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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1U5D

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 **04/03/2014** (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:

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

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

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

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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Michele McFarland, HFE NE II 05/27/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 06/27/2014 (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
05/21/2014
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

CCN 24-5317

On 05/22/14, a Post Certification Revisit (PCR) was completed by the Department of Health and on 05/06/14, the Minnesota Department of Public Safety completed a PCR. Based on the PCRs, it has been determined that the facility had achieved substantial compliance pursuant to the 04/03/2014 standard survey, effective May 10,2014. Refer to the CMS 2567b for both health and life safety code.

Effective May 10, 2014, the facility is certified for 45 skilled nursing facility beds.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Medicare Provider # 245317

June 25, 2014

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

Dear Ms. Falk:

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 May 10, 2014 the above facility is certified for or recommended 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,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

May 27, 2014

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

RE: Project Number S5317025

Dear Mr. Falk:

On April 18, 2014, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on April 3, 2014. 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 May 22, 2014, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on May 6, 2014 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 April 3, 2014. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 10, 2014. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on April 3, 2014, effective May 10, 2014 and therefore remedies outlined in our letter to you dated April 18, 2014, 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.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112 Fax: (651) 215-9697
Enclosure

cc: Licensing and Certification File

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	5/22/2014

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 **F0176** Reg. # **483.10(n)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	Correction Completed **05/10/2014**
ID Prefix **F0371** Reg. # **483.35(i)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0425** Reg. # **483.60(a),(b)** LSC	Correction Completed **05/10/2014**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **05/10/2014**
ID Prefix **F0441** Reg. # **483.65** LSC	Correction Completed **05/10/2014**	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	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	GN/kfd	05/28/2014	31217	05/22/2014
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?
4/3/2014	YES NO

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245317	A. Building B. Wing 02 - BUILT IN 2007	5/6/2014

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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix Reg. # NFPA 101 LSC K0069	04/25/2014	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	Reviewed By PS/kfd	Date: 05/28/2014	Signature of Surveyor: 25822	Date: 05/07/2014
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:
Followup to Survey Completed on: 4/3/2014		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 1U5D

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 **04/03/2014** (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:
X A. In Compliance With Program Requirements
Compliance Based On:
X 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: **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):

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Jonathan Hill, HFE NE II 05/12/2014 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 05/19/2014 (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

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM **STATE AGENCY REMARKS**

24-5317

At the time of the Standard survey, the facility was not in substantial compliance with Federal Certification Regulations. This survey found the most serious deficiencies in the facility to widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), Post Certification Revisit to follow. Please refer to the CMS 2567 along with the facility's plan of correction.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5143 4837

April 18, 2014

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

RE: Project Number S5317025

Dear Ms. Falk:

On April 3, 2014, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

This survey found the most serious deficiencies in your facility to be widespread deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level F), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff
Minnesota Department of Health
18 Wood Lake Drive Southeast
Rochester, Minnesota 55904
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 May 13, 2014, 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 May 13, 2014 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 July 3, 2014 (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 October 3, 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.

Sincerely,

Kamala Fiske-Downing, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
Telephone: (651) 201-4112
Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

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

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 _____ MAY 5 2014 MN Dept of Health	04/03/2014

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 176 SS=D	483.10(n) RESIDENT SELF-ADMINISTER DRUGS IF DEEMED SAFE An individual resident may self-administer drugs if the interdisciplinary team, as defined by §483.20(d)(2)(ii), has determined that this practice is safe. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure 1 of 1 resident, (R110), was assessed to safely self-administer a nebulizer treatment before leaving him alone when treatment was being done. Findings include: R110 was admitted on 3/25/14 according to the admission face sheet. The discharge summary from the hospital dated 3/25/14 indicated that R110's diagnoses included COPD (chronic obstructive pulmonary disease), right hemiplegia, and aphasia. The Social Services assessment dated 4/1/14 indicated that R110 had a BIMS (brief interview for mental status) of 10 out of 15, which indicated moderate cognitive impairment.	F 176	5-12-14 GPM	5-10-14 GPM

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

Sara Falk, Administrator — 5/1/14

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____ MAY 5 2014	04/03/2014

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F 176	Continued From page 1 During observation on 4/3/14 at 7:29 a.m. R110 was sitting in a wheelchair in their room with the nebulizer mask over nose and mouth with nebulizer solution being dispensed. No licensed staff had been present in room. A few minutes later, R110 had removed the mask from his face. During interview on 4/3/14 at 7:40 a.m. the licensed practical nurse (LPN) -A indicated that she set R110 up with the medication in the nebulizer, and then left him alone to return to remove it after it was completed. LPN-A was unaware if an assessment had been completed for safe administration of the nebulizer for R110. The signed physician orders dated 4/2/14 indicated R110 was to receive budesonide suspension 0.5 mg/2 ml, one vial, two times a day related to chronic airway obstruction. After review of the physician orders there was no order indicated for R110 to self-administer the nebulizer. Review of the resident ' s medical record showed no assessment was completed to ascertain that R110 was safe to self-administer a nebulizer treatment. During an interview on 4/3/14 at 7:50 a.m. with the Director of Nursing (DON), the DON stated her expectation for self-administration of medications would include that the resident would be assessed to see if they were capable of keeping the mask in place and that there would also be a doctor's order to self-administer the nebulizer treatment. The policy titled Procedure, Resident Self-Administration of Medication, indicated that the interdisciplinary team must make a determination for each resident who expresses a desire to self-administer medications if the resident can do this safely. The interdisciplinary team would determine if the resident had any specific educational needs or if he or she required	F 176	F 176 The nurse on duty for R 110 was immediately reeducated on the expectation of not leaving a resident alone with a nebulizer running unless an assessment for self-administration of medication has been completed and approved by the multidisciplinary team. We will consider all residents with a nebulizer order to be at risk therefore all resident's care plans were reviewed and updated as appropriate. Re-education on GSS policy and procedure for self-administration of medications will be provided for all staff responsible for administering medications by 5-9-2014. DNS or designee will schedule and conduct random audits of residents receiving medications via nebulizer weekly X 4 then monthly X 3 to ensure compliance with GSS policy and procedure for self- administration. Results will be presented to Quality Meeting for further recommendations.	

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F 176	Continued From page 2 any accommodation in order to self-administer medications. The interdisciplinary team's determination that the resident can safely self-administer medications must be documented in the medical record. A physician's order must be obtained prior to the resident self-administering medications.	F 176		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on interview and record review, the facility failed to develop care plan interventions related to urinary incontinence for 1 of 5 residents (R45) reviewed for unnecessary medications.	F 279	F 279 R45's care plan was immediately updated with appropriate goals and interventions for urinary incontinence. We will consider all residents with urinary incontinence on admission to be at risk, therefore all resident's care plans were reviewed and updated as appropriate. Re-education on GSS policy and procedures for comprehensive care planning will be provided for the appropriate nursing staff by 5-9-2014. DNS or designee will schedule and conduct random audits of new admissions to ensure appropriate identification, goals, and interventions are care planned for residents with urinary incontinence. These audits will be done weekly X 4 and then monthly x 3. Results will be reviewed with the Quality committee for further recommendations.	5-10-14

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F 279	Continued From page 3 Findings include: R45's admission Minimum Data Set (MDS) dated 3/7/14, identified occasional incontinence urinary, UTI last 30 days, pneumonia, septicemia, CHF, anxiety disorder, depression, one person physical assist with toileting, medications received: antidepressant and antibiotic. R45's Resident Care Area Assessment (CAA) dated ARD (assessment reference date) 3/7/14, identified R45 requires assistance for toileting, incontinency which ranges from occasionally to always, urinary tract infection (UTI), pain, psychological or psychiatric problems, congestive heart failure (CHF), depression and antidepressants. Analysis of findings included requires staff assistance with toileting related to weakness from hospitalization for aspiration pneumonia with septicemia. Decision was to care plan problem of urinary incontinence. Document review of physician orders dated 3/1/14, revealed orders for trospium chloride (Sanctura) (an antispasmodics medication used to treat overactive bladder and symptoms of urinary incontinence) 20 milligrams two times a day. Document review of facility Medication and Treatment Record dated 3/1/14 through 4/2/14, revealed R45 had received tropsium chloride tablet 20 milligrams by mouth two times a day related to urinary tract infection. R45's care plan dated 3/11/14, had not addressed urinary incontinence.	F 279		

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F 279	Continued From page 4 During interview on 4/2/14, at 2:58 p.m., registered nurse (RN)-B and RN-C verified R45's current care plan dated 3/11/14, had not addressed urinary incontinence. During interview on 4/3/14, at 11:28 a.m., director of nursing verified CAA dated 3/7/14, identified R45 had occasional incontinence, UTI and R45's care plan dated 3/11/14, had not addressed urinary incontinence. Director of nursing stated she would expect urinary incontinence to be care planned. Document review of the facility policy CARE PLAN dated 9/09, read " Residents will receive and be provided the necessary care and services to attain or maintain the highest practicable well-being in accordance with the comprehensive assessment. Each resident will have an individualized comprehensive plan of care that will include measurable goals and timetables directed toward achieving and maintaining the resident ' s optimal medical, nursing, physical, functional, spiritual, emotional, psychological and educational needs. Through use of departmental assessments, the Resident Assessment Instrument and review of the physician ' s orders, any problems, needs and concerns identified will be addressed. " Document review of the facility Procedure COMPREHENSIVE CARE PLAN AND CARE CONFERENCES dated 9/13, read, "PROCEDURE 5. FORMULATING THE CARE PLAN. The interdisciplinary team will ensure that the care plan is comprehensive by incorporating the following: · All triggered Care Area Assessments (CAAs) that the staff has decided to proceed on. Physicians ' orders and diagnoses	F 279		

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F 279	Continued From page 5 that are currently being treated. Educational goals and approaches specific to the resident's needs, abilities, readiness, preferences and length of stay."	F 279		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure the comprehensive resident centered care plan was followed for fall precautions as directed by the plan of care for 1 of 3 residents (R28) reviewed for accidents. Findings included: R28's Face Sheet dated 1/24/11, identified R28 had been admitted on 1/21/2011 with diagnoses that included but were not limited to paralysis agitans, osteoporosis, depressive disorder and glaucoma. The current plan of care dated 2/6/14, indicated R28 had history of falls related to Parkinson's disease, depression, impaired mobility, impaired safety judgment with intervention of but not limited to, when resident in bathroom keep phone within reach. During observation on 4/3/14, at 9:19 a.m.,	F 282	F 282 Staff caring for R28 were immediately re-educated on the care planned intervention for falls prevention. We would consider any resident with specific individualized fall precaution interventions as being at risk to be affected by the same deficient practice. All residents with falls prevention plans were reviewed and staff were informed/ reminded of the care planned interventions. All staff caring for residents at risk for falls will be provided with re-education on the facilities procedures for communicating care planned interventions by 5-9-2014. DNS or designee will conduct scheduled audits of random residents with falls prevention plans to ensure staff caring for them know the care planned interventions and how to access the interventions. These audits will be conducted weekly X 4 and then monthly X 3. Results will be presented to Quality Meeting for further recommendations.	5-10-14 KPM

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F 282	Continued From page 6 nursing assistant (NA)-A had walked out of R28's room and had stated R28 was in the bathroom. Observation at that time revealed R28's phone was located on shelf in room and not accessible for R28 as directed in the care plan. During interview on 4/3/14, at 9:54 a.m., NA-A verified phone had not been placed in reach for R28 when resident had been in the bathroom. NA-A stated, " I did not know R28's care plan stated phone to be in reach when in bathroom." NA-A showed surveyor fall prevention interventions in place for R28 on computer and then stated, "R28 is supposed to have phone in reach when in bathroom." During interview on 4/3/14, at 11:42 a.m., director of nursing stated she would expect nursing assistant to know intervention and care plan to be followed. Director of nursing verified on 4/3/14, at 12:17 p.m., R28's care plan dated 2/6/14, had intervention when resident in bathroom to keep phone in R28 ' s reach.	F 282		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced	F 371	F 371 Based on the findings from the Minnesota State Health Department on 3/31/14 the dietary staff immediately discarded any products that were found expired and un-labeled from the kitchen. Staff immediately cleaned the toaster, microwave, and the shelf above the stove top on 4/1/14 before surveyors exited the building.	5-10-14 MPN

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F 371	Continued From page 7 by: Based on observation, interview, and document review, the facility failed to maintain a clean and sanitary kitchen environment, failed to ensure food containers were sealed when not in use, labeled and dated as to when they were opened and failed to ensure expired food was discarded after expiration date. This had the potential to affect 41 of 41 residents being served meals from the kitchen. Findings include: During the initial kitchen tour on 3/31/14 at 2:00 p.m., with the certified dietary manager (CDM) the following items were observed: -Pearl Golden potatoes seasoned with butter, salt and white pepper, 50 pound (lb.) bag sitting on the floor in the dry storage room, leaning against a wall. -Generic brand peanut butter five lb. container, 1/2 full on a shelf in the dry storage room. Manufacturer expiration was stamped as 5/6/14. Handwritten date on the top of the container indicated the container had been opened on 7/17/13. CDM verified opened containers of peanut butter are only good for three to four months. -Lawry's seasoning salt, five lb. container on a shelf in a kitchen cupboard. The container did not identify when opened. Manufacturer expiration date was stamped 3/10/10. There was visible dark " mold " substance observed on the outside of the container that covered the area of the lid, surrounding the lid and down the outside of the container. CDM verified the " mold " type	F 371	A full kitchen inspection was conducted to ensure compliance with labeling, dating, and proper storage. The cleaning schedule has been updated to include all equipment. Re-education was provided to staff on the facility's policy and procedures for food storage, label/dating, expiration dates, and completing tasks and duties listed on the cleaning schedule daily during the week of 3/31-4/3. This re-education will be presented to all dietary staff again on 5/13/14. Procedures have been developed for daily checking of areas for label/dates, and expiration dates. The Dietary Manager or designee will conduct Audits weekly X 4 then monthly X 3. Results will be presented to Quality Committee for further recommendations. The audits will include making sure items are stored properly and are labeled and dated, checking for expired food, and checking cleaning list/utensils.	

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F 371	Continued From page 8 substance and was unable to determine what year the container had been opened. -Hershey's chocolate syrup 24 ounce (oz.) container ½ full on a shelf in a kitchen cupboard. The container had no identification as to when opened, the manufactures instruction read refrigerate when opened. -Generic brand grape jelly 24 oz. container ½ full on a shelf in a kitchen cupboard. The container had no identification as to when opened, the manufactures instruction read refrigerate when opened. -Nectar thick orange juice, six 46 oz. boxes stored in the walk in cooler. Manufacturer expiration was stamped as 2/11/13, on all containers. -A small bag of sliced onions was stored on a shelf in the walk in cooler. The bag was not labeled or dated. -One 30 lb. box of vegetable blend ¾ full was noted in the walk in freezer. The plastic bag containing the vegetables was wide open (not sealed) and not dated when opened. -One case of ham patties containing 25 patties was noted in the walk in freezer. The plastic bag containing the patties was wide open and not dated. Thick frost build up was noted on the patties. -The stainless steel shelf located above the stove had a thick layer of dust and sticky debris that covered the entire surface of the shelf. This shelf was used for food storage.	F 371		

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F 371	Continued From page 9 -The four slice toaster was covered with dark sticky debris. -The microwave located on a counter across from the stove had food splatters on the inside of the unit. The above was verified during the tour by the CDM. Document review of the kitchen cleaning schedule dated March 2014, revealed the following cleaning: the toaster and all shelves to be checked and cleaned daily. The schedule did not identify microwave cleaning. Review of the facility Food Storage policy revised 11/2010; directed foods which have been opened or prepared will be placed in enclosed containers, dated and labeled. Dry storage room food will be stored 6 inched off the floor and away from the wall. Expiration dates checked regularly and expired foods and fluids will be discarded.	F 371		
F 425 SS=D	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and	F 425		

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F 425	Continued From page 10 administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to ensure all medications ordered by the physician were administered as ordered to minimize medication errors for 1 of 1 resident (R108) who received a muscle relaxant three times after the discontinued date provided by the physician. Findings include: R108's record revealed a signed physician orders dated 3/18/2014. The physician orders stated Cyclobenzaprine HCL (Flexeril) 5 mg every 8 hours as needed for muscle spasms for 10 days. The medication should have been discontinued on 3/29/2014. During review of the 3/2014 and 4/2014 medication administration record (MAR), the medication had been given twice on 3/31/14 and once on 4/1/2014. On 4/2/2014 at 4:15 p.m., the director of nursing (DON) was interviewed regarding the administration of the medication Cyclobenzaprine. She stated the medication	F 425	F 425 The order associated with the medication error on R108 was immediately corrected/discontinued. The physician was informed, and the DNS informed the resident of the error. The staff members involved were provided with immediate re-education of the facilities policy and procedures for medication transcription and administration. We will consider all residents to be at risk for possibly being affected by this same deficient practice. All staff responsible for medication administration will be provided with re-education of GSS policy and procedures for medication transcription and administration by 5/9/2014. We will audit a specified percentage of new medication orders for accuracy weekly X 4 and then monthly X 3. Results will be taken to the quality committee for further recommendations.	5-10-14 SPN

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F 425	Continued From page 11 should have been discontinued. The DON verified the physician order on 3/18/2014 stated it said for 10 days but no end date was identified. The DON also verified the resident received the 3 doses before they had it discontinued today (4/2/14.)	F 425		
F 431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of 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	F 431	F 431 The open narcotic box padlocks were immediately locked and the nurses on duty were provided with re-education of GSS policy and procedure for medication storage. We will consider all residents possibly at risk for being affected by this same deficient practice. Reeducation will be provided to all nurses on the facility's policy and procedure for narcotic storage by 5-9-2014. DNS or designee will conduct randomly timed audits of all medication storage areas weekly X 4 and then monthly X 3 to ensure compliance. Results will be taken to quality committee for further recommendations.	5-10-14

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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 431	Continued From page 12 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 failed to provide safe and secure medication storage of narcotics in two of three of their medication storage areas. Findings include: During the tour of the medication storage rooms on Healing Grace and The Garden units it was observed that the cupboards which contained narcotic medication had unlocked padlocks. The narcotics were stored under a single secure lock only and are to be stored in separately locked, permanently affixed compartments, except when the facility uses single unit medication distribution systems in which the quantity stored is minimal and a missing dose can be readily detected; and controlled medications are reconciled accurately. On 4/3/14 at 7:31 a.m. it was observed that the narcotic cupboard in Healing Grace had an unlocked padlock on the cupboard door. The licensed practical nurse (LPN)-A confirmed this. Among the medications in the cupboard were the following schedule II (Defined by the U.S. Controlled Substance Act for medications that are high potential for abuse): percocet, norco, hydromophone, and Tylenol #3. This medication cupboard also contained the emergency kit which included fentanyl patches, hydrocodone/Acetaminophen (5/325 mg tab), morphine, and oxycodone. Also Ativan which is	F 431		

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F 431	Continued From page 13 not a schedule II but subject to abuse. On 4/3/14 at 10:08 a.m. it was observed that the narcotic cupboard in The Garden unit had an unlocked padlock on the cupboard door and RN-A confirmed this. Medications noted in the cupboard included morphine, fentanyl patches, oxycontin, Percocet, norco, oxycodone, hydrocodone. Also lyrica, and lorazepam which are not a schedule II but are subject to abuse. The Director of Nursing (DON) during an interview on 4/3/14 at 10:15 a.m. indicated that she would expect that the narcotic cupboard that have narcotics and other highly sought after medications stored in them would be locked so a double lock system would be in place. A policy titled Acquisition, receiving, dispensing and storage of medications issued 11/2002 and revised 1/2014 indicated that controlled drugs (Schedule II) and other drugs subject to possible abuse will be stored in separate, locked, permanently fixed compartments, except when a single unit package drug distribution is used.	F 431		
F 441 SS=F	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	F 441	F 441 As all residents are potentially affected, the DNS reviewed all residents with infections and updated the facilities infection control logs and conducted analysis and trending per the facility's policy and procedure for infection control program. This information on the past 2 months was reported to the Quality Meeting on 4-29-2014.	5/10/14 MPN

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F 441	Continued From page 14 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. (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 interview and document review, the facility failed to establish an infection control program to include surveillance (tracking of resident's infections, analyzing resident and employees infections) of infections that occur in the facility in order to prevent, recognize and control to the extent possible spread of infection in the facility. This had the potential to affect all 42 residents residing in the facility, employees and visitors.	F 441	Analysis of data from months noted has been completed including correlation of resident and employee data. The Director of Nursing will be responsible for monitoring of neighborhood infection control logs and employee illness logs weekly. All nurses will be re-educated on documenting and communicating infections per the facility's policy and procedure for infection control program by 5-9-2014 The Director of Nursing or designee will conduct audits of all neighborhood infection control logs and employee illness logs weekly X 4 and then monthly X 3 to ensure compliance with the facility's infection control plan. The audits will be presented to Quality committee for further recommendations. In addition to the focused audits, the Infection control data and trending will be presented to quality committee on a monthly basis on-going.	

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F 441	Continued From page 15 Findings include: This surveyor requested the facility monthly infection log(s) for residents and employees from July 2013, through March 2014, they were received and there were no resident logs found for the months of October 2013 and January 2014. For the months of October, November, December 2013 and January, February, March 2014, analysis of infections and actions to resolve related problems for residents and employees had not been documented. During interview on 4/3/14, at 11:44 a.m., director of nursing (DON) indicated she took over infection control tracking and trending since November 2013. During interview on 4/3/14, at 11:52 a.m., the DON verified there were no resident infection logs available or the information which would have been included on these two logs for October 2013 and January 2014. DON verified data analysis for resident and employee infections had not been done after September 2013. DON stated, "Not doing data analysis currently, know things need to be pulled in." Document review of the facility Policy Infection Control Policies/Procedures Infection Control Plan dated 11/11, read, "POLICY The center will maintain an infection control plan/program to provide a safe, sanitary and comfortable environment for residents, families, visitors and employees; and to help prevent the development and transmission of disease and infection. The infection control program will attempt to meet federal and state regulations for infection control.	F 441		

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F 441	Continued From page 16 The infection preventionist (IP), the infection control committee and the quality committee will direct the functions of the infection control plan."	F 441		

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

F5317022

PRINTED: 04/17/2014
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
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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**	

Do: 5-13-14
Exit: 4-3-14

RECEIVED
MAY - 2 2014
MN DEPT. OF PUBLIC SAFETY
STATE FIRE MARSHAL DIVISION

POC ok
TB 5-5-14

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Sara Falla	Administrator	5/1/14

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: 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. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		

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K 069 K 069 SS=D	Continued From page 2 NFPA 101 LIFE SAFETY CODE STANDARD Cooking facilities are protected in accordance with 9.2.3. 18.3.2.6, NFPA 96 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility's kitchen cooking hood fire extinguishing system was not arranged in accordance with 2000 NFPA 101 - Sections 18.3.5 and 9.7 and 1998 NFPA 96 section 9-1.2.2. The deficient practice could affect 5 out of 41 residents. Findings include: On facility tour between 1:00 PM and 3:00 PM on 04/03/2014, observation of the kitchen hood fire protection system, revealed that the kitchen stove was moved 8 inches to the right to accommodate an additional table to the left of the stove. The kitchen hood fire protection system spray nozzles are now out of alignment and stove is not properly protected. This deficient practice was confirmed by Director of Facility Maintenance (PC) at the time of discovery. *TEAM COMPOSITION* Gary Schroeder, Life Safety Code Spc.	K 069 K 069	K 069 The kitchen stove has been moved back under the kitchen hood fire protection system; the stove is now in alignment with the kitchen hood. The corrective date for this was 4/25/14.	

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