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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 16W7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**
2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY 08/07/2013 (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
___1. Acceptable POC

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

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
Post Certification Revisit by review of the facility's plan of correction, to verify that the facility has achieved and maintained compliance with Federal Certification Regulations. Please refer to the CMS 2567B. Effective July 23, 2013, the facility is certified for 45 skilled nursing facility beds.

17. SURVEYOR SIGNATURE Date :
Garey Nederhoff, Unit Supervisor 08/22/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Colleen B. Leach, Program Specialist 12/20/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
08/08/2013
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 Leach

Colleen B. Leach, Program Specialist
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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245317	A. Building B. Wing	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
ID Prefix **F0156** Reg. # **483.10(b)(5) - (10), 483.10(b)(1)** LSC	Correction Completed **07/23/2013**	ID Prefix **F0164** Reg. # **483.10(e), 483.75(l)(4)** LSC	Correction Completed **07/23/2013**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **07/23/2013**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **07/23/2013**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **07/23/2013**	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	MM/GPN	08/22/2013	10160	08/07/2013
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
6/13/2013			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245317	A. Building B. Wing 02 - BUILT IN 2007	7/17/2013

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
ID Prefix Reg. # **NFPA 101** LSC K0025	Correction Completed **06/14/2013**	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By MM/PS	Date: 08/22/2013	Signature of Surveyor: 25822	Date: 07/17/2013
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 6/13/2013		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

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

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:

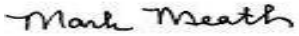
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL — ID: 16W7

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY — Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**

2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **06/13/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

16. STATE SURVEY AGENCY REMARKS (IF APPLICABLE SHOW LTC CANCELLATION DATE):
At the time of the June 13, 2103 standard survey the facility was not in substantial compliance with Federal participation requirements. Please refer to the CMS-2567 for both health and life safety code along with the facility's plan of correction. Post Certification Revisit to follow.

17. SURVEYOR SIGNATURE — Date :
Michelle McFarland, HFE NEII — 07/16/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Mark Meath, Program Specialist — 08/05/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 8/8/2013 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA MDH DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

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

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/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:

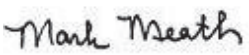
Mr. Patrick Sheehan, Supervisor
Health Care Fire Inspections
State Fire Marshal Division
444 Cedar Street, Suite 145
St. Paul, Minnesota 55101-5145

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
Telephone: (651) 201-4118 Fax: (651) 215-9697
Email: mark.meath@state.mn.us

Enclosure

cc: Licensing and Certification File 5317s13.rtf

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	06/13/2013

JUL 15 2013 MN Dept of Health Rochester

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - COMFORCARE	1201 17TH STREET NE AUSTIN, MN 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	**Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual**	
F 156 SS=D	483.10(b)(5) - (10), 483.10(b)(1) NOTICE OF RIGHTS, RULES, SERVICES, CHARGES The facility must inform the resident both orally and in writing in a language that the resident understands of his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility. The facility must also provide the resident with the notice (if any) of the State developed under §1919(e)(6) of the Act. Such notification must be made prior to or upon admission and during the resident's stay. Receipt of such information, and any amendments to it, must be acknowledged in writing. The facility must inform each resident who is entitled to Medicaid benefits, in writing, at the time of admission to the nursing facility or, when the resident becomes eligible for Medicaid of the items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and	F 156	7/16/13 upn	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sara Falk (formerly Ruptalvis) — TITLE: Administrator — (X6) DATE: 7/11/13

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

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MAY 2013 MN Dept of Health Rochester

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F 156	Continued From page 1 inform each resident when changes are made to the items and services specified in paragraphs (5)(i)(A) and (B) of this section. The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare or by the facility's per diem rate. The facility must furnish a written description of legal rights which includes: A description of the manner of protecting personal funds, under paragraph (c) of this section; A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment under section 1924(c) which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his or her process of spending down to Medicaid eligibility levels. A posting of names, addresses, and telephone 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 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	F 156	F 156 Resident 15's Medicare coverage ended on 1/11/13 and she discharged from facility on 1/12/13. A notice of non-coverage was signed, and according to CMS Bulletin S&C-09-20 this is the only notice the resident needs to receive. R15 did not need to receive the Skilled Nursing Facility Advanced beneficiary notice or denial letter according to the Bulletin on attachment 1. Resident 47's Medicare coverage ended on 5/13/13 and she discharged from facility on 5/14/13. A notice of non-coverage was signed and according to CMS Bulletin S&C-09-20 this is the only notice the resident needs to receive. R47 did not need to receive the Skilled Nursing Facility Advanced beneficiary notice or denial letter according to the Bulletin on attachment 1.	

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JUL 15 2013
MN Dept of Health
Rochester

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F 156	Continued From page 2 misappropriation of resident property in the facility, and non-compliance with the advance directives requirements. The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits. This 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 the Skilled Nursing Facility Advanced Beneficiary Notice or denial letter that	F 156	Resident 70's Medicare coverage ended on 1/15/13 and she discharged from the facility on 1/16/13. A notice of non-coverage was signed on 1/11/13 (see attachment 2) and according to CMS Bulletin S&C-09-20 this is the only notice the resident needs to receive. R70 did not need to receive the Skilled Nursing Facility Advanced beneficiary notice or denial letter according to the Bulletin on attachment 1. All resident have the potential to be affect by this practice. Non coverage notices are issued according to the CMS Bulletin S&C-09-20. No residents have been identified to be affected at this time. We review each notice of non-coverage at the Medicare Meeting weekly. An audit will be done monthly X3 months by Social Services Director or designee. Audit results will be presented to Quality Committee for further recommendations 7/23/13 SPN	

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F 156	Continued From page 3 informed R15 of the right to have the bill submitted to Medicare for a decision. R15 received Notice of Medicare Non-Coverage only. Document review revealed no other liability notices were provided. During interview at that time, social worker stated R15 was on Medicare Part A, Medicare services ended on 1/11/13, and R15 had been discharged from facility on 1/12/13. During interview at that time, social worker verified no other liability notices were given. R47 was not given the Skilled Nursing Facility Advanced Beneficiary Notice or denial letter that informed R47 of the right to have the bill submitted to Medicare for a decision. R47 received Notice of Medicare Non-Coverage only. Document review revealed no other liability notices were provided. During interview at that time, social worker stated R47 was on Medicare Part A, Medicare services ended on 5/13/13, and discharged from facility 5/14/13. During interview at that time, social worker verified no other liability notices were given. R70 had not been given the Skilled Nursing Facility Advanced Beneficiary Notice or denial letter that informed R70 of the right to have the bill submitted to Medicare for a decision and did not provide R70 the Notice of Medicare Non-Coverage which included the Quality Improvement Organization information to request an immediate appeal of the facility decision to stop Medicare. R70 lacked evidence of provided liability notices. During interview at that time, social worker stated	F 156		

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F 156	Continued From page 4 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	F 156		

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F 156	Continued From page 5 makes the initial determination that the services are not covered by Medicare."	F 156		
F 164 SS=D	483.10(e), 483.75(l)(4) PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS The resident has the right to personal privacy and confidentiality of his or her personal and clinical records. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident. Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility. The resident's right to refuse release of personal and clinical records does not apply when the resident is transferred to another health care institution; or record release is required by law. 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 by: Based on observation, interview and document review, the facility failed to ensure privacy during	F 164	F 164 Re-education was provided to all Nurses/TMA's regarding Personal Privacy and Confidentiality of Records 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 Privacy during treatments and Confidentiality of MAR (medication administration record) will be conducted by DNS or designee weekly X4 and monthly X3. Audit results will be presented to Quality Committee for further recommendations.	7/23/13 DPN

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F 164	Continued From page 6 treatments and confidentiality of medical records for 1 of 2 residents (R2) reviewed in the sample for privacy. Findings include: R2 diagnoses included cerebrovascular accident (stroke), hemiparesis and aphasia. The quarterly Minimum Data Set (MDS) dated 3/19/13 revealed R2 had a mild cognitive impairment, was non-verbal and required extensive to total assistance for activities of daily living. 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	F 164		

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F 164	Continued From page 7 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 164		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of	F 431		

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F 431	Continued From page 8 a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medication refrigerator temperatures were properly	F 431	F 431 Refrigerator was cleaned and 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 to all Nurses regarding Medication refrigerator policy & procedure through a packet on 7/10/2013. Processes will be reviewed again at July Nurse's meeting 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. 7/23/13 SPN	

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F 431	Continued From page 9 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: During observation of the medication storage room on 6/13/13, at 1:05 p.m. with registered nurse (RN)-A, a small refrigerator was noted in the room that contained emergency medication for resident use. Inside the refrigerator there was a small freezer section on the top which was surrounded by approximately 1 ½- 2 inches of thick ice on the side and bottom of the freezer's outer and inner shell. The thermometer in the refrigerator identified the temperature was 32 degrees Fahrenheit (F.) The findings were verified by RN-A. Request was made to review the medication temperature logs. The following medications were stored in the refrigerator; medication used for treating diabetes which included one vial of aspart insulin, one vial of Novolog insulin, one vial of Lantus insulin, one vial of NPH insulin and one vial of Regular insulin. Three vials of tubersol (used to test for tuberculosis,) and two vials of Ativan (used to treat anxiety.) Request was made for copies of manufacturer's guidelines. The manufacturer's guidelines indicated Lantus insulin should be stored in the refrigerator at the temperature range of 36-46 degrees F before opening. Tubersol had a manufacture's guideline that directed to store the medication in the refrigerator at a temperature range of 36-46 degrees F. Manufacturer's recommendation for	F 431		

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F 431	Continued From page 10 storage of Ativan was to keep refrigerated between 36-46 degrees. No further guidelines 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.	F 431	F 441 R10 and R30's eye drop containers were disposed of upon notification by employees that contamination 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 completed weekly X 4 and monthly X 3 by DNS or designee. Audit results will be presented to Quality Committee for further recommendations.	7/23/13 DPN
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 11 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote practices to prevent the spread of infection for 2 of 2 residents (R10 and R30) observed for eye drop 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	F 441	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.	

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F 441	Continued From page 12 bottle touch the eye lids. R10 had diagnosis that included macular degeneration. Document review of physician orders dated 4/9/13; revealed physician orders for artificial tears two drops both eyes four times a day. Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R10 received 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. R30 had diagnosis that included macular degeneration. Document review of physician orders dated 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.	F 441	R2's tube feeding syringe was immediately changed out. We have added to our process to date the syringe storage bag and continue to change the syringe every 24 hours. In addition, we have added to our Enteral Feeding Flow Sheet "syringe" for nurses to document their initials when changing the syringe every 24 hours. Re-education was provided to all Nurses regarding dating of the tube feeding syringe storage bag and the changes to the Enteral Feeding Flow sheet through a packet on 7/10/2013. Processes will be reviewed again at July Nurse's meeting on 7/25/2013. Audits for dating the syringe storage bag and documentation of flow sheet will be conducted by DNS or designee weekly X4 and monthly X3. Audit results will be presented to Quality Committee for further recommendations.	

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F 441	Continued From page 13 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 eye. During interview on 6/13/13, at 1:45 p.m., director of nursing (DON) verified staff was not to touch any part of the eye with the eye drop bottle when administering eye drops. The DON stated if staff did touch the eye they are told to get a new bottle, as the bottle is considered contaminated. Review of facility Eye Medication policy dated 1/09, revealed Procedure 6."NEVER TOUCH EYEBALL SURFACE WITH DROPPER OR OINTMENT TUBE. To instill eye drops: Instruct resident to look up and away. Instill into lower conjunctiva, have resident close eyes gently" R3's nebulizer equipment was observed to not be cleaned and air dried after administration of medication had been completed. R3 had diagnosis that included cough. Document review of physician orders dated 5/13/13, revealed physician orders for duonebs (ipratropium bromide with albuterol sulfa) one vial by nebulizer four times daily and every four hours as needed.	F 441		

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F 441	Continued From page 14 Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R3 received nebulizer medication as ordered. Observations on 6/12/13, at 11:53 a.m., licensed practical nurse (LPN)-C washed hands, put on gloves, placed medication in nebulizer cup and attached the cup to the face mask. LPN-C handed nebulizer mask to R3 and started the nebulizer machine. Observations at 12:09 p.m., R3 came out of room, nebulizer machine was turned off, nebulizer cup and mask remained connected to the machine and lay on R3 ' s tray table. There was moisture droplets in the medication cup observed. Observation at 12:26 p.m., noted the nebulizer cup and mask remained undisturbed on R3's tray table. Observations at 1:49 p.m., revealed the same with droplets in the nebulizer cup and no evidence the tubing and medication cup had been rinsed and allowed to air dry. During interview on 6/12/13, at 2:15 p.m., LPN-C verified the nebulizer equipment had not yet been cleaned and that she normally cleaned it right after the nebulizer treatment. During interview on 6/13/13, at 1:45 p.m., DON verified staff was expected to clean nebulizer equipment when done with the nebulizer treatment. She expected staff to take it apart, rinse it in warm water, and lay flat to air dry. 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.	F 441		

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F 441	Continued From page 15 Then wash hands." R2's syringe for medication administration through a gastrostomy tube (A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall, directly into the stomach) lacked evidence of replacement every 24 hours. R2 had diagnoses that included cerebrovascular disease, hemiplegia and hemiparesis affecting dominant side. Document review of physician orders dated 5/07/13, revealed physician orders for medications to be given by gastrostomy tube. Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R2 received medications as ordered. Observations on 6/10/13, at 6:45 p.m., revealed LPN-B administered six medications one at a time after they were crushed then mixed with water, placed into the medication syringe and administered into the gastrostomy tube. The medication syringe was not dated to identify if it had been in service past 24 hours when it needed to be replaced to prevent infections. During interview on 6/10/13, at 6:45 p.m., LPN-B indicated she did not know when the syringe had been replaced. Observations on 6/12/13, at 4:58 p.m., revealed R2's medication syringe lay on the counter on a paper towel. There was no evidence to when the medication syringe had been replaced.	F 441		

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F 441	Continued From page 16 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 hours and that staff did not date the syringe. Review of facility Tube Feedings: Gastrostomy or Jejunostomy policy dated 3/11 directed staff, "Syringes should be changed every 24 hours."	F 441		
F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to submit a demand bill timely and failed to suspend billing while Medicare demand bill decision was pending for 1 of 1 resident (R83) reviewed in the sample who requested bill submitted to Medicare for review. Findings include: R83 requested bill submitted to intermediary for review and was billed for services while waiting for the determination by the intermediary. R83 received Skilled Nursing Facility	F 492	F 492 Resident 83 was issued a refund check from the center on 6/30/13 for the demand bill dates of 3/1/13 to 3/7/13. No other residents have requested a demand bill to date. We have updated our current process on 7/10/13 and at the billing center on 6/14/13 to ensure timely and accurately billing for demand bills. Education was provided to staff affected: Social Services Director and Business Office on 7/10/13. Audits for timely billing and suspending billing to residents with demand bills will be put into place as they occur; as demand bills are so infrequent at the center. Audits will be conducted by Billing Supervisor and/or Administrator monthly to ensure accurate and timely billing. Audit results will be presented to Quality committee for further recommendations.	7/23/13

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F 492	Continued From page 17 Determination on Continued Stay, a denial letter notice dated 2/25/13, which indicated Medicare covered services would cease effective 2/28/13. The notice indicated R83 wanted the bill submitted to the intermediary for a Medicare decision. R83 also received Notice of Medicare Provider Non-Coverage which indicated Medicare services would end on 2/28/13, and included the Quality Improvement Organization information to request an immediate appeal of the facility decision to stop Medicare. Document review of the facility history of claim charges for R83, revealed the claim was forwarded to payer for processing on 6/13/13. Review of the facility Medicare Part A Non-Coverage Notifications policy dated 4/10, read, "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 makes the initial determination that the services are not covered by Medicare." During interview on 6/13/13, at 4:00 p.m., social	F 492		

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F 492	Continued From page 18 worker verified R83 had received Medicare Part A. During interview at that time, the administrator explained R83 went off Medicare 3/1/13 to 3/7/13, back on Medicare 3/7/13, and off Medicare again on 3/16/13. During interview at that time, the administrator stated from 3/1/13-3/7/13, R83 was billed private pay, then on Medicare from 3/7/13 to 3/15/13, off Medicare 3/16/13 and billed private pay to current time. The administrator verified R83 requested a demand bill for the period of 3/1-3/7/13. The administrator explained that although the bill for 3/1-3/7/13 was submitted to Medicare on 3/15/13, there was some confusion and the bill needed to be cleared before submitted for the period of 3/1-3/7/13. The administrator verified the demand bill for 3/1-3/7/13, was submitted to Medicare for consideration on 6/13/13. The administrator verified R83 had been billed private pay for 3/1-3/7/13 and 3/16/13 to the present. Also the administrator verified the Medicare decision was still pending. Although requested, no evidence of R83's billing was provided.	F 492		

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CENTERS FOR MEDICARE & MEDICAID SERVICES

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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING 02 - BUILT IN 2007 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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY 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 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Samaritan Society Comforcare was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 18 New Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	**Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.**	

DC: 07.23.2013

EXIT: 06.13.2013

RECEIVED
JUL 16 2013
FIRE MARSHAL DIVISION
DEPARTMENT OF PUBLIC SAFETY

POC ph
FS 7-16-13

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sara Falk (formerly Rupkalvis)	Administrator	7/11/13

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

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K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Barbara.Lundberg@state.mn.us and Marian.Whitney@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Comforcare, is a 1-story building with no basement. The building was constructed in 2007 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification. There is smoke alarm in all resident rooms that are monitored by the nurse call system and light outside each resident room. The facility has a capacity of 45 beds and had a census of 44 at the time of the survey.	K 000		

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JUN 25 2013 Dept of Health Rochester

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K 000	Continued From page 2 The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 025 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoke barriers are constructed to provide at least a one-hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels in approved frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 18.3.7.3, 18.3.7.5, 18.1.6.3 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:	K 025	K025. The smoke barrier wall in the Lodge Neighborhood, above the ceiling has been repaired using an approved method as of 6/14/13, by the Environmental Services Director. The Environmental Services Director inspected other smoke barrier walls in the facility on 6/14/13. This facility is in substantial compliance as of 6/14/13.	

JUL 15 2013
MN Dept of Health
Rochester

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K 025	Continued From page 3 1. Bundle of several cables 2. open 1/2 inch conduit end NOTE: Ensure ALL smoke barrier walls from exterior wall to exterior wall are checked for this deficiency. This deficient practice was confirmed by the Maintenance Director (PC) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 025		

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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 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, 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

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On June 10, 11, 12 and 13, 2013, surveyors of this Department's staff visited the above provider and the following licensing orders were issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health, Division of Compliance Monitoring, Licensing and	2 000	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.	

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2 000	Continued From page 1 Certification Program; 18 Wood Lake Drive SE, Rochester, MN 55904.	2 000	The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction. 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.	
21375	MN Rule 4658.0800 Subp. 1 Infection Control; Program Subpart 1. Infection control program. A nursing home must establish and maintain an infection control program designed to provide a safe and sanitary environment. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to promote practices to prevent the spread of infection for 2 of 2 residents (R10 and R30) observed for eye drop	21375		

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21375	Continued From page 2 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. Document review of physician orders dated 4/9/13; revealed physician orders for artificial tears two drops both eyes four times a day. Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R10 received 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. R30 had diagnosis that included macular degeneration. Document review of physician orders dated	21375		

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21375	Continued From page 3 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 eye. During interview on 6/13/13, at 1:45 p.m., director of nursing (DON) verified staff was not to touch any part of the eye with the eye drop bottle when administering eye drops. The DON stated if staff did touch the eye they are told to get a new bottle, as the bottle is considered contaminated. Review of facility Eye Medication policy dated 1/09, revealed Procedure 6."NEVER TOUCH EYEBALL SURFACE WITH DROPPER OR OINTMENT TUBE. To instill eye drops: Instruct resident to look up and away. Instill into lower conjunctiva, have resident close eyes gently" R3's nebulizer equipment was observed to not be cleaned and air dried after administration of medication had been completed. R3 had diagnosis that included cough.	21375		

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21375	Continued From page 4 Document review of physician orders dated 5/13/13, revealed physician orders for duonebs (ipratropium bromide with albuterol sulfa) one vial by nebulizer four times daily and every four hours as needed. Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R3 received nebulizer medication as ordered. Observations on 6/12/13, at 11:53 a.m., licensed practical nurse (LPN)-C washed hands, put on gloves, placed medication in nebulizer cup and attached the cup to the face mask. LPN-C handed nebulizer mask to R3 and started the nebulizer machine. Observations at 12:09 p.m., R3 came out of room, nebulizer machine was turned off, nebulizer cup and mask remained connected to the machine and lay on R3 ' s tray table. There was moisture droplets in the medication cup observed. Observation at 12:26 p.m., noted the nebulizer cup and mask remained undisturbed on R3's tray table. Observations at 1:49 p.m., revealed the same with droplets in the nebulizer cup and no evidence the tubing and medication cup had been rinsed and allowed to air dry. During interview on 6/12/13, at 2:15 p.m., LPN-C verified the nebulizer equipment had not yet been cleaned and that she normally cleaned it right after the nebulizer treatment. During interview on 6/13/13, at 1:45 p.m., DON verified staff was expected to clean nebulizer equipment when done with the nebulizer treatment. She expected staff to take it apart, rinse it in warm water, and lay flat to air dry.	21375		

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21375	Continued From page 5 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." R2's syringe for medication administration through a gastrostomy tube (A gastrostomy feeding tube insertion is the placement of a feeding tube through the skin and the stomach wall, directly into the stomach) lacked evidence of replacement every 24 hours. R2 had diagnoses that included cerebrovascular disease, hemiplegia and hemiparesis affecting dominant side. Document review of physician orders dated 5/07/13, revealed physician orders for medications to be given by gastrostomy tube. Document review of the facility medication administration record dated 6/01/13 to 6/12/13, revealed R2 received medications as ordered. Observations on 6/10/13, at 6:45 p.m., revealed LPN-B administered six medications one at a time after they were crushed then mixed with water, placed into the medication syringe and administered into the gastrostomy tube. The medication syringe was not dated to identify if it had been in service past 24 hours when it needed to be replaced to prevent infections. During interview on 6/10/13, at 6:45 p.m., LPN-B indicated she did not know when the syringe had been replaced. Observations on 6/12/13, at 4:58 p.m., revealed R2's medication syringe lay on the counter on a	21375		

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21375	Continued From page 6 paper towel. There was no evidence to when the medication syringe had been replaced. 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 hours and that staff did not date the syringe. Review of facility Tube Feedings: Gastrostomy or Jejunostomy policy dated 3/11 directed staff, "Syringes should be changed every 24 hours." Suggested Method of Correction: The director of nursing or her designee could review policy and procedures regarding infection control program. The director of nursing or her designee could educate staff on policy and procedures and develop a monitoring system to ensure compliance with surveillance analysis and trending was completed. Time Period for Correction: Twenty one (21) days.	21375		
21610	MN Rule 4658.1340 Subp. 1 Medicine Cabinet and Preparation Area;Storage Subpart 1. Storage of drugs. A nursing home must store all drugs in locked compartments under proper temperature controls, and permit only authorized nursing personnel to have access to the keys. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility did not ensure medication refrigerator temperatures were properly	21610		

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21610	Continued From page 7 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: During observation of the medication storage room on 6/13/13, at 1:05 p.m. with registered nurse (RN)-A, a small refrigerator was noted in the room that contained emergency medication for resident use. Inside the refrigerator there was a small freezer section on the top which was surrounded by approximately 1 ½- 2 inches of thick ice on the side and bottom of the freezer's outer and inner shell. The thermometer in the refrigerator identified the temperature was 32 degrees Fahrenheit (F.) The findings were verified by RN-A. Request was made to review the medication temperature logs. The following medications were stored in the refrigerator; medication used for treating diabetes which included one vial of aspart insulin, one vial of Novolog insulin, one vial of Lantus insulin, one vial of NPH insulin and one vial of Regular insulin. Three vials of tubersol (used to test for tuberculosis,) and two vials of Ativan (used to treat anxiety.) Request was made for copies of manufacturer's guidelines. The manufacturer's guidelines indicated Lantus insulin should be stored in the refrigerator at the temperature range of 36-46 degrees F before opening. Tubersol had a manufacture's guideline that directed to store the medication in the refrigerator at a temperature range of 36-46 degrees F. Manufacturer's recommendation for storage of Ativan was to keep refrigerated between 36-46 degrees. No further guidelines	21610		

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21610	Continued From page 8 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. SUGGESTED METHOD FOR CORRECTION: The Director of Nursing could monitor to assure medications are stored appropriately. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21610		
21800	MN St. Statute144.651 Subd. 4 Patients & Residents of HC Fac.Bill of Rights Subd. 4. Information about rights. Patients and residents shall, at admission, be told that there are legal rights for their protection during their stay at the facility or throughout their course of treatment and maintenance in the community and that these are described in an accompanying written statement of the applicable rights and responsibilities set forth in this section. In the case of patients admitted to residential programs as defined in section 253C.01, the written statement shall also describe the right of a	21800		

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21800	Continued From page 9 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 the Skilled Nursing Facility	21800		

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21800	Continued From page 10 Advanced Beneficiary Notice or denial letter that informed R15 of the right to have the bill submitted to Medicare for a decision. R15 received Notice of Medicare Non-Coverage only. Document review revealed no other liability notices were provided. During interview at that time, social worker stated R15 was on Medicare Part A, Medicare services ended on 1/11/13, and R15 had been discharged from facility on 1/12/13. During interview at that time, social worker verified no other liability notices were given. R47 was not given the Skilled Nursing Facility Advanced Beneficiary Notice or denial letter that informed R47 of the right to have the bill submitted to Medicare for a decision. R47 received Notice of Medicare Non-Coverage only. Document review revealed no other liability notices were provided. During interview at that time, social worker stated R47 was on Medicare Part A, Medicare services ended on 5/13/13, and discharged from facility 5/14/13. During interview at that time, social worker verified no other liability notices were given. R70 had not been given the Skilled Nursing Facility Advanced Beneficiary Notice or denial letter that informed R70 of the right to have the bill submitted to Medicare for a decision and did not provide R70 the Notice of Medicare Non-Coverage which included the Quality Improvement Organization information to request an immediate appeal of the facility decision to stop Medicare. R70 lacked evidence of provided liability notices. During interview at that time, social worker stated R70 was on Medicare Part A, went off Medicare,	21800		

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21800	Continued From page 11 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 makes the initial determination that the services are not covered by Medicare."	21800		

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21800	Continued From page 12 SUGGESTED METHOD FOR CORRECTION: The administrator or designee could review and revise polices and procedures regarding demand bill and Medicare non-coverage notices to ensure Medicare rights are maintained. The administrator or designee could educate all appropriate staff. The administrator or designee could develop a monitoring system to ensure on going compliance. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21800		
21855	MN St. Statute 144.651 Subd. 15 Patients & 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. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure privacy during treatments and confidentiality of medical records for 1 of 2 residents (R2) reviewed in the sample for privacy. Findings include: R2 diagnoses included cerebrovascular accident (stroke), hemiparesis and aphasia.	21855		

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21855	Continued From page 13 The quarterly Minimum Data Set (MDS) dated 3/19/13 revealed R2 had a mild cognitive impairment, was non-verbal and required extensive to total assistance for activities of daily living. 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.	21855		

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21855	Continued From page 14 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." 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.	21855		