the expelicable. In accordance with Staccility must store all decked compartments and permit or ave access to the key one facility must provide remanently affixed controlled drugs listed in accordance on the legitle drugs is the provider of the legitle drugs is the provided and the legitle drugs is the provided and the legitle drugs is the	and disposition of all afficient detail to enable an on; and determines that drug and that an account of all aintained and periodically aused in the facility must be with currently accepted and include the vand cautionary expiration date when the authorized personnel to value	F 4:	Refrigerator was cleaned a defrosted immediately on 6/13/2013. Refrigerator temperature logs were immediately put into place Contacted Consultant Pharmacist for guidance related to the medications that were in the refrigerator Re-education was provided all Nurses regarding Medication refrigerator policy & procedure through packet on 7/10/2013. Processes will be reviewed again at July Nurse's meetin on 7/25/2013. Audits on medication refrigerator temperature/cleaning schedule logs will be conducted by DNS or designee weekly X4 and monthly X3. Audit results will be presented to Quality Committee for further recommendations.	r. I to	23//3 1PM	

			AND HUMAN SERVICES & MEDICAID SERVICES		JUL 15 2813	FOR	D: 06/25/2013 M APPROVED		
SA	TATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUIL	ULTIPLE CONSTRUCTION of Health LDING Rochaster	(X3) DA	O. 0938-0391 ATE SURVEY DMPLETED		
L			245317	B. WIN	G	06	6/13/2013		
1		PROVIDER OR SUPPLIER SAMARITAN SOCIETY	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912						
	(X4) ID PREFIX TAG	(EACH DEFICIENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	IX (EACH CORRECTIVE ACTION SHO	TION SHOULD BE COMPLETION THE APPROPRIATE DATE			
	th free who for the tree man instruction operations to the tree that refrired the tree tree tree tree tree tree tree	storage rooms. This is residents who require emergency. Findings include: During observation of room on 6/13/13, at 1: nurse (RN)-A, a small the room that contained for resident use. Inside a small freezer section surrounded by approxibition in the side and the s	the medication in an	F4	131				

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

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		A MEDICAID SERVICES		JUL 15 2019	OMB N	O. 0938-039
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING Knowledge Knowledge		(X3) DATE SURVEY COMPLETED	
		245317	B. WING		0	8/43/2043
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		06/13/2013	
	SAMARITAN SOCIETY			1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	PROVIDER'S PLAN OF CORRE ((EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 431	storage of Ativan wa	re 10 s to keep refrigerated ses. No further guidelines	F 43	31		
F 441 At SS=E Single In Sa to of (a) The	interviewed on 6/13/1 the facility had been or refrigerator temperature verified the findings a nurse was responsible temperatures on a dather efrigerator as need the storage of medical temperature of medical temperature log policy 1/2010 indicated, refrigerator as need to be recorded daily. 83.65 INFECTION COPREAD, LINENS The facility must establified fection Control Prografie, sanitary and comfinely prevent the development of the development of the facility must establified the sanitary and comfinely prevent the development of the facility must establified the facility must establified and comfinely prevent the development of the facility must establified	ations policy with a revised ed refrigerators holding insulin will be kept at 36-46 the refrigerator/freezer with an effective date of igerator temperatures are DNTROL, PREVENT is and maintain an im designed to provide a cortable environment and elopment and transmission is an Infection Control	F 441	F 441 R10 and R30's eye drop containers were disposed of upon notification by employees that contaminatio had occurred. Re-education was provided to all nurses and TMA's regarding eye drop administration procedure through a packet on 7/10/2013. Processes will be reviewed again at Nurse's meeting on 7/25/2013 and TMA meeting on 7/18/2013. Audits on eye drop administration will be	n	1/23/13 DPn
(1) in t (2) sho	Investigates, controls he facility; Decides what proced ould be applied to an in	ures, such as isolation, ndividual resident; and incidents and corrective		completed weekly X 4 and monthly X 3 by DNS or designee. Audit results will be presented to Quality Committee for further recommendations.		

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

PRINTED: 06/25/2013 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLI/ IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MUL A. BUILDI	MAN Dept of Union	(X3) DATE SURVEY COMPLETED	
	245317	B. WING_	Rochester	00	6/13/2013
NAME OF PROVIDER OR SUPPLIES GOOD SAMARITAN SOCIET	Y - COMFORCARE	5	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912		
PREFIX (EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
determines that a r prevent the spread isolate the resident (2) The facility mus communicable dise from direct contact will the direct contact will the facility must hands after each direct hand washing is ind professional practice (c) Linens Personnel must hand transport linens so a infection. This REQUIREMENT by: Based on observation review, the facility fail prevent the spread of (R10 and R30) observadministration, 1 of 1 nebulizer administration cleaned or air dried af (R2) who had an undaruse. Findings include:	ead of Infection tion Control Program esident needs isolation to of infection, the facility must t prohibit employees with a ase or infected skin lesions with residents or their food, if ansmit the disease. require staff to wash their ect resident contact for which icated by accepted a. dle, store, process and s to prevent the spread of is not met as evidenced n, interview and document ed to promote practices to infection for 2 of 2 residents yed for eye drop resident (R3) observed for on who's equipment was not ter use, and 1 of 1 resident ted medication syringe in	F 44	R3's nebulizer equipment was immediately changed out. Re-education was provided to all Nurses and TMA's regarding nebulizer cleaning procedure through a packet on 7/10/2013. Processes will be reviewed again at July Nurse's meeting on 7/25/2013 and TMA meeting 7/18/2013. Audits for nebulizer cleaning will be conducted by DNS or designee weekly X4 and monthly X3. Audit results will be presented to Quality Committee for further recommendations.	5	
administration to have	the tip of the eye drop				

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/25/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED OMB NO. 0938-0391 STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION 2013 AND PLAN OF CORRECTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING MN Dapt of Health COMPLETED Rochester 245317 B. WNG 06/13/2013 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **GOOD SAMARITAN SOCIETY - COMFORCARE** 1201 17TH STREET NE AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX PREFIX (X5) COMPLETION (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 12 F 441 R2's tube feeding syringe bottle touch the eye lids. was immediately changed out. We have added to our R10 had diagnosis that included macular process to date the syringe degeneration. storage bag and continue to change the syringe every 24 Document review of physician orders dated hours. In addition, we have 4/9/13; revealed physician orders for artificial added to our Enteral Feeding tears two drops both eyes four times a day. Flow Sheet "syringe" for nurses to document their Document review of the facility medication initials when changing the administration record dated 6/01/13 to 6/12/13, syringe every 24 hours. Rerevealed R10 received eye drops as ordered. education was provided to all Nurses regarding dating of During medication administration observation on the tube feeding syringe 6/10/13, at 3:30 p.m., trained medication storage bag and the changes assistant-B (TMA-B) washed hands and put on gloves. R10 held lower eye lids open as TMA-B to the Enteral Feeding Flow administered eye drops into R10's eyes. sheet through a packet on 7/10/2013. Processes will be Observation at that time revealed TMA-B touched tip of eye drop bottle on both lower eye lids when reviewed again at July Nurse's meeting on administering eye drops. 7/25/2013. During interview on 6/10/13, at 3:45 p.m., TMA-B Audits for dating the syringe verified she had touched the lower eye lids with storage bag and documentation of flow sheet the tip of the bottle. will be conducted by DNS or R30 had diagnosis that included macular designee weekly X4 and degeneration. monthly X3. Audit results will be Document review of physician orders dated presented to Quality 5/28/13; revealed physician orders for natural Committee for further tears one to two drops to both eyes two times a

day and as needed for dry eyes.

Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R30 received eye drops as ordered.

recommendations.

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

PRINTED: 06/25/2013 FORM APPROVED

STATEME AND PLAN	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	(X2) MULTIPLE CONSTRUCTION A. BUILDING MN Dapt of Health Rocheste		(X3) DATE SUF COMPLET		
		245317	B. WING	3	Rochester		NG/42/2042	
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - COMFORCARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULDEE	(X5) COMPLETION DATE	
R3 Doc 5/13 (ipraby n	put on gloves, pulled lids and administered Observation at that tin tip of eye drop bottle owhen administering eye drop bettle owhen administering eye of the country of nursing (DON) verified she had touch for nursing (DON) verifient of the eye with dministering eye drop id touch the eye they as the bottle is considered by the country of facility Eye MO9, revealed Procedury EBALL SURFACE WINTMENT TUBE. To its sident to look up and an junctiva, have residently is nebulizer equipmentaned and air dried afted dication had been corthad diagnosis that incomment review of physicial atropium bromide with	Iministration observation on registered nurse-B (RN-B) down on R30's lower eye eye drops into eyes. The revealed RN-B touched on upper eye lids and lashes ye drops. 13/13, at 7:27 a.m., RN-B ed the lashes of the right 13/13, at 1:45 p.m., director ed staff was not to touch the eye drop bottle when s. The DON stated if staff are told to get a new bottle, red contaminated. Idedication policy dated re 6."NEVER TOUCH /ITH DROPPER OR nstill eye drops: Instruct away. Instill into lower and close eyes gently" It was observed to not be er administration of mpleted.	F4	41				

	DEPA	EPARTMENT OF HEALTH AND HUMAN SERVICES				PRINTED: 06/25/2013	
_	CENTERS FOR MEDICARE & MEDICAID SERVICES				1111	FOR	M APPROVED
1	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MU A. BUILI	JUL 1 5 JULTIPLE CONSTRUCTION 2013 DING Rochester	(X3) DA	O. 0938-0391 ATE SURVEY MPLETED
L			245317	B. WING	-10)		
Γ	NAME OF	PROVIDER OR SUPPLIER					/13/2013
1	GOOD S	SAMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE		
H			2074 - 3 2074 (2020)		AUSTIN, MN 55912		
	(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFII TAG	PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OUT D BE	(X5) COMPLETION DATE
	F 441	Continued From pag	e 1 <i>1</i>				
		Document review of	the facility medication	F 44	41		
	.	administration record	dated 6/01/13 to 6/12/13	1			
		ordered.	nebulizer medication as				1
	1	→ ******					
		Observations on 6/12 practical nurse (LPN).	/13, at 11:53 a.m., licensed C washed hands, put on				8 20
	1 9	gioves, placed medica	ation in nebulizer cup and				
	18	attached the cup to the	e face mask. LPN-Ċ k to R3 and started the				
	jr	nebulizer machine. Ob	servations at 12:09 n m				
	()	k3 came out of room.	nebulizer machine was			1	
	C	onnected to the mach	ip and mask remained ine and lay on R3 's tray		1		
	1 (8	able. There was moist	ure droplets in the			-	
	D.	nedication cup observentsm noted the nebuliz	ed. Observation at 12:26 er cup and mask remained				
	ur	ndisturbed on R3's tra	v table. Observations at				
	1:49 p.m., revealed the same with droplets in the nebulizer cup and no evidence the tubing and						
	me	edication cup had bee	en rinsed and allowed to				
	air	dry.		1			
	Du	ring interview on 6/12	1/13, at 2:15 p.m., LPN-C	1	9 6		
	AGI	illed the nebulizer eq	Ulbment had not vet heen	ļ	•		
	afte	aned and that she no er the nebulizer treatn	rmally cleaned it right	1			1
	- 1						
	veri	ring interview on 6/13/ ified staff was expected	/13, at 1:45 p.m., DON				,
	equ	iipinent when done wi	th the nebulizer				
	trea	itment. She expected	staff to take it apart				1
	111131	e it in warm water, an	u lay flat to air dry.				
	Rev	iew of facility Nebulize	er policy dated 9/10,				
	med	er procedure number ication administration	16. "Following , rinse equipment with				
	hot v	vater and place on pa	per towel to air dry.				
	1		,	1			1'

	CENT	ERS FOR MEDICARE	AND HUMAN SERVICES & MEDICAID SERVICES			JUL 15 2019	FOR	ED: 06/25/2013 RM APPROVED
	STATEME	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII	IULT LDII	riple constituction NGRochester	(X3) D	O. 0938-0391 ATE SURVEY OMPLETED
L			245317	B. WIN	IG_			
	NAME OF	PROVIDER OR SUPPLIER			s	TREET ADDRESS, CITY, STATE, ZIP CODE	1 0	6/13/2013
	GOOD	SAMARITAN SOCIETY	- COMFORCARE	Æ		1201 17TH STREET NE		.
	(X4) ID	SUMMARY STAT	EMENT OF DEFICIENCIES	ID		AUSTIN, MN 55912		
	PREFIX TAG	(EACH DEFICIENCY)	MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREF	ΊX	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	DRE	COMPLETION DATE
	F 441	Continued From page Then wash hands."	e 15	F4	141			
	1	feeding tube insertion feeding tube through the wall, directly into the s replacement every 24	y tube (A gastrostomy is the placement of a the skin and the stomach stomach) lacked evidence of hours.					
3	1	disease, hemiplegia ar dominant side. Document review of ph 5/07/13, revealed phys	t included cerebrovascular and hemiparesis affecting bysician orders dated ician orders for by gastrostomy tube.					
	a re	Document review of the dministration record da evealed R2 received m	e facility medication ated 6/01/13 to 6/12/13, redications as ordered.					
	tin wa ad me	PN-B administered six me after they were crus ater, placed into the me iministered into the gas adication syringe was a	shed then mixed with edication syringe and strostomy tube. The not dated to identify if it					
	Ina	ring interview on 6/10/ icated she did not kno en replaced.	13, at 6:45 p.m., LPN-B w when the syringe had					
	pap	s medication syringe la	at 4:58 p.m., revealed by on the counter on a devidence to when the deen replaced.			e e		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 06/25/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING COMPLETED 245317 B. WING NAME OF PROVIDER OR SUPPLIER 06/13/2013 STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - COMFORCARE **1201 17TH STREET NE** AUSTIN, MN 55912 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE (X5) COMPLETION TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) F 441 Continued From page 16 F 441 During interview on 6/13/13, at 1:45 p.m., DON stated she expected the syringe to be changed every 24 hours. DON verified there was no documentation on the treatment record to indicate the syringe had been changed in 24 F 492 hours and that staff did not date the syringe. Review of facility Tube Feedings: Gastrostomy or Resident 83 was issued a refund Jejunostomy policy dated 3/11 directed staff, check from the center on 6/30/13 for "Syringes should be changed every 24 hours." the demand bill dates of 3/1/13 to F 492 483.75(b) COMPLY WITH 3/7/13. No other residents have F 492 SS=D | FEDERAL/STATE/LOCAL LAWS/PROF STD requested a demand bill to date. The facility must operate and provide services in compliance with all applicable Federal, State, and We have updated our current process local laws, regulations, and codes, and with on 7/10/13 and at the billing center accepted professional standards and principles on 6/14/13 to ensure timely and that apply to professionals providing services in accurately billing for demand bills. such a facility. Education was provided to staff affected: Social Services Director This REQUIREMENT is not met as evidenced and Business Office on 7/10/13. Based on interview and document review, the facility failed to submit a demand bill timely and Audits for timely billing and failed to suspend billing while Medicare demand suspending billing to residents with bill decision was pending for 1 of 1 resident (R83) demand bills will be put into place as reviewed in the sample who requested bill they occur; as demand bills are so submitted to Medicare for review. infrequent at the center. Audits will be conducted by Billing Supervisor Findings include: and/or Administrator monthly to R83 requested bill submitted to intermediary for ensure accurate and timely billing. review and was billed for services while waiting Audit results will be presented to for the determination by the intermediary. Quality committee for further R83 received Skilled Nursing Facility recommendations.

CENT	ERS FOR MEDICARI	H AND HUMAN SERVICES & MEDICAID SERVICES		IIII A P	FOR	D: 06/25/2 M APPRO\
STATEME	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		DING MN Dept of Health Rochester	(X3) DA	O. 0938-0 ATE SURVEY OMPLETED
		245317	B. WIN			22 (B - 12)
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 06	5/13/2013
GOOD S	SAMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREF TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO	HIDDE	(X5) COMPLETIC DATE
F 492	Continued From pag	0.17				
	Determination on Co notice dated 2/25/13, covered services wor The notice indicated submitted to the inter decision. R83 also re Provider Non-Covera	ntinued Stay, a denial letter which indicated Medicare uld cease effective 2/28/13. R83 wanted the bill mediary for a Medicare ceived Notice of Medicare	F 4	92		
	included the Quality Information to request acility decision to store the comment review of the comment review	mprovement Organization an immediate appeal of the Medicare.	ż			*
R N re M be M ce De lea da a n adr ber den req the male	deview of the facility Mon-Coverage Notifical and, "When a resident dedicare-certified section used because skilled because skilled and because skilled are) is no longer rust receive a written inter fulfills this requirest one day prior to the stremination on Continust one day prior to the y." "If you believe that on-covered level of comission or at some positicary proper notice deficiary disagrees and bill to the MAC, west or accept depositions and the second conficiary for the second conficiary for the second conficiary for the second conficial was a second conficial to the machine the second conficial was a second conficial to the machine the second conficial was a second conficial to the s	edicare Part A tions policy dated 4/10, is moved from the on before 100 days have lled care (as defined by necessary, the beneficiary on-coverage notice. The ement by issuing the SNF nued Stay (GSS 926) at a last covered Medicare a beneficiary requires on are beginning with int thereafter, give the to that effect. If the d asks you to submit a you may not require, t or other payment from vices until the MAC ation that the services				

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

JUL 15 2013

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		301 13 2013	OMB N	O. 0938-039
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION DON	(X3) D	O. 0936-039 ATE SURVEY OMPLETED
	245317	B. WING			
NAME OF PROVIDER OR SUPPLIER				06	/13/2013
GOOD SAMARITAN SOCIETY	COMFORCARE	12	EET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE	8	
(X4) ID SUMMARY STAT	EMENT OF DEFICIENCIES	101	USTIN, MN 55912		
	MUST BE PRECEDED BY FULL DIDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	MIII D mm	(X6) COMPLETION DATE
explained R83 went of back on Medicare 3/7/ on 3/16/13. During into administrator stated from billed private pay, then to 3/15/13, off Medicar private pay to current to verified R83 requested period of 3/1-3/7/13. The that although the bill for to Medicare on 3/15/13, confusion and the bill nebefore submitted for the administrator verified the	me. The administrator a demand bill for the le administrator explained 3/1-3/7/13 was submitted there was some leeded to be cleared period of 3/1-3/7/13. The				
3/1-3/7/13, was submitted consideration on 6/13/13 verified R83 had been bited 3/1-3/7/13 and 3/16/13 to administrator verified the still pending. Although reconstruction R83's billing was provided	d to Medicare for The administrator Iled private pay for the present. Also the Medicare decision was		,		

F53170Z1

DEPA	ARTMENT OF HEALTH	H AND HUMAN SERVICES		JUL 15 2013	PRINTED: 06/25/201 FORM APPROVE
		& MEDICAID SERVICES		MN Dept of Health	OMB NO. 0938-039
	ENT OF DEFICIENCIES N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA		ultiple construction	(X3) DATE SURVEY COMPLETED
VIAD LITAL	NONCOMPINE	IDENTIFICATION NUMBER	A. BUIL	LDING 02 - BUILT IN 2007	COMPLETED
		245317	B. WIN	G	06/13/2013
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	8
GOOD	SAMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE	
				AUSTIN, MN 55912	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREF		LD BE COMPLETION
TAG	REGULATORY OR LS	C IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE DATE
	 		1-		
K 000	INITIAL COMMENTS	S	K	000	1
M =	1		}	Preparation and execution	on of
2013	FIRE SAFETY			this response and plan of	on or
i	THE FACILITY'S PO	Ç WILL SERVE AS YOUR		correction does not const	244
in .	ALLEGATION OF CO	OMPLIANCE UPON THE		an admission or agreeme	nate
12		CEPTANCE, YOUR BOTTOM OF THE FIRST		the provider of the truth	nt by
2		-2567 WILL BE USED AS	1	the facts allowed and the truth	ot
o'	VERIFICATION OF C		1	the facts alleged or	1
3	LIDON DECEIDT OF	AN ACCEPTABLE POC,		conclusions set forth in th	
• *		T OF YOUR FACILITY MAY		statement of deficiencies.	The
U	BE CONDUCTED TO	VALIDATE THAT	1	plan of correction is prepa	ared
A	SUBSTANTIAL COMP REGULATIONS HAS		[and/or executed solely	1
		I YOUR VERIFICATION.	į	because it is required by t	he
1	27			provisions of federal and s	tate
1	A Life Safety Code Su	rvey was conducted by the		law. For the purposes of a	nv
		t of Public Safety - State		allegation that the center is	S
m	Fire Marshal Division.	At the time of this survey,		not in substantial complian	ice
	Good Samarltan Socie not in substantial comp	ty Comforcare was found		with federal requirements	of
	equirements for partici	pation in		participation, this response	
101	/ledicare/Medicaid at 4	2 CFR, Subpart		and plan of correction	
		rom Fire, and the 2000 Protection Association	11/	constitutes the center's	
- 0		Mr. Onfat. Onda (LOO)	_ [allegation of compliance in	
	hapter 18 New Health	Care.	JUL	accordance with section 73(15
Qp	LEASE RETURN THE	PLANOE		of the State Operations	13
	ORRECTION FOR TH	1 1 1	ත ්	Manual.	1
	EFICIENCIES	125	2013	E Dac A	1
5	K-TAGS) TO:	tions Sapril	ω I	1	
	ealth Care Fire Inspect	HOIIS]0	1/10/13	
	ate Fire Marshal Divisi				
44	5 Minnesota St., Suite	145		7.	
CATORY DIF	RECTOR'S OR PROVIDER/SU	IPPLIER REPRESENTATIVE'S SIGNA	TURE	TITLE	(X6) DATE
Wa	talk (to	ormerly Rupk	alus) Administrator	7/11/13

ny deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days illowing 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 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued ogram participation.

If annihmentian street make the

DEPA CENT	RTMENT OF HEALT ERS FOR MEDICARI	H AND HUMAN SERVICES E & MEDICAID SERVICES		JUL 15 2013	FORM	D: 06/25/20 M APPROVE D. 0938-039
	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL	ULTIPLE CONSTRUCTION DING 02 - BUILT IN 2007	(X3) DA	TE SURVEY MPLETED
		245317	B. WING	G	06	/13/2013
	PROVIDER OR SUPPLIER BAMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP COD 1201 17TH STREET NE AUSTIN, MN 55912		13/2013
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K 000	Continued From pag St Paul, MN 55101-t		KO	900		
	By email to: Barbara.Lundberg@ Marian.Whitney@sta	state.mn.us and te.mn.us	*	~		
- 11	THE PLAN OF CORF DEFICIENCY MUST FOLLOWING INFOR	RECTION FOR EACH INCLUDE ALL OF THE MATION:				L.
1	A description of who correct the deficient	at has been, or will be, done cy.				ø
2	. The actual, or propo	esed, completion date.				
re	. The name and/or titlesponsible for corrective revent a reoccurrence	on and monitoring to			.	
co	illding with no baseme	y Comforcare, Is a 1-story ent. The building was I was determined to be of n.				
fire det mo noti roo	e alarm system with fur ection, spaces open to nitored for automatic	to the corridors that is fire department oke alarm in all resident of the nurse call	*	ei ei		
The	e facility has a capaci sus of 44 at the time o	by of 45 beds and had a of the survey.		N		

DEPARTMENT OF HEALTH AND HUMAN SERVICES PRINTED: 08/25/2013 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES OMB NO. 0938-0391 (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: (X3) DATE SURVEY A. BUILDING 02 - BUILT IN 2007 COMPLETED pl of Health Rochester 245317 B. WING NAME OF PROVIDER OR SUPPLIER 06/13/2013 STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - COMFORCARE 1201 17TH STREET NE AUSTIN, MN 55912 SUMMARY STATEMENT OF DEFICIENCIES (X4) ID (EACH DEFICIENCY MUST BE PRECEDED BY FULL PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX (X6) COMPLETION REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE TAG DATE DEFICIENCY) K 000 Continued From page 2 K 000 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD K 025 K025. K 025 SS=D Smoke barriers are constructed to provide at least a one-hour fire resistance rating in The smoke barrier wall in the Lodge accordance with 8.3. Smoke barriers may Neighborhood, above the ceiling has terminate at an atrium wall. Windows are been repaired using an approved protected by fire-rated glazing or by wired glass method as of 6/14/13, by the panels in approved frames. A minimum of two Environmental Services Director. separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted The Environmental Services Director heating, ventilating, and air conditioning systems. inspected other smoke barrier walls 18.3.7.3, 18.3.7.5, 18.1.6.3 in the facility on 6/14/13. This facility is in substantial compliance as of 6/14/13. This STANDARD is not met as evidenced by: This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier wall in accordance with the following requirements of 2000 NFPA 101, Section 18.3.7.3, and 8.3.4.1. The deficient practice could affect all 47 residents. Findings include: On facility tour between 9:00 AM and 11:30 AM on 06/13/2013, observation revealed that the

smoke barrier wall in the Lodge wing - above the

ceiling has open penetrations around:

	MENT OF DEFICIENCIES AN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI	JUL 15 PLE CONSTRUCTION 13	OMB N	ED: 06/25/ RM APPRO IO. 0938-0 PATE SURVE	
	-	245317	B. WING_	G 02 - BUILT IN 2007	C	OMPLETED	
NAME O	F PROVIDER OR SUPPLIER				0	6/13/2013	
	SAMARITAN SOCIETY	92	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)		(X6) COMPLETI DATE	
K 025	Continued From pag	ge 3	K 025	our locator)			
	Bundle of several open 1/2 inch con	cables duit end			ž¥.		
	NOTE: Ensure ALL sexterior wall to exterio deficiency.	smoke barrier walls from or wall are checked for this					
ж.	This deficient practice Maintenance Director (discovery.	was confirmed by the (PC) at the time of					
Ğ	TEAM COMPOSITION Pary Schroeder, Life Sa	N* afety Code Spc.					
	2						
				**			
				340			
				90			
			1				
2567(02-99)	Previous Versions Obsolete	Event ID; 16W721	Facility ID: 0098			1	



Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 2654

June 25, 2013

Ms. Sara Rupkalvis, Administrator Good Samaritan Society - Comforcare 1201 17th Street Ne Austin, MN 55912

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5317024

Dear Ms. Rupkalvis:

The above facility was surveyed on June 10, 2013 through June 13, 2013 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and to investigate complaint number . that was found to be unsubstantiated. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

The State licensing orders are delineated on the attached Minnesota Department of Health order form (attached). The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

Good Samaritan Society - Comforcare June 25, 2013 Page 2

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

When all orders are corrected, the order form should be signed and returned to this office at Minnesota Department of Health, 18 Wood Lake Drive, Southeast Rochester, Minnesota 55904. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact Gary Nederhoff at (507) 206-2731.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Program Specialist Program Assurance Unit Licensing and Certification Program Division of Compliance Monitoring

Telephone: (651) 201-4118 Fax: (651) 215-9697

Email: mark.meath@state.mn.us

Enclosure(s)

cc: Original - Facility
Licensing and Certification File

s5417s13lic.rtf

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00967		B. WING		06/13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CC	MFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
2 000	Initial Comments			2 000			
	*****ATTENTION*****						
	NH LICENSING CORRECTION ORDER						
	In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been						
	Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected.		ow. o red n will item				
	You may request a hearing on any assessmenthat may result from non-compliance with the orders provided that a written request is made the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 10, 11, 12 and 13, 2013, surveyors of this Department's staff visited the above prove and the following licensing orders were issued. When corrections are completed, please sign date, make a copy of these orders and return original to the Minnesota Department of Health Division of Compliance Monitoring, Licensing		ese de to				
			vider ed. n and n the ılth,		Minnesota Department of Health is documenting the State Licensing Correction Orders using federal softw Tag numbers have been assigned to Minnesota state statutes/rules for Nur Homes.		

Minnesota Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		00967		B. WING		06/13/2013			
NAME OF PR	ROVIDER OR SUPPLIER	•	STREET ADD	ADDRESS, CITY, STATE, ZIP CODE					
GOOD SA	MARITAN SOCIETY - CO	OMFORCARE		TH STREET NE MN 55912					
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2 000	Continued From page	e 1		2 000					
	Certification Program Rochester, MN 55904	n; 18 Wood Lake Drive	SE,		The assigned tag number appears in far left column entitled "ID Prefix Ta The state statute/rule out of compliant listed in the "Summary Statement of Deficiencies" column and replaces the Comply" portion of the correction ord This column also includes the finding which are in violation of the state state after the statement, "This Rule is not as evidence by." Following the surve findings are the Suggested Method of Correction and Time period for Correction and Time period for Correction and Time period for Corrections." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. TWILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION VIOLATIONS OF MINNESOTA STATUTES/RULES.	g." nce is ne "To ler. gs tute met eyors of ection. NG OF HIS			
21375	MN Rule 4658.0800 Program	Subp. 1 Infection Contr	ol;	21375					
	home must establish	control program. A nu and maintain an infecti gned to provide a safe	on						
	by: Based on observation review, the facility fail	nt is not met as evidence n, interview and docum led to promote practice f infection for 2 of 2 res ved for eye drop	ent s to						

Minnesota Department of Health

STATE FORM 6899 16W711 If continuation sheet 2 of 15

Minnesota Department of Health

AND PLAN OF CORRECTION IDENTIFI		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME		l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00967		B. WING		06/13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	-	
GOOD SA	MARITAN SOCIETY - CC	OMFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912			
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21375	Continued From page	2		21375			
	administration, 1 of 1 resident (R3) observed for nebulizer administration who's equipment was not cleaned or air dried after use, and 1 of 1 resident (R2) who had an undated medication syringe in use. Findings include: R10 and R30 were observed during eye drop administration to have the tip of the eye drop bottle touch the eye lids. R10 had diagnosis that included macular degeneration.		as not ident				
	4/9/13; revealed phys	physician orders dated sician orders for artificia eyes four times a day.	àl				
		he facility medication dated 6/01/13 to 6/12/ d eye drops as ordered	•				
	During medication administration observation on 6/10/13, at 3:30 p.m., trained medication assistant-B (TMA-B) washed hands and put on gloves. R10 held lower eye lids open as TMA-B administered eye drops into R10's eyes. Observation at that time revealed TMA-B touched tip of eye drop bottle on both lower eye lids when administering eye drops. During interview on 6/10/13, at 3:45 p.m., TMA-B verified she had touched the lower eye lids with the tip of the bottle.		on A-B uched				
	R30 had diagnosis the degeneration.	at included macular					
	Document review of p	physician orders dated					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 1	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
				A. BUILDING: _				
		00967		B. WING		06/	13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - CC	MFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
21375	Continued From page	: 3		21375				
	5/28/13; revealed physician orders for natural tears one to two drops to both eyes two times a day and as needed for dry eyes.							
	Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R30 received eye drops as ordered.							
	During medication administration observation on 6/13/12, at 7:15 a.m., registered nurse-B (RN-B) put on gloves, pulled down on R30's lower eye lids and administered eye drops into eyes. Observation at that time revealed RN-B touched tip of eye drop bottle on upper eye lids and lashes when administering eye drops. During interview on 6/13/13, at 7:27 a.m., RN-B verified she had touched the lashes of the right							
			N-B					
	eye.							
	of nursing (DON) veri any part of the eye wi administering eye dro	/13/13, at 1:45 p.m., dir fied staff was not to tou th the eye drop bottle v ps. The DON stated if s y are told to get a new le lered contaminated.	ich vhen staff					
	1/09, revealed Proced EYEBALL SURFACE OINTMENT TUBE. To resident to look up an	Medication policy date dure 6."NEVER TOUCH WITH DROPPER OR o instill eye drops: Instr d away. Instill into lowe ident close eyes gently	d uct er					
	R3's nebulizer equipment was observed to not be cleaned and air dried after administration of medication had been completed.		ot be					
	R3 had diagnosis tha	t included cough.						

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00967		B. WING		06/	/13/2013	
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - CC	OMFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21375	5/13/13, revealed phy (ipratropium bromide by nebulizer four time as needed. Document review of the administration record revealed R3 received ordered. Observations on 6/12 practical nurse (LPN)-gloves, placed medical attached the cup to the handed nebulizer machine. O R3 came out of room, turned off, nebulizer connected to the machine attached the republication cup obserp.m., noted the nebulication cup of the nebulizer cup and no medication cup had be air dry. During interview on 6 verified the nebulizer tree cleaned and that she after the nebulizer tree.	ohysician orders dated visician orders for duone with albuterol sulfa) on as daily and every four limited facility medication dated 6/01/13 to 6/12/10 nebulizer medication at 12:03 a.m., licer-C washed hands, put of ation in nebulizer cup at face mask. LPN-C sk to R3 and started the bservations at 12:09 p., nebulizer machine was the and lay on R3 's started droplets in the eved. Observation at 12 izer cup and mask remained the eved. Observations at 12:12 izer cup and mask remained the eved. Observation at 12 izer cup and mask remained and allowed with droplets in evidence the tubing an een rinsed and allowed 12/13, at 2:15 p.m., LF equipment had not yet normally cleaned it right atment.	e vial hours 13, as nsed on and e m., as detray 2:26 ained as at an the aid detro PN-C been and on the aid detro ON er	21375				

6899

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				A. BUILDING: _				
		00967		B. WING		06/	13/2013	
NAME OF PF	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	•		
GOOD SA	MARITAN SOCIETY - CO	OMFORCARE		TH STREET NE MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF CORREI (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21375	Continued From page	e 5		21375				
	Review of facility Nebulizer policy dated 9/10, under procedure number 16. "Following medication administration, rinse equipment with hot water and place on paper towel to air dry. Then wash hands."							
	feeding tube insertion feeding tube through	y tube (A gastrostomy is the placement of a the skin and the stoma stomach) lacked evider						
	R2 had diagnoses that included cerebrovascular disease, hemiplegia and hemiparesis affecting dominant side.							
	5/07/13, revealed phy	physician orders dated vsician orders for en by gastrostomy tube	e.					
		he facility medication dated 6/01/13 to 6/12/ medications as ordere						
	LPN-B administered stime after they were considered into the administered into the medication syringe with the syring	1/13, at 6:45 p.m., reveal six medications one at a crushed then mixed with medication syringe an gastrostomy tube. The as not dated to identify least 24 hours when it no yent infections.	a n d if it					
	During interview on 6/10/13, at 6:45 p.m., LPN-B indicated she did not know when the syringe had been replaced.							
		:/13, at 4:58 p.m., revea ge lay on the counter o						

Minnesota Department of Health

STATE FORM 6899 16W711 If continuation sheet 6 of 15

Minnesota Department of Health

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00967		B. WING		00	6/13/2013	
NAME OF PR	OVIDER OR SUPPLIER	•	STREET ADI	DRESS, CITY, STA	ΓE, ZIP CODE			
			1201 17TH AUSTIN, N	I STREET NE IN 55912				
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
21375	Continued From page	e 6		21375				
	paper towel. There w medication syringe ha	as no evidence to whe	n the					
	stated she expected every 24 hours. DON documentation on the indicate the syringe hours and that staff documentation on the indicate the syringe hours and that staff documentation in the indicate the syringe hours and that staff documentation in the indicate the syringe hours are stated in the indicate the syringe hours.	6/13/13, at 1:45 p.m., Do the syringe to be changed I verified there was no e treatment record to had been changed in 24 did not date the syringe. the Feedings: Gastrosto hated 3/11 directed staff changed every 24 hour	ged 1 my or f,					
	nursing or her design procedures regarding The director of nursin educate staff on polic develop a monitoring compliance with surv trending was complete	eillance analysis and	and am. d					
21610	MN Rule 4658.1340 and Preparation Area	Subp. 1 Medicine Cabii a;Storage	net	21610				
	must store all drugs i under proper tempera	of drugs. A nursing hor n locked compartments ature controls, and perr ng personnel to have	3					
	by: Based on observation	nt is not met as evidence n, interview and docum d not ensure medication ures were properly	ent					

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Minnesota Department of Health

		(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB			CONSTRUCTION	I ' '	(X3) DATE SURVEY COMPLETED	
		00967		B. WING		06	/13/2013	
NAME OF PR	ROVIDER OR SUPPLIER			ORESS, CITY, STA	TE, ZIP CODE			
GOOD SA	MARITAN SOCIETY - CO	OMFORCARE	1201 17TH AUSTIN, M	STREET NE IN 55912				
(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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
21610	Continued From page			21610				
	maintained above freezing for 1 of 1 medication storage rooms. This had the potential to affect residents who required medication in an emergency.							
	Findings include:							
	room on 6/13/13, at 1 nurse (RN)-A, a small the room that contain for resident use. Inside a small freezer section surrounded by appropriation of the side and th	quest was made to revierature logs. Itions were stored in the on used for treating dial ial of aspart insulin, one ine vial of Lantus insulind one vial of Regular in the control of the	d I in ion was of er's e 2 ew ebetes e vial , one nsulin.					
	treat anxiety.) Requemanufacturer's guide The manufacturer's ginsulin should be stortemperature range of opening. Tubersol hat that directed to store refrigerator at a temp degrees F. Manufact storage of Ativan was	st was made for copies lines. Juidelines indicated Langed in the refrigerator at 36-46 degrees F befor d a manufacture's guid the medication in the erature range of 36-46 turer's recommendation	of tus the e eline					

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STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
74101274	or derived their	IDENTIFICATION I) LT (.	A. BUILDING: _		0011111	
		00967		B. WING		06/1	3/2013
NAME OF PR	OVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY - CO	OMFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21610	Continued From page	e 8		21610			
	were provided.						
	The director of nursing services (DNS) was interviewed on 6/13/13, at 2:55 p.m. and reported the facility had been unable to locate medication refrigerator temperature logs for 2013. DNS verified the findings and indicated the night shift nurse was responsible for logging the refrigerator temperatures on a daily basis, and for defrosting the refrigerator as needed.						
	The storage of medications policy with a revised date of 1/2012 indicated refrigerators holding medications such as insulin will be kept at 36-46 degrees Fahrenheit. The refrigerator/freezer temperature log policy with an effective date of 11/2010 indicated, refrigerator temperatures are to be recorded daily.						
		OD FOR CORRECTIOng could monitor to assed appropriately.					
	TIME PERIOD FOR (21) days.	CORRECTION: Twent	y one				
21800	MN St. Statute144.65 Residents of HC Fac.			21800			
	residents shall, at adrare legal rights for the stay at the facility or the treatment and mainted that these are describustion written statement of the responsibilities set for case of patients admit as defined in section	on about rights. Patient mission, be told that the eir protection during the hroughout their course enance in the communitied in an accompanying he applicable rights and the to residential programment to the toresidential programment of the written describe the right of a	ere eir of cy and g d				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X2) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X3) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X4) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X5) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X6) PROVIDER/SUPPLIER/ IDENTIFICATION NUMBER (X7) PROVIDER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUPPLIER/SUP			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		00967		B. WING		06	/13/2013
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE		
GOOD SAMADITAN SOCIETY COMEODCADE			1201 17TH AUSTIN, M	STREET NE N 55912			
(X4) ID PREFIX TAG				ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
21800	Continued From page	e 9		21800			
	person 16 years old or older to request release as provided in section 253B.04, subdivision 2, and shall list the names and telephone numbers of individuals and organizations that provide advocacy and legal services for patients in residential programs. Reasonable accommodations shall be made for those with communication impairments and those who speak a language other than English. Current facility policies, inspection findings of state and local health authorities, and further explanation of the written statement of rights shall be available to patients, residents, their guardians or their chosen representatives upon reasonable request to the administrator or other designated staff person, consistent with chapter 13, the Data Practices Act, and section 626.557, relating to vulnerable adults.						
	This MN Requirement is not met as evidenced by: Based on interview, and document review, the facility failed to provide the appropriate Medicare non-coverage notices for 3 of 4 residents (R15, R47, and R70) reviewed who were discharged from Medicare. Findings include: R15, R47, and R70 did not receive the Skilled Nursing Facility Advanced Beneficiary Notice or one of five denial letters, which would inform the resident of the right to have the claim submitted to Medicare for review when the facility had determined Medicare no longer would pay for services.						
	R15 was not given th	e Skilled Nursing Facili	ty				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			SURVEY PLETED
		00967		B. WING		06	/13/2013
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	·	
GOOD SA	MARITAN SOCIETY - CO	DMFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
21800	Advanced Beneficiary informed R15 of the r submitted to Medicard R15 received Notice only. Document revie notices were provided time, social worker st Part A, Medicare serv R15 had been dischad During interview at the verified no other liabil R47 was not given the Advanced Beneficiary informed R47 of the r submitted to Medicard R47 received Notice only. Document revie notices were provided time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that time, social worker st Part A, Medicare serv discharged from faciliat that tim	y Notice or denial letter ight to have the bill e for a decision. of Medicare Non-Cover w revealed no other lia d. During interview at the ated R15 was on Medicines ended on 1/11/13 gred from facility on 1/13 at time, social worker lity notices were given. e Skilled Nursing Facility of Notice or denial letter light to have the bill e for a decision. of Medicare Non-Cover ew revealed no other liad. During interview at the ated R47 was on Medicines ended on 5/13/13 ity 5/14/13. During interview reversitied no other liad to the skilled Nursing interview at the Skilled Nursing interview or denial reficiary Notice or denial reficial ref	rage bility nat care , and 12/13. ty that rage ability nat care , and rview hat care did rview hat care did rview hat care hat c	21800			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967		B. WING		06/1	3/2013
NAME OF PR	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	ATE, ZIP CODE	1 00/1	0/2010
GOOD SA	MARITAN SOCIETY - CO	OMFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912			
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
21800	and was discharged finterview at that time, facility lacked evidence provided. Document is sheet revealed R70 with facility on 1/16/13. During interview on 6 social worker stated to Medicare Non-Coveradetermined residents Medicare coverage. Stacility expected their person to contact the Organization to request the facility decision to the facility did not pronotices. Review of the facility Non-Coverage Notific revealed, "When a re Medicare-certified see been used because so Medicare) is no longer must receive a writter center fulfills this request one day prior to day." "If you believe to a non-covered level of admission or at some beneficiary proper no beneficiary disagrees demand bill to the Marequest or accept depthe beneficiary for the	from the facility. During social worker verified to that liability notices were view of the facility factors and discharged from the vas discharged from the facility provided Notage when the facility no longer qualified for Social worker stated the esident or responsible Quality Improvement est an immediate appears to the vast of the variety of the last covered from the country of the variety of the last covered Medicare Part A stations policy dated 4/1 sident is moved from the country of the last covered from the variety of the last covered Medicare Deginning with a point thereafter, give the last covered from the variety of the last covered from the variety of the last covered from the variety of the variety	e e e e e e e e e e e e e e e e e e e	21800			

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Minnesota Department of Health

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00967		B. WING		06	:/13/2013	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	1 00	, 10.2010	
GOOD SAMADITAN SOCIETY COMEODCADE 1201 17			STREET NE	,				
(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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE		
21800	Continued From page	e 12		21800				
	The administrator or revise polices and probil and Medicare nor Medicare rights are nadministrator or design appropriate staff. The could develop a mongoing compliance.	OD FOR CORRECTION designee could review occdures regarding der occoverage notices to en aintained. The gnee could educate all e administrator or designitoring system to ensure CORRECTION: Twent	and mand nsure nee e on					
21855		51 Subd. 15 Patients & .Bill of Rights	:	21855				
	Residents of HC Fac.Bill of Rights Subd. 15. Treatment privacy. Patients and residents shall have the right to respectfulness and privacy as it relates to their medical and personal care program. Case discussion, consultation, examination, and treatment are confidential and shall be conducted discreetly. Privacy shall be respected during toileting, bathing, and other activities of personal hygiene, except as needed for patient or resident safety or assistance.							
	by: Based on observation review, the facility fail treatments and confidence.	nt is not met as evidence n, interview and docum- led to ensure privacy do dentiality of medical rec R2) reviewed in the sam	ent uring ords					
	Findings include:							
	R2 diagnoses include	ed cerebrovascular acci	ident					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIES		CLIA (X2) MULTIF		(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN	AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		BER:	A. BUILDING: _		COMP	COMPLETED	
		00967		B. WING		06/	13/2013	
NAME OF PE	ROVIDER OR SUPPLIER		STREET ADD	DRESS, CITY, STA	ATE, ZIP CODE			
GOOD SAMARITAN SOCIETY - COMFORCARE			1201 17TH AUSTIN, M	STREET NE IN 55912				
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21855	Continued From page 13			21855				
	3/19/13 revealed R2 impairment, was non extensive to total ass living.	-verbal and required istance for activities of	daily					
	During a random observation on 6/10/13 at 1:37 p.m., the medication administration record (MAR) was noted to be opened and unattended, on the top shelf of a cart located outside of R2's resident room in the facility's Lodge unit. The opened MAR exposed a record of R2's medications, doses, routes, schedules and treatments. At 1:40 p.m., trained medication aide (TMA)-A was noted to exit a nearby resident room, assisting another resident down the hallway, traveling past the open MAR. At 1:42 p.m., a visitor and nursing assistant (NA)-B were noted to walk past the open MAR. At 1:45 p.m., licensed practical nurse (LPN)-A exited R2's resident room and closed the MAR. R2's medication information was exposed to passersby for a total of eight minutes.							
	During a medication administration observation on 6/10/13 at 6:45 p.m., LPN-B administered medications to R2 via a gastric tube (g-tube), without providing privacy by closing the door of R2 's room during this treatment. R2 was seated in his recliner, which faced the hallway and was located almost directly in front of the hallway door. LPN-B stood to the side of the recliner, while she checked for placement of the g-tube and then administered the medications. At 7:10 p.m., two unidentified facility employees were noted to walk past the opened door and R2's family member (Family-A) entered and remained in the room for a visit. At 7:12 p.m., another resident was noted to walk past R2's room while the administration of his medications continued.							

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STATEMENT OF DEFICIENCIES (X		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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GOOD SA	MARITAN SOCIETY - CO	OMFORCARE	1201 17TH AUSTIN, M	STREET NE N 55912			
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21855	Continued From page	e 14		21855			
		/10/13 at 7:40 p.m., LP aware she had left R2's t administration of his					
	administration via a g treatment. DON indic	ON) verified that medic tube was a private ated that LPN-B typical					
	close the door of resident rooms during treatments and this occasion "was an oversight." DON verified it was her expectation that resident room doors be closed during procedures and treatments. DON also verified it was her						
	a plastic divider when	AR be closed or covered unattended by a nursed of resident medical reconstruction.	e, to				
	The facility's Confidentiality of Protected Health Information policy revised 4/05 read, "The [facility] will protect the resident's/client's right to personal privacy and confidentiality of his or her personal records."						
	SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could review the importance of treatment privacy with staff. The Director of Nursing could also randomly audit care to ensure that privacy is afforded for residents during treatments.						
	TIME PERIOD FOR CORRECTION: Seven (7) days.						
I							

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