

#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 22, 2024

Administrator Good Samaritan Society - Comforcare 1201 17th Street Ne Austin, MN 55912

RE: CCN: 245317

Cycle Start Date: December 28, 2023

#### Dear Administrator:

On December 28, 2023, a 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 constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F), as evidenced by the electronically attached CMS-2567 whereby corrections are required.

#### ELECTRONIC PLAN OF CORRECTION (ePoC)

Within ten (10) calendar days after your receipt of this notice, you must submit an acceptable ePOC for the deficiencies cited. An acceptable ePOC will serve as your allegation of compliance. Upon receipt of an acceptable ePOC, we will authorize a revisit to your facility to determine if substantial compliance has been achieved.

To be acceptable, a provider's ePOC must include the following:

- How corrective action will be accomplished for those residents found to have been affected by the deficient practice.
- How the facility will identify other residents having the potential to be affected by the same deficient practice.
- What measures will be put into place, or systemic changes made, to ensure that the deficient practice will not recur.
- How the facility will monitor its corrective actions to ensure that the deficient practice is being corrected and will not recur.
- The date that each deficiency will be corrected.
- An electronic acknowledgement signature and date by an official facility representative.

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

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

- Denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417);
- Civil money penalty (42 CFR 488.430 through 488.444).
- Termination of your facility's Medicare and/or Medicaid agreement (488.456(b)).

#### **DEPARTMENT CONTACT**

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

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

#### PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

#### VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable ePoC, a Post Certification Revisit (PCR), of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of

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

# 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 March 28, 2024 (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).

In addition, if substantial compliance with the regulations is not verified by June 28, 2024 (six months after the identification of noncompliance) your provider agreement will be terminated. 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.

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.

#### INFORMAL DISPUTE RESOLUTION (IDR) / INDEPENDENT INFORMAL DISPUTE RESOLUTION (IIDR)

In accordance with 42 CFR 488.331, you have one opportunity to question cited deficiencies through an informal dispute resolution process. You are required to send your written request, along with the specific deficiencies being disputed, and an explanation of why you are disputing those deficiencies, to:

Nursing Home Informal Dispute Process Minnesota Department of Health Health Regulation Division P.O. Box 64900 St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: <a href="https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm">https://mdhprovidercontent.web.health.state.mn.us/ltc\_idr.cfm</a>

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 electronic plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>

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:

Travis Z. Ahrens
Interim State Fire Safety Supervisor
Health Care & Correctional Facilities/Explosives
MN Department of Public Safety-Fire Marshal Division
445 Minnesota St., Suite 145
St. Paul, MN 55101
travis.ahrens@state.mn.us

Cell: 1-507-308-4189

Feel free to contact me if you have questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



#### Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered January 22, 2024

Administrator Good Samaritan Society - Comforcare 1201 17th Street Ne Austin, MN 55912

Re: State Nursing Home Licensing Orders

Event ID: 2KDF11

#### Dear Administrator:

The above facility was surveyed on December 26, 2023 through December 28, 2023 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules and Statutes. At the time of the survey, the survey team from the Minnesota Department of Health - Health Regulation Division noted one or more violations of these rules or statutes that are issued in accordance with Minn. Stat. § 144.653 and/or Minn. Stat. § 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 and/or statute of the Minnesota Department of Health.

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

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at <a href="https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html">https://www.health.state.mn.us/facilities/regulation/infobulletins/ib04\_8.html</a>. The State licensing orders are delineated on the Minnesota Department of Health State Form and are being delivered to you electronically. 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 or rule after the statement, "This MN Requirement 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.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. 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:

Jennifer Kolsrud Brown, RN, Unit Supervisor Rochester District Office Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: jennifer.kolsrud@state.mn.us

Office: (507) 206-2727 Mobile: (507) 461-9125

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 feel free to call me with any questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us

PRINTED: 02/02/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDII	IPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED
		245317	B. WING		12/28/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP COD  1201 17TH STREET NE  AUSTIN, MN 55912	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE COMPLÉTION
E 000	Initial Comments		E 00	00	
	compliance with CN Emergency Prepare conducted during a survey. Good Samawas found not in correquirements.				
	as your allegation of Department's accelerated in ePOC, year the bottom of the form. Upon receipt POC, an onsite rev	t Population	E 00	07	1/31/24
	§441.184(a)(3), §4 §483.73(a)(3), §483 §485.68(a)(3), §483	16.54(a)(3), §418.113(a)(3), 460.84(a)(3), §482.15(a)(3), 3.475(a)(3), §484.102(a)(3), 5.542(a)(3), §485.625(a)(3), 85.920(a)(3), §491.12(a)(3),			
	and maintain an en that must be review	n. The [facility] must develop nergency preparedness plan red, and updated at least every nust do the following:]			
	but not limited to, p services the [facility an emergency; and	t/client] population, including, ersons at-risk; the type of /] has the ability to provide in continuity of operations, as of authority and succession			
_ABORATOR\	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE	TITLE	(X6) DATE

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.

Electronically Signed

01/26/2024

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		1 ` ′	` '			DATE SURVEY COMPLETED	
		245317	B. WING		1	C <b>28/2023</b>	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
E 007	plans.**  *[For LTC facilities Plan. The LTC facility an emergency prepreviewed, and updated plan must do all of (3) Address resider limited to, persons LTC facility has the emergency; and coincluding delegation plans.  *NOTE: ["Persons hospice, PACE, HERHC/FQHC, or ES]	at §483.73(a):] Emergency lity must develop and maintain paredness plan that must be ated at least annually. The the following: In the population, including, but not at-risk; the type of services the ability to provide in an entinuity of operations, has of authority and succession at risk" does not apply to: ASC, IA, CORF, CMCH,		07			
	Based on an interviacility failed to add preparedness plan including, but not linat-risk and the type provide these populated the potential to in the facility.  Findings include:  A review of the facility.  Findings include:  A review of the facility plan dated 5/9/23, the resident popularisk and the type of provide them in an	riew and document review, the ress in their emergency, the resident population mited to, the residents most of services the facility could lations in an emergency. This affect all 35 residents residing tions including the persons at services the facility could emergency.  You 12/28/23 at 11:00 a.m., the		Preparation and execution of this response and plan of correction do constitute an admission or agreen the provider of the truth of the fact alleged or conclusions set forth in statement of deficiencies. The pla correction is prepared and/or executed solely because it is required by the provisions of federal and state law the purposes of any allegation that center is not in substantial compliant with federal requirements of particution this response and plan of correction constitutes the center sallegation compliance in accordance with se 7305 of the State Operations Man	nes not nent by s the n of the nce ipation, n of ction ual.		
	director of nursing	(DON) stated that the facility an electronic medical record		During survey it was noted the was not a patient population of res	at there		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING		(X3) DATE SURVEY COMPLETED	
		245317	B. WING _			2 <b>8/2023</b>
NAME OF F	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE	12/2	20/2023
	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
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E 007	population if an emconfirmed that the include the specific population, the personal services the facility emergency.  A review of the facility emergency.  A review of the facility was to a at-risk; the type of a ability to provide in of operations, inclu	em of their current resident ergency occurred. The DON emergency plan did not a sabout their resident sons at risk, and the types of could provide them in an emergency Management and emergency; and continuity ding delegations of authority ans in their emergency	EOC	with special needs in the emergent management plan. A resident poptable was developed by the DON to added into the emergency manager plan.  2. All residents have the potential affected by this deficient practice. Specifically resident with potential of special medical treatments. On January 24, 2024 the DON comples special resident population and suit to the emergency management plans. To ensure systemic changes a sustained, the DON or designee we review the resident population annual the administrator during the annual of the emergency management plans, education was provided to stimportance of having a resident population table to ensure proper or residents during the all staff meeting January 18, 2024 in the case of an emergency or evacuation.  4. The Administrator or designee conduct quarterly audits of the Emmanagement Binder to ensure resigned to ens	ulation be ment I to be needs ted the bant lan. re ill ual with I review an. aff the care of ng on will ergency dent siding	
F 000	INITIAL COMMEN	ΓS	F 00			
	from the Minnesota	ey was conducted by surveyors a Department of Health (MDH). laint investigation was also				

STATEMENT OF DEFICIENCIES  (X1) PROVIDER/SUPPLIER/CLIA  (X2) MULTIPLE CONSTRUCTION OF CORRECTION  (DENTIFICATION NUMBER:  A. BUILDING			(X3) DATE SURVEY COMPLETED			
		245317	B. WING		,	C 12/28/2023
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912	<u>.</u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE
F 000	Continued From pa	ige 3	F(	000		
	requirements of 42 Requirements for L The following comp	cund not in compliance with the CFR 483, Subpart B, ong Term Care Facilities.  Claint was reviewed with no cies cited: H53178078C				
	as your allegation of Departments accepted in ePOC, year the bottom of the form. Your electron be used as verificative receipt of an accepton onsite revisit of you validate substantial regulations has been	scntnue Trmnt;Formlte Adv Dir	F	578		1/31/24
	discontinue treatment to participate in explorement formulate an advantage of the provision of me	right to request, refuse, and/or ent, to participate in or refuse perimental research, and to not directive.  Ing in this paragraph should be ght of the resident to receive edical treatment or medical nedically unnecessary or				
	requirements speci subpart I (Advance (i) These requirements	e facility must comply with the lifted in 42 CFR part 489, Directives). ents include provisions to written information to all adult				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	12/	20/2023	
GOOD SAMARITAN SOCIETY	COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		D BE	(X5) COMPLETION DATE	
medical or surgical fresident's option, for (ii) This includes a water facility's policies to it and applicable State (iii) Facilities are perentities to furnish this legally responsible for requirements of this (iv) If an adult individual may give advance of individual's resident with State law.  (v) The facility is not provide this information to the information to the appropriate time. This REQUIREMENT by:  Based on interview facility failed to ensure mergency treatment resuscitation) were experienced for advance for individual for advanced in the information to the appropriate time. The resuscitation is the province of the information for the information for the information for the information in the in	g the right to accept or refuse treatment and, at the rmulate an advance directive. Written description of the implement advance directives in law.  I mitted to contract with other is information but are still for ensuring that the esection are met. I dual is incapacitated at the indiscent of the individual once he wance directive, the facility directive information to the representative in accordance in relieved of its obligation to the individual once he eive such information. The individual once he eive such information. The individual directly at the section are as evidenced and document review, the lare wishes and directives for int (i.e., cardio-pulmonary obtained upon admission and ble to ensure appropriate ded for 1 of 1 resident (R96)		F578 Request/Refuse/Discontinu Treatment; Advance Directive- 1. Resident R96 was identified to have documented wishes and directives were entered into the El system based on resident wishes clinical documentation from reside hospital medical record. A POLST filled out by nursing staff and reside The medical provider then signed POLST and it was submitted to be	not ectives v of npleted vanced MR and ent s ent. the		

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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT ( (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
	Continued From paimpairment, shorth blood cells), and gableed in the digesti indicated he was in personal hygiene, a care center on 12/2. Review of R96's phacked evidence of emergent treatment receive if their hear R96. In addition, Rand his electronic malso lacked evidence to ensure space which read, space which read, space was left blank R96's medical receive assessed upon evidence to ensure were assessed upon evidence the facility determine what, if a implemented during Further, the record	age 5 ess of breath, anemia (low red astrointestinal hemorrhage (a ve tract). Further, the MDS adependent with mobility, and eating; and admitted to the 11/23.  Tysician orders on 12/26/23, a code status (type of a person would or would not a person would not a person would or would not a person would or would not a person would not a person would not a person would not a person would not a	F 57	DEFICIENCY)	code soon as al to be All viewed /26/2023 anced electronic ents. changes dere, the nd an all lesignee ode it is ek for weeks.	
	emergent situation unable to speak for During interview or registered nurse unable EMR there is no RN-A stated if a confacility would do CFRN-A indicated the	happen and R96 would be himself.  12/26/23, at 3:01 p.m., hit manager (RN)-A verified in code status listed for R96. de status is not listed, then the PR and start compressions. re is a red-colored folder with each person listed, but upon		committee with appropriate follow initiated to ensure compliance is sustained.  5. The date of correction will be 31, 2024 with the DON, Administ designee verifying correction of deficiency.	January	

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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP C 1201 17TH STREET NE AUSTIN, MN 55912	<u> </u>	
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F 578	again stated they we nurse (RN)-C then indicated the nurse complete POLST (plife-sustaining treat complete to ensure upheld), question a record it in EMR so RN-C indicated the progress note but of the EMR and reiters should have "conveadmission about the EMR banner and On 12/26/23, at 3:1 and was unable to verified R96 was concluding R96's, information would check EMR bunresponsive, if the CPR. RN-C stated verify code status, if paperwork placed in RN-C verified R96 code status remain be". RN-C verified R96 code status remain be". RN-C verified in resuscitate) then we possibly be "agains reviewed hospital prode status.	I that R96 was not listed and rould start CPR. Registered joined the interview and who does admission should ohysician order for ment: a form which residents their healthcare wishes are resident code status and it shows on banner. RN-A and code status is likely not in lirectly on banner at the top of ated the "admission nurse" ersation with them" on is, and record it directly into		578		
	done if unresponsiv	e. R96 was unable to recall if				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ` ′	(X2) MULTIF A. BUILDING	PLE CONSTRUCTION  G	CON	(X3) DATE SURVEY COMPLETED	
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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	<u> </u>		
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F 578	on 12/26/23, at 3:2 to the surveyor and provided a hospital code status. RN-A doing extensive revand other binders in located in a "typical for a code status ar EMR.  During an interview family member (FM not consulted with tor code status of the stated that R96 was code status should stated they are wor document (health of January 5th.  During an interview director of nursing of nurse reviews a research a resident wish, and representative sign the physician to sign admission. DON stainto the EMR.  During an interview licensed practical in code statuses are of the code statuses are system. LPN-A veri	out his wishes. R96 stated his	F 578	3			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION  IG	(X3) DATE SURVEY COMPLETED	
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	D BE COMPLÉTION	
F 637	including Cardiopul and Automated Ext 8/1/23, was provide purpose is to provide opportunity to make care and select a pto make resident de Comprehensive As	tled Advance Directive monary Resuscitation (CPR) ernal Defibrillator, dated ed. The policy indicated the de each resident the edecisions related to medical rovide and to define a process ecisions known.	F 63		1/31/24	
33-0	determines, or shorthere has been a siresident's physical purpose of this secomeans a major decresident's status the itself without furthe implementing standinterventions, that hone area of the restrequires interdiscip care plan, or both.) This REQUIREMED by:  Based on interview facility failed to ensistatus Minimum Dacomprehensive assistatus Minimum Dacomprehensive assistant depressive synfor 1 of 4 residents accuracy.  Findings include:	Aithin 14 days after the facility ald have determined, that gnificant change in the or mental condition. (For tion, a "significant change" cline or improvement in the at will not normally resolve intervention by staff or by dard disease-related clinical has an impact on more than ident's health status, and linary review or revision of the NT is not met as evidenced and document review, the ure the significant change in the Set (MDS; i.e., a sessment) was completed in a consure areas of cognition inptoms were fully evaluated (R13) reviewed for MDS		F637 □ Comprehensive Assessment After Significant Change Resident R13 had blank MDS Sections from C0200 to C1000, Se was left blank from D0150 to D060 during a SCSA MDS with an ARD f 11/11/23 to 11/18/23.  1. Resident R13□s MDS was rev and noted to have incomplete secting 12/27/2023. The needed assessment were reviewed and competed if reserves able to respond to guestions of	ection D 0 from iewed ions on ents sident	
	The Centers for Me	edicare and Medicaid Services		was able to respond to questions of	rstill	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	TIPLE CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		245317	B. WING		<b>I</b>	28/ <b>2023</b>	
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912	<u>'</u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 637	Assessment Instrudated 10/2023, identified R13 administration and this RAI) was mandated included a section Assessments," who change in status (states assessments wou to be completed who conditions and resulting the manual included assessments wou to be completed who conditions and resulting the manual included the section determine the resiliability to register of the manual included and instructions to coding of the MDS another section labeled which outlined the address mood distinction and instructions to coding of the MDS another section labeled which outlined the address mood distinction and instructions to coding of the MDS another section labeled which outlined the address mood distinction and instructions to coding of the MDS another section labeled which outlined the address mood distinctions and instructions to coding of the MDS another section labeled which outlined the address mood distinctions and instructions to coding of the MDS another section labeled which outlined the address mood distinction and instructions to coding of the MDS another section labeled which outlined the address mood distinctions and instructions to coding of the MDS another section labeled which outlined the address mood distinctions and instructions to coding of the MDS another section labeled which outlined the address mood distinctions are recommended.	Care Facility Resident Iment (RAI) 3.0 User's Manual, Intified the RAI consists of Inents including the MDS, the Iment (CAA) and the utilization Is process (i.e., use of the entire Is do by CMS. The manual Iabeled, "Comprehensive Isich included a significant Is CSA) and outlined such Id yield corresponding CAA(s) Inch were triggered from Inponses marked on the MDS. Ised a section labeled, Information adding, Isich attention, orientation and Information adding, Isich section would be used to help Is section would be used to help It is associated with provided Information and included Information included Informa	F 6	available for interview.  2. All residents could be af deficient practice. Specifical who recently had a significant status and needed to have a completed. All residents who affected by this were review. MDS nurse and verified to be correctly.  3. To ensure systemic chasustained, education was promounded education was promounded education to the sousing the MDS 3.0 RAI Policy and Procedure on January 24, 2 were notified of this deficient education was provided on a timely manner on January an all staff meeting. The DO Worker, Dietary Manager, A Director, and MDS nurse will be to ensure MDS assessment completed and ready for sufficient education was provided on a timely manner on January and MDS assessment completed and ready for sufficient education was provided on a timely manner on January and MDS assessment completed and ready for sufficient education weeks and ready for sufficient education weeks and reviewed by the QAPI comma appropriate follow-up initiate compliance is sustained.  5. The correction of this deficient education of correction on January and date of correction and date of correction and date of correction and date of correcti	lly, resident nt change in a new MDS no could be ed by the ecompleted nges are rovided to using the MDS re. The DON ocial worker by and 024. All staff cy and completing of the MDS in 18, 2024 in N, Social activities II meet weekly is are omission. The property of the MDS in the meet weekly is are omission. The property of the MDS in the meet weekly for will be nitted with the ed to ensure efficiency will will have a		

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	LTIPLE CONSTRUCTION  DING	` '	ATE SURVEY OMPLETED
		245317	B. WING	}	1	C 2/28/2023
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  ' MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		HOULD BE	(X5) COMPLETION DATE
F 637	addition, the subset assessment (used never understood) completed. In total, left blank and not completed and interview, incompleted and, in a section for the staff resident is rarely or blank and not completed and not completed and section for the staff resident is rarely or blank and not complete addressed.  R13's medical recoveridence either of the corresponding evaluated had been completed assessment referent to 11/18/23) to detect to 11/18/23) to detect to 11/18/23) to detect to 11/18/23) to detect the MDS verified they had resident they had	nk and not completed and, in quent section for the staff if the resident is rarely or was also left blank and not section C0200 to C1000 was ompleted. The 'Section D - d and the spacing to record a luding with symptom presence ression, was left blank and not addition, the subsequent assessment (also used if the never understood) was left bleted. In total, section D0150 lank and not completed or d was reviewed and lacked hese sections and uations (i.e., BIMS, PHQ-9) d during the SCSA acce date (ARD; from 11/11/23 armine what, if any, sues R13 demonstrated with		637		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(2) MULTIPLE CONSTRUCTION BUILDING			(X3) DATE SURVEY COMPLETED	
		245317	B. WING				C <b>28/2023</b>	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, 2  1201 17TH STREET NE  AUSTIN, MN 55912	ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE	
F 637	assessments to the either, adding, "I do RN-B stated an MD including the applic status and mood, or to not trigger adding stated "going forwar out" more time to g for the MDS' and exensure MDS(s) were thoroughly so "we know cognitive levels are When interviewed of director of nursing RN-B being pulled the floor) was "slow workload, however, just being dashed as a result. DON stated as a result. DON stated all areas on the MD as they help determine they help determine they help determine the plans," too.  A provided MDS 3.0 (Resident Assessment Rehab/Skilled & The 6/2023, identified a within the federally policy outlined, "The conducted during the period. The [BIMS]	e floor nurses' to complete, on't know if we could or not."  OS not completed thoroughly, able evaluations for mental ould cause various CAA items g, "It might." Further, RN-B rd" they were going to "block et the evaluations completed expressed it was important to be completed accurately and know where their [resident]."  On 12/27/23 at 12:51 p.m., the (DON) stated he was aware to work on other things (i.e., ving [them] down" on MDS', he was unaware they were and not thoroughly completed ated they had recently hired a was "still in training" and were would improve the situation. Ted it was important to ensure os were thoroughly completed nine "how we care for our nelp "develop better care.	F 6	37				
	-	eferably completed the day ARD. Complete means that						

	OF DEFICIENCIES F CORRECTION	1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SU COMPLET				
		245317	B. WING			C <b>28/2023</b>
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	and locked." Furthed discipline is unable RN coordinator will complete this section.	ons have been saved, signed er, the policy outlined, "If any to complete its section, the assign another person to on within the time frame."		337		
F 638 SS=D	S483.20(c) Quarter A facility must assequarterly review instant approved by Conce every 3 month This REQUIREMENTS.	NT is not met as evidenced		538		1/31/24
	facility failed to enso Data Set (MDS) was manner to ensure a depressive sympto	and document review, the ure the quarterly Minimum is completed in a thorough areas of cognition and ms were screened and, if ated for 2 of 4 residents (R3, MDS accuracy.		F638- Quarterly Review Ass Least Every 3 Months-Reside R28 were identified to have s to C1000 and Section D0150 blank on their MDS assessm 1. These residents MDS se reviewed by the MDS nurse, nurse coordinated the compl sections in the MDS for residents	ents R3 and section C0200 to D0600 ents. ections were the MDS letion of these	
	(CMS) Long-Term (Assessment Instruction dated 10/2023, idea three basic comport Care Area Assessinguidelines and this RAI) was mandated outlined a quarterly non-comprehensive completed every 92 resident' status between the complete designation of the com	edicare and Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual, ntified the RAI consists of nents including the MDS, the nent (CAA) and the utilization process (i.e., use of the entire d by CMS. The manual assessment was a e assessment which was to be d days and was used to track a ween comprehensive o ensure critical indicators of		R28.  2. All residents have the positive affected by the deficient practices resident MDS sections were the MDS nurse to ensure the completed in a timely manner 3. To ensure systemic charms sustained, the DON provided MDS Nurse on 12/27/2024 un 3.0 RAI Policy and Procedure provided education to the social using the MDS 3.0 Policy and on January 24, 2024. All stanotified of this deficiency and	reviewed by at they are are leducation to sing the MDS e. The DON cial worker d Procedure off were	

· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	) COM	E SURVEY IPLETED
		245317	B. WING			C <b>28/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPROPRIES (PROVIDENCY)	OULD BE	(X5) COMPLETION DATE
F 638	monitored." The malabeled, "SECTION which outlined the section ability to register or "These items are corresplanning decis and instructions to coding of the MDS another section lab which outlined the address mood district adding, "Mood district is underdiagnosed nursing home and morbidity," and against methods and instruct comprehensive evaluated and the several medical blood pressure, destroke. The 'Section reviewed and the section (used if the resident understood) was also completed. In total, left blank and not compused interview, incompleted and, in a section for the staff resident is rarely or section for the staff resident is rarely or section.	a resident's status are anual included a section I C: COGNITIVE PATTERNS," section would be used to help lent's attention, orientation and recall information adding, rucial factors in many sions;" with provided methods ensure accurate, thorough Further, the manual included seled, "SECTION D: MOOD," section would be used to help ress and social isolation ress is a serious condition that and undertreated in the is associated with significant and undertreated in the aluation of these conditions.  6, dated 12/7/23, identified R3 all conditions including high pression, and a history of a C - Cognitive Patterns' was pacing to record a completed Mental Status (BIMS) was left bleted and, in addition, the a for the staff assessment	F 6	was provided on completing UE ensure completion of the MDS in manner on January 18, 2024. The Social Worker, and MDS nurse weekly to ensure MDS assessing completed and ready for submited 4. MDS assessments will be at the DON, Administrator, or designated as week for four weeks and week eight weeks. Audit results will be reviewed by the QAPI committed appropriate follow-up initiated to compliance is sustained.  5. The correction of this deficible conducted the DON and will date of correction on January 3.	in a timely he DON, will meet nents are suited by ignee twice kly for each with the ensure ency will have a	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUL A. BUILD	TIPLE CONSTRUCTION ING	(X3) DATE SURVEY COMPLETED	
		245317	B. WING			C 12/28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP C 1201 17TH STREET NE AUSTIN, MN 55912	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD BE	(X5) COMPLETION DATE
F 638	R3's medical record evidence either of the corresponding eval had been completed assessment reference to 12/7/23) to deter complications or isset those corresponding R28's quarterly MD R28 had several modern history of stroke. The Patterns' was revied a completed and, in a section for the staff blank and not completed and, in a section D - Mood' to record a mood in symptom presence was left blank and the subsequent section bl	d was reviewed and lacked hese sections and uations (i.e., BIMS, PHQ-9) and during the quarterly nee date (ARD; from 12/1/23 mine what, if any, sues R3 demonstrated with a gareas.  S, dated 11/29/23, identified edical conditions including he 'Section C - Cognitive wed and the spacing to record was left blank and not addition, the subsequent cassessment was also left bleted. In total, section C0200 blank and not completed. The was reviewed and the spacing nterview, including with a of frequency of depression, not completed and, in addition, ction for the staff assessment not completed. In total, section as left blank and not essed.  In dwas reviewed and lacked these sections and uations (i.e., BIMS, PHQ-9) and during the quarterly ARD 1/29/23) to determine what, if or issues R28 demonstrated		538		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′		· /	(X3) DATE SURVEY COMPLETED	
	245317	B. WING		4	C 2/20/2022	
PROVIDER OR SUPPLIER  AMARITAN SOCIETY				<u> </u>	2/28/2023	
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION S	SHOULD BE	(X5) COMPLETION DATE	
(RN)-B was intervied completed the MDS verified they had refrecord, including the expressed all the anot completed. RN-have a social worker result, the assessments, the assessments and PHQ-9) managers who coutimely, if at all. RN-to dash the correspexpressed they had assessments to the either, adding, "I do Further, RN-B state going to "block out" evaluations completed acknow where their [r. When interviewed director of nursing RN-B being pulled the floor) was "slow workload, however just being dashed as a result. DON state as a result. DON state as a result such hire who hopeful such hire who had hire who had hire who had hire who hire who had hire who hire who hire who hire who hire who hire w	ewed and verified they S(s) for the campus. RN-B viewed R3 and R28 medical e completed MDS(s), and reas had been "dashed" and -B explained the facility' did not er for many months and, as a nents used for the MDS (i.e., were being left to the nurse Id not always complete them B stated, as a result, they had conding MDS areas. RN-B d not delegated any of these er floor nurses' to complete, on't know if we could or not." ed "going forward" they were enter the MDS' and important to ensure MDS(s) curately and thoroughly so "we resident] cognitive levels are."  In 12/27/23 at 12:51 p.m., the (DON) stated he was aware to work on other things (i.e., ving [them] down" on MDS', he was unaware they were and not thoroughly completed atted they had recently hired a was "still in training" and were yould improve the situation. Ited it was important to ensure DS were thoroughly completed nine "how we care for our nelp "develop better care		638			
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	Continued From particles of the particle	PROVIDER OR SUPPLIER  AMARITAN SOCIETY - COMFORCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  (RN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R3 and R28 medical record, including the completed MDS(s), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. RN-B stated, as a result, they had to dash the corresponding MDS areas. RN-B expressed they had not delegated any of these assessments to the floor nurses' to complete, either, adding, "I don't know if we could or not." 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However, DON stated it was important to ensure all areas on the MDS were thoroughly completed as they help determine "how we care for our patients" and they help "develop better care	A BUILD PROVIDER OR SUPPLIER  AMARITAN SOCIETY - COMFORCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  (RN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R3 and R28 medical record, including the completed MDS(s), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility' did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. RN-B stated, as a result, they had to dash the corresponding MDS areas. 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However, DON stated it was important to ensure all areas on the MDS were thoroughly completed as they help determine "how we care for our patients" and they help "develop better care plans," too.  A provided MDS 3.0 (Minimum Data Set) RAI	A BUILDING  245317  PROVIDER OR SUPPLIER  AMARITAN SOCIETY - COMFORCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  (RRN)-B was interviewed and verified they completed the MDS(s) for the campus. RN-B verified they had reviewed R3 and R28 medical record, including the completed MDS(s), and expressed all the areas had been "dashed" and not completed. RN-B explained the facility did not have a social worker for many months and, as a result, the assessments used for the MDS (i.e., BIMS and PHQ-9) were being left to the nurse managers who could not always complete them timely, if at all. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245317	B. WING		12	C 2/28/2023
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	12012023
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOOT CROSS-REFERENCED TO THE APPOPULATION DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 656	6/2023, identified a within the federally policy outlined, "The conducted during the period. The [BIMS] the observation period assessment are present are present and locked." Further discipline is unable RN coordinator will complete this section Develop/Implement CFR(s): 483.21(b)(2)	erapy and Rehab policy, dated purpose to complete the RAI mandated timeline(s). The einterviews must be the designated observation will be completed during field. The [PHQ-9] and Pain eferably completed the day ARD. Complete means that ons have been saved, signed r, the policy outlined, "If any to complete its section, the assign another person to on within the time frame."  Comprehensive Care Plan	F6			1/31/24
	§483.21(b)(1) The fimplement a comproser plan for each resident rights set for §483.10(c)(3), that is objectives and time medical, nursing, an needs that are identical assessment. The condescribe the following (i) The services that or maintain the resident physical, mental, an required under §483 (ii) Any services that under §483.24, §48 provided due to the under §483.10, includer §483.1	ehensive person-centered esident, consistent with the orth at §483.10(c)(2) and includes measurable frames to meet a resident's and mental and psychosocial diffied in the comprehensive care plan must are to be furnished to attain dent's highest practicable and psychosocial well-being as 3.24, §483.25 or §483.40; and the would otherwise be required 3.25 or §483.40 but are not resident's exercise of rights adding the right to refuse				

<b>1</b> ` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		(X3) DATE SURVEY COMPLETED	
		245317	B. WING		12/	C 29/2022
NAME OF I	PROVIDER OR SUPPLIER	1 240017		STREET ADDRESS, CITY, STATE, ZIP CODE	1 12/	28/2023
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		.D BE	(X5) COMPLETION DATE
F 656	provide as a result recommendations. findings of the PAS rationale in the resi (iv)In consultation versident's represent (A) The resident's redesired outcomes. (B) The resident's refuture discharge. Fawhether the resident community was associated contact agence entities, for this pure (C) Discharge plans plan, as appropriate requirements set for section.  §483.21(b)(3) The section.	es the nursing facility will of PASARR If a facility disagrees with the ARR, it must indicate its dent's medical record. with the resident and the tative(s)-goals for admission and preference and potential for acilities must document at's desire to return to the sessed and any referrals to be and/or other appropriate pose. In accordance with the porth in paragraph (c) of this services provided or arranged atlined by the comprehensive mpetent and trauma-informed. Note that it is not met as evidenced.		F656- Develop/Implement		
	facility failed to ensign plan was developed with assessed bowed consumed, high-rist continuity of care a complication for 1 of for care planning.  Findings include:  R95's Medicare - 5	and document review, the ure a comprehensive care do to reflect resident' condition el incontinence and k medications to promote nd reduce the risk of of 2 residents (R95) reviewed  Day Minimum Data Set 7/23, identified sections to		F656- Develop/Implement Comprehensive Care Plans-Residence Plan displayed Plans Plan displayed Plans Plan displayed Plans Plan displayed Plans P	d not nat the cking nce. The the care on on	
	\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	tion, however, these were left		psychotropic medication use mon	itoring	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
	245317	B. WING			C <b>28/2023</b>	
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>		
GOOD SAMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 656 Continued From page	ge 18	F 6	656			
On 12/26/23 at 11:2 and expressed cond "I haven't had a reg months." R95 stated late, had been "very control over it" so stincontinence product R95's most recent B12/20/23, identified having bowel inconf "months" with a list control is present." contributing factors and not completed. listed a section labe corresponding optic what, if any, probler interventions would for R95's incontinent left blank and not concern the section of the sec	eleted (see F637, F638).  27 a.m., R95 was interviewed beens over his bowels adding, ular bowel movement in this bowel movements, as of a loose" and he had "no taff were changing his ets often.  Bowel Evaluation, dated R95 had been assessed as tinence which existed for ed frequency, "Daily, but some The sections to record history, and cognition were left blank Further, the assessment eled, "Care Planning," with the statements or goals or be completed or implemented are; however, these were all ompleted.  If Care) Response History, entified a 14-day look back of R95's bowel continence tified R95 had 10 episodes of recorded during the period.  The sections to record history, entified a 14-day look back of R95's bowel continence tified R95 had 10 episodes of recorded during the period.  The sections to record history, entified a 14-day look back of R95's bowel continence tified R95 had 10 episodes of recorded during the period.  The sections to record history, entified a 14-day look back of R95's bowel continence tified R95 had 10 episodes of recorded during the period.  The report are report and redications which an anti-coagulant medication, which an anti-coagulant medication),		and triggered monitoring que the electronic medical record program was developed in the provide resident R95 with bowel incontinence care/pre 2. All residents have the paraffected by the deficient prace Specifically, residents who a high-risk medications and high-risk medications and high-risk medications and bowel/bladder incontinence. all residents care plans was the nurse managers and DC these items were in resident including interventions and go 12/28/2024 The DON provide to the nurse managers using Comprehensive Care Plans and Conference Policy and Proceensure understanding.  3. To ensure systemic chas sustained, all nursing staff won comprehensive care plans 18, 2024 during and all staff using the Comprehensive Corare Conference Policy and 4. The DON or designee wand was a week for four weeks weekly for eight weeks spechazards medications and Bo incontinence. Audit results were reviewed by the QAPI comma appropriate follow-up initiate compliance is sustained.  5. The DON will assure condeficiency by January 31, 200 deficiency deficiency deficiency deficiency defic	d. A toileting he Care Plan appropriate vention. Itential to be ctice. Ire taking ave A review of completed by N to ensure care plans goals. On led education of the and Care edure to the led on January meeting are Plan and procedure. It complete are plans and then diffically for owel will be nittee and ed to ensure trection of this or the led of the ensure the led to en		

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		245317	B. WING	<del>}</del>	4	C 2/28/2023
	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912	<u>.</u>	212012023
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F 656	However, R95's caridentified R95 admin 12/20/23 but lacked statements, goals, for R95's bowel inchigh-risk medication associated risk factorecord, including Trecord (TAR), was evidence of ongoing monitoring or how scare planned); in action acked evidence at completed or initiation nearly a week prior.  On 12/27/23 at 2:25 (NA)-B was intervieworked with R95 promost of the time in so, as a result, wou when he was incomended in the was inc	medication).  re plan, dated 12/26/23, tted to the care center on any identified problem or subsequent interventions ontinence or consumed as (i.e., side effect monitoring, tors). Further, the medical eatment Administration reviewed and lacked appsychotropic medication use such would be completed (i.e., addition, the medical record baseline care plan had been and upon R95's re-admission and the wed and verified they had and ior. NA-B explained R95 was an bed and rarely used the toilet ald call for staff assistance tinence of bowel. NA-B stated autty like" most of the time, ar report that to the nurses it." NA-B stated they were any, other interventions for being done aside from just		656		

AND PLAN OF CORRECTION INTERPRETATION NUMBER:		(X2) MUL <sup>-</sup> A. BUILDI	TIPLE CONSTRUCTION  NG	(X3) DATE SURVEY COMPLETED		
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F 656	re-hospitalized and the bed so, as a resconsidered a new a primary diagnosis of a result of those, we transfusions. RN-B plan was developed included basic information care with evaluation verified a formal 'bardone, rather the care the comprehensive added to it as things reviewed R95's care problem statements R95's assessed both any, interventions of completed for the homolitoring). RN-B statements repeat the bowel even the full assessment completed the origin "obviously didn't confus acknowledge the impulled to the NA kare cares to provide) are to add certain items monitor for bruising RN-B stated it was plan was developed you're [staff] actually assessment."	however, he was then the family elected to not hold sult, on 12/20/23 he was dmission adding R95 had a f cancer and anemia and, as ould get routine blood explained a "24 hour" care I upon admission which mation for the NA(s) to use for as are completed. RN-B seline care plan' was not re center just started building care plan right away and s were evaluated. RN-B e plan and verified it lacked s, goals, or interventions for wel incontinence or what, if r monitoring would be	F 6	56		
F 689 SS=D	_	zards/Supervision/Devices	F 6	89		1/31/24

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			DATE SURVEY COMPLETED	
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F 689	system of accident §483.25(d)(2)Each supervision and assaccidents. This REQUIREMED by: Based on observative review, the facility for reassess and deverage adequate intervention residents (R96) after the facility for residents (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate intervention (R96) after the facility for reassess and deverage adequate (R96) after the facility for reassess and deverage adequate (R96) after the facil	ats. Insure that - Iresident environment remains hazards as is possible; and Iresident receives adequate sistance devices to prevent  INT is not met as evidenced tion, interview and document ailed to comprehensively lop interventions to provide ons and supervision for 1 of 1 per found smoking in the facility.  Becord printed 12/28/23, admitted on 12/11/23, and cluded tobacco use, mild ant, shortness of breath, and	F 6	F689- Fee of Accident/Hazards/Supervision/Desident R96 had history of tobaccowas observed smoking in care centre December 25, 2023. Resident was observed with pack of Marlborocin the pocket of his shirt by survey December 27, 2024  1. Cigarettes were removed for resident R96□s room on December 2023 to ensure resident did not statheir room. Resident was remindent the care center was a smoke free and that tobacco use was prohibit used by anyone inside the buildin 2. All residents have potential to affected by the deficient practice. Specifically, those residents who identified to use tobacco products review of residents who use tobac products was complete by the DC January 24, 2024 and assessments.	use and enter on as igarettes yors on that enter a facility ted to be are a. A cco on the and on th		
	assessment, dated current tobacco use	e-Admit Data Collection 12/11/23, indicated R96 was a er. Assessment indicated ducation, cognitive barriers to		care plans were reviewed to ensure items were addressed.  3. To ensure systemic changes sustained all staff were given edured on the Smoking and Tobacco Use	are cation		

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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY			STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912		20/202
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F 689	Continued From pa	ge 22	F 6	89		
	learning and reside understand".  A Tobacco Use Evacompleted. It indicate everyday tobacco (susing 10+ times perday. Evaluation identify impaired, and "resident "has entered to smoke in the learn that resident "has entered to quit smoke patch per physician plan lacked any evicto smoking, cigarett interventions.  R96's Order Summan order for Nicode mg (milligram)/24 has transdermally (via semoking cessation. The order had a state 3 days after admissionate for any non-personating cessation.  A progress note, day was found smoking indicates the cigare educated can't smoking indicates the cigare educated can't smoking cessation.	aluation, dated 12/16/23, was ted that R96 was a current smoking/vaping) user, current day, and uses throughout the ntified R96 is severely dent is unable to know that he building". Evaluation indicated xit seeking behaviorsdoes are he isconfused/agitated."  Ited 12/28/23, identified R96 king and to apply nicotine order on 12/26/23. R96's care dence for interventions related tes, or recent use or  ary, dated 12/28/23, indicated rm CQ Transdermal Patch 21 our: Apply 1 patch our: Apply 1 patch own one time a day for and remove per schedule. The orders lacked any harmalogical intervention for		and Procedure during an all staff on January 18, 2024. A review o do if a resident is found smoking the care center was completed a included: verbal reminder that resont allowed to smoke in the build nearest nurse that a resident is s in the building, remove smoking if from the area (cigarettes, vapes, matches), nurses are to complete tobacco assessment if a resident caught smoking in the building, a care plan should be updated with appropriate interventions.  4. The DON or designee will co audits on tobacco assessments i uses tobacco products, will also a plan twice a week for four weeks weekly for eight weeks. The audi will be reviewed by the QAPI com with appropriate follow-up initiate ensure compliance is sustained.  5. The DON will ensure correctideficiency by January 31, 2024	within and sident is ng, notify moking tems lighters, a is and the and then and then and then are sults mittee d to	

1 ` ′		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION  3	` '	(X3) DATE SURVEY COMPLETED	
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F 689	through 12/27/23, additional assessmup related to tobacon on 12/27/23, at 8:2 sitting on the edge breakfast tray. R96 cigarettes in the positive R96 indicated that facility since he has understands that hoxygen and it is a smoked for many year a nicotine patch but observed that he hoserved that smowith sis a smoke fre "smoker", they must leave the property indicated that if a resist the facility, the tobal locked in the medicine mortant to proper don't want resident themselves or star resident was found would immediately contraband, notify nursing and administration.	ic medical record (EMR) lacked evidence of any nents, progress notes or follow co use.  25 a.m., R96 was observed of his bed with an empty 6 had a pack of Marlboro					

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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		SHOULD BE	(X5) COMPLETION DATE	
F 689	with the resident armore cigarettes we sitting on the nursing they were obtained they are not aware matches.  During an interview director of nursing smoke free facility property to smoke bring tobacco production and cigarettes are drawer and the addreviewed. He state is completed upon resident need. He smoking on the gradminister would for immediately address would be notified a would be completed indicated it would be ensure that smoking education provided tobacco assessments.	nent would follow up as well and family. LPN-A stated that are found on R96 as they are and desk. It is unknown when I from R96. LPN-A indicated of R96 having a lighter or and residents must leave the He stated that if residents ucts into the facility, the lighter locked in the medication missions agreement is d that a smoking assessment admission to assess a stated if a resident is found ounds or within the facility, the ollow up after the issue was assed. He stated the family and a tobacco assessment as a soon as possible. He be added to the care plan and and cessation is offered, and I. DON verified that a follow up and that anot been completed for bound smoking. DON verified no		689			
	information/interveravailable regarding A facility policy title dated 10/11/23, was indicated all reside		F 7	732		1/31/24	
SS=C							

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(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL		(EACH CORRECTIVE ACTION	N SHOULD B E APPROPRI	5.475	
S483.35(g) (1) Data must post the follow basis: (i) Facility name. (ii) The current date (iii) The total number by the following cat unlicensed nursing resident care per sh (A) Registered nurse (B) Licensed practic vocational nurses (C) Certified nurse (iv) Resident censure (iv) Reside	Staffing Information. requirements. The facility ving information on a daily  e. er and the actual hours worked egories of licensed and staff directly responsible for nift: ses. cal nurses or licensed as defined under State law). aides. s.  ng requirements. post the nurse staffing data aph (g)(1) of this section on a eginning of each shift. ested as follows: able format. clace readily accessible to rs.  c access to posted nurse facility must, upon oral or ke nurse staffing data elic for review at a cost not to nity standard.  ity data retention facility must maintain the staffing data for a minimum of		732			
is greater.						
	Continued From particles (EACH DEFICIENCY REGULATORY OR LETT)  Continued From particles (System) (Syst	AMARITAN SOCIETY - COMFORCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 25  CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.  §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.  §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	A BUILD  PROVIDER OR SUPPLIER  AMARITAN SOCIETY - COMFORCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 25  CFR(s): 483.35(g)(1)-(4)  §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census.  §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.  §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever	PROVIDER OR SUPPLIER  AMARITAN SOCIETY - COMFORCARE  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 25  CFR(s): 483.35(g)(1)-(4)  \$483.35(g)(1) Data requirements. The facility must post the following and the actual hours worked by the following categories of licensed and unicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses.  (B) Licensed practical nurses or licensed vocational nurses (as defined under State law).  (C) Certified nurse aides. (ii) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors.  \$483.35(g)(4) Facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.  \$483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data or a minimum of 18 months, or as required by State law, whichever	## ABUILDING   B. WIND    ## AMARITAN SOCIETY - COMFORCARE    ## AMARITAN SOCIETY - COMFORCARE    ## SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)    ## CONTINUED FROM THE STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)    ## CONTINUED FROM THE STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)    ## CONTINUED FROM THE STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)    ## CONTINUED FROM THE STATEMENT OF DEFICIENCIES (EACH DEFICIENCY)    ## CONTINUED FROM THE STATEMENT OF DEFICIENCY    ## CONTINUED FROM THE STATEMENT OF DEFICIENCY	

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F 732	by: Based on observareview, the facility for nurse staffing information basis. This had the residents residing in who may wish to vision who may wish to vision interview on 12/26/staff posting was of the entrance and working the staffing coordinated the morning. The staffing coordinated the nursing an interview the SC stated sheen had not updated the weekend or the hole updated the staff posting staffing an interview the staff posting shift. The and the holidays, the process to update the have been helpful.  During an interview the director of nursion oversaw staffing an interview the director of nursions regarding staffing coordinator.	Inge 26  NT is not met as evidenced atton, interview and document railed to ensure the required mation was posted on a daily potential to affect all 35 in the facility and/or visitors ew the information.  In document review, and 23 at 10:10 a.m., the nursing beserved in the main lobby near ras dated 12/19/23 with a of 36. The staff posting ing shift began at 6:00 a.m. anator (SC) stated she had not g staff posting for the day yet.  If on 12/28/23 at 10:26 a.m., oversaw the staff posting and e staff posting over the iday. The SC stated she postings when she arrived at did not have a process to sting at the beginning of the SC stated during the weekend are facility did not have a che staff posting, but this would at on 12/28/23 at 10:34 a.m., fing (DON) stated that the SC and would better answer of this top but, he expected the reto update the staff posting brining when she arrived.		F732 Posted Nurse Staffing  1. Upon surveyor entry on 12 surveyors noted the daily nurs hours were noted to be dated The schedule was updated an 12/26/2023 and following days survey process  2. All residents have the pote affected by the deficient practinurse hour schedule was post when the scheduler arrived to center and completed the nec corrections to it.  3. To ensure systemic chang sustained the scheduler receiveducation and procedure charemail on January 23, 2024 to a correct nurse hours schedul for the day. A message was supported to the posting of meschedule hours on January 26 the OnShift application. The swill post daily schedule and keep of past schedules available for residents, and guests to review 4. The DON, Administrator, will audit the posted schedule week for four weeks and then eight weeks. Audit results will reviewed by the QAPI commit appropriate follow-up initiated compliance is sustained.  5. The DON will ensure corrected deficiency by January 31, 202.	2/26/2023 se schedule 12/19/2023. Ind posted on so during the ential to be idea. The ted correctly the care researy  ges are ved ages via ensure that the is posted sent to all new ursing 5, 2024 via scheduler rep a binder or staff, w.  or designee twice a weekly for the tee with to ensure ection of ection ection of ection ection ection of ection ection of ection		

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	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912			
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F 732	Continued From pa A facility policy rega was not provided.	ge 27 arding the nursing staff posting	F 732	2			
	•	ear, Palatable/Prefer Temp 1)(2)	F 804	4		1/31/24	
	§483.60(d)(1) Food conserve nutritive v §483.60(d)(2) Food	ves and the facility provides- prepared by methods that alue, flavor, and appearance; and drink that is palatable,					
	temperature. This REQUIREMENT by: Based on observation review, the facility facility facility of life and numbers and facility of life and numbers (R95, R16 stay (i.e., TCU) unit	NT is not met as evidenced and interview, and document ailed to ensure meals were calatable manner to promote atritional intake for 2 of 2 (200) reviewed on the short-term in this had potential to affect a ents identified to reside on the ls were served.		F804- Nutritive Value/Appearance, Palatable/Prefer Temperature-  1. On 12/26/2023 it was noted that tray food was not seasoned, room temperature and could be warmer  2. All residents have the potential affected by the deficient practice. Extending the staff received education from the Nand Food Service Supervisor using	at room to be Dietary Jutrition		
	12/26/23, identified number within the control of 11 residents resided on the TCU R95's Daily Skilled identified multiple starious health issue included a section I	at Listing Report, printed all residents and their room care center. This outlined a s, including R95 and R100, l.  Note - V2, dated 12/24/23, ections to recorded R95's es or concerns. This note abeled, "Summary of Skilled entified R95 was alert and		Food Preparation-Food and Nutrition Policy and Procedure on January 2 2024.  3. To ensure systemic changes as sustained the Nutrition and Food S Supervisor will have all cooks compared the ServSafe Training on January 2 2024. The Nutrition and Food Servisor is also going to implement additional dietary meeting with residual monthly which began on January 2 2024.  4. The Nutrition and Food Service 4.	re ervice plete 29, ice ent an dents 2,		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245317	B. WING			C <b>28/2023</b>	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - COMFORCARE				STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	<u> </u>		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUTH ACTI	OULD BE	(X5) COMPLETION DATE	
F 804	R95 stated he didne the care center. R9 allowed to have a dexpressed the only breakfast meal. R9 meals, such as lun lacking in flavor and the room. R95 add temperature] are vehe had not reported center but rather whose breakfast meal so or less satisfies meals or less satisfies meals after set-up.  On 12/26/23 at 1:1 food is always cold she eats meals here.  On 12/27/23, the formade: -11:36 a.m. steam Unit. The staff set of the food to be particle. The items on the staff is the foil which included hamburger) and culti-11:39 a.m. two reservaiting for lunch to -11:41 a.m. the staff set of the food.	place, and time.  O7 a.m., R95 was interviewed. It care for the meal service at 95 stated he was rarely, if ever, choice on the meal served and meal he enjoyed was the 95 explained the rest of the ch and supper, were typically dicool when served to him in ed, "Both [taste and ery unsatisfying." R95 stated did this to anyone at the care as just trying to eat a bigger there was "one meal that more e."  Winimum Data Set (MDS) which indicated she was not independent with eating  9 p.m., R100 stated that the when it is served. She stated meals in her room.  Ollowing observations were  table arrives to Healing Grace up empty trays in preparation lated to be served to rooms. It is allowed to be served to rooms. It is allowed to be served to rooms. It is allowed to the dining room be served ff asked both residents sitting what type of pizza they want	F 804	Supervisor or designee will aud palatability/temperature two tim and then weekly for eight weeks 5. The Administrator or designensure correction of deficiency 31, 2024.	es a week s. nee will		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 804	and two unidentifier food trays resident pieces of pieces are plate and then cover plate and then cover plate is then placed -11:52 a.m. the last plated -11:52 a.m. a sample the steam table -11:54 a.m. the same nursing assistant (I much seasoning" warmer". NA-A stamediocre".  During interview or stated there have be resident about the amount of food. The and given to the did nursing for follow understary manager (E complaints about fladdressing it. DM stable a couple of we temperatures are from plaints. He statemperatures. DM complaint, he follow meeting with the readdressed.	od was plated onto the trays d nursing staff delivered the rooms. The food items (two hd lettuce) are placed onto a ered with a plate cover. The d on the tray. It resident tray finished being the plate was requested from higher tray was sampled by NA)-A who stated there is "not room temperature" "could be ted the sample tray was  1. 12/27/23, at 12:27 p.m., NA-A been "some" complaints from temperature, flavor, and the complaints are written down tetary manager and director of	F 8	304			
	(DON) stated that of passed along to did	e p.m., director of nursing complaints regarding food get etary and the administrator will eded. DON indicated he					

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MUI A. BUILE	TIPLE CONSTRUCTION DING	· · · ·	TE SURVEY MPLETED
		245317	B. WING	i	12	C 2/28/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CO 1201 17TH STREET NE AUSTIN, MN 55912	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREF TAG		SHOULD BE	(X5) COMPLETION DATE
F 883	A facility policy titled Standard-Food and date of 7/21/23 was residents will be pronourishing, attractive served at a safe and Influenza and Pneur CFR(s): 483.80(d) (1) Influenze immunizations §483.80(d) (1) Influenze immunizations §483.80(d) (1) Influenze immunization of the receives education potential side effect (ii) Each resident is immunization Octobe annually, unless the contraindicated or to the resident or the reside	when needed if it is related to impacting a resident's health.  d, Dining Service Nutrition Services, review is provided. It indicated that ovided meals that are read appetizing temperature. Impococcal Immunizations 1)(2)  and pneumococcal  enza. The facility must develop dures to ensure that he influenza immunization, are resident's representative regarding the benefits and its of the immunization; offered an influenza over 1 through March 31 immunization is medically the resident has already been his time period; the resident's representative to refuse immunization; and nedical record includes indicates, at a minimum, the int or resident's representative ation regarding the benefits	F	383		1/31/24

NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - COMFORCARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 883  Continued From page 31  §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-  (i) Before offering the pneumococcal	SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - COMFORCARE  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 883  Continued From page 31  §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-  (i) Before offering the pneumococcal	28/2023
PREFIX TAG  (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  F 883  Continued From page 31  \$483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-  (i) Before offering the pneumococcal	
§483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal	(X5) COMPLETION DATE
must develop policies and procedures to ensure that-  (i) Before offering the pneumococcal	
immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;  (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;  (iii) The resident or the resident's representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:  (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and  (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.  This REQUIREMENT is not met as evidenced by:  Based on interview and document review, the facility failed to ensure recommended pneumococcal vaccinations, as outlined by the Centers for Disease Control (CDC), were offered and/or provided in a timely manner to reduce the risk of severe disease for 2 of 5 residents (R13, R27) reviewed for immunizations.  Findings include:  Frindings include:  Frindings include:  A CDC Pneumococcal Vaccine Timing for Adults  Brand R27 had not received pneumococcal immunizations during the survey process.  1. The DON provided education to the IP nurse using the Immunization/Vaccinations for Residents, Pneumococcal, Influenza, COVID-19, Other Policy and Procedure on December 28, 2024. The IP nurse reviewed the	

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F 883	with corresponding receive various ver PCV20) of the pne labeled, "Adults 19 immunocompromis multiple columns to vaccine(s) had alrewhich were now recontained various acconsidered immune "Chronic renal failu with a previous adrat least one year the PCV20 vaccine.  R13's significant che (MDS), dated 11/18 the nursing home in than 65 years old, acconditions including disease (CKD). However, the affirmative response. This ide "Pneumococcal (Pethe affirmative response. However, the conditions including the conditions in the conditio	23, identified several tables recommendations when to sions (i.e., PPSV23, PCV13, umococcal vaccine. The graph -64 years old with specified sing conditions," listed oreference with which eady been given and, from that, commended. The graph conditions which were occompromising including, are," and the graph identified ministration of PPSV23, to wait then provide either a PCV15 or mange Minimum Data Set 3/23, identified R13 admitted to an December 2022, was less and had several medical granemia and chronic kidney wever, the section to record a left blank and not completed sent - Multiple Vaccines form, and dated, identified multiple in a corresponding space to efusal via a "yes" or "no" intified a space which read, CV15, PCV20; PPSV23)" with bonse (i.e., yes) circled as his here were no written date of	F 8	electronic medical record ar forms for residents R13 and provided education and con residents before proceeding immunizations.  2. All residents have the paffected by the deficient pracomprehensive review of all Influenza and Pneumococca Immunizations was complet nurse. Education, consent, immunization was given/acc resident or resident represe documented in the electroni record. Those who gave con immunized received the apprimmunization and this was of the electronic medical record. To ensure systemic chasustained all nursing staff reeducation on Immunization/for Residents, Pneumococc COVID-19, Other Policy and on January 18, 2024. Immuneducation will be provided to admissions to care center, a refusal of immunization will from resident or resident repappropriate immunizations of given to those who have conthem. These items will be of the electronic medical record. The DON or designee were resident or resident record.	d R27 then sent to the with otential to be actice. A I resident al ted by the IP or refusal of quired from entative and ic medical nsent to be propriate documented in ed. Influenza, of Procedure nization of all new and consent or be obtained presentative, will then be nsented to document in ed. Influencedure will then be nsented to document in ed. Influencedure to document in ed. Influencedure to document in ed.	
	recorded vaccines. R13's electronic m Immunizations listi	d as there were with the other edical record (EMR) ng, undated, identified all of munizations per the care		audits of random resident in information in the electronic record two times a week for and then weekly for eight we results will be reviewed by the committee with appropriate	medical four weeks eeks. Audit he QAPI	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	<b>l</b> `´´	TIPLE CONSTRUCTION ING	· /	TE SURVEY MPLETED
		245317	B. WING		12	C 2/28/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP COD 1201 17TH STREET NE AUSTIN, MN 55912	E	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETION DATE
F 883	on 11/2008 with did lacked evidence an immunizations were Further, R13's entire the scanned Minned Connect (MIIC) infollacked evidence and vaccinations, included been offered, refusive recommended due.  When interviewed extated he was unable his physician, had exaccinations with hem R13 verified he had voiced he was open needed.  A CDC Pneumocod feature, dated 3/20 with corresponding receive various ver vaccine. The graph old with chronic heamultiple columns to vaccine(s) had alrewhich were now recontained various hem considered chronic diabetes mellitus and graph identified with PCV13, to wait at leather a PCV20 or leather a PCV20	included a PPSV23 vaccine station, "Historical," however, by of the other pneumococcal e offered, provided or refused. The medical record, including sota Immunization Information ormation, was reviewed and by of the other pneumococcal sting PCV15 or PCV20, had sed or provided despite being to history of CKD.  In 12/27/23 at 11:04 a.m., R13 ble to recall if anyone, including ever discussed the subsequent im adding, "I don't remember." If CKD and diabetes and in to getting the vaccinations, if accal Vaccine Timing for Adults 23, identified several tables recommendations when to sions of the pneumococcal labeled, "Adults 19-64 years alth conditions," listed oreference with which ady been given and, from that, commended. The graph health conditions which were (i.e., high risk) including and cigarette smoking, and the ha previous administration of seast one year then provide PPSV23 with dictation,		initiated to ensure compliance sustained. 5. The DON will ensure corredeficiency by January 31, 202	ection of	

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		245317	B. WING			C <b>12/2</b>	8/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP ( 1201 17TH STREET NE AUSTIN, MN 55912	CODE		
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F 883	R27 had diabetes in to record R27's cog completed (see F65 R27's Vaccine Condated 12/28/23, idea years old and outling corresponding space via a "yes" or "no" in space which read, "PCV20; PPSV23)" (i.e., yes) circled as R27's EMR Immunidentified all of R27 the care center' recon 8/2015 with dictal lacked evidence an immunizations were Further, R27's entire the scanned Minner Connect (MIIC) infollacked evidence an vaccinations, included been offered, refusive recertification survey obtained (dated 12 recommended due When interviewed distanced in the care center in the care center in the scanned Minner Connect (MIIC) infollacked evidence and vaccinations, included the scanned dated the had diable smoker. R27 stated anyone from the care physician, discussing pneumococcal vaccinations and content in the care center in the care center in the scanned diable smoker. R27 stated anyone from the care physician, discussing pneumococcal vaccinations are content in the care center	S, dated 12/6/23, identified mellitus. However, the section gnition was left blank and not 37, F638).  sent - Multiple Vaccines form, entified R27 was less than 65 ned multiple vaccines with a ce to circle consent or refusal response. This identified a "Pneumococcal (PCV15, with the affirmative response is his choice.  izations listing, undated, 's complete immunizations per cord. This included a PCV13 referred, provided or refused. The other pneumococcal refused of the other pneumococcal refused or medical record, including sota Immunization Information formation, was reviewed and refused or provided prior to the refus		383			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILE	LTIPLE CONSTRUCTION DING	` '	ATE SURVEY OMPLETED
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	PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	<u> </u>	ZIZUIZUZ
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		OULD BE	(X5) COMPLETION DATE
F 883	manager (RN)-A way they were the infect campus. RN-A explainments of the work of the MIIC for data are would offer applicate the process was "king RN-A reviewed R13 conditions. RN-A state of the process was "king RN-A reviewed R13 conditions. RN-A stated they authorization" from illness-related episor going to wait awhile RN-A stated they halast evening (on 12 about it by the survemedical record lack the delay in administ R27 and verified his a current smoker. Frecently ordered more ceived them to proceed them to proceed them to proceed they were unsure worst offering any of the seppsylvanian prior. As a just discussed the rwith R27 the day proceed the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned about it R27 did indeed war the lack of timely actioned action.	ge 35 D a.m., registered nurse unit as interviewed and verified ion preventionist (IP) for the ained immunizations were mission but admitted the of varied" lately with personnel sible to do it. RN-A stated they in it. RN-A stated they it. RN-A stated they it. RN-A stated they it. RN-A stated they it. RN-A stated adding and of like a group effort." It. RN-A stated R13 had signed a in November 2023 for the ococcal vaccine but there had it in it. As a result, and just given R13 the vaccine it due to a needed "prior an insurance payer then an ode happened so they were before giving it. As a result, and just given R13 the vaccine (27/23) after being questioned eyor, and acknowledged the ited any information explaining stration. RN-A then reviewed its medical conditions and being RN-A stated the facility had just one PCV20 doses and had ovide to residents, including not done so yet. RN-A stated thy there was such a delay in subsequent vaccines (i.e., noce he had admitted several result, RN-A stated they had remaining series of vaccines ior (on 12/27/23) after being by the surveyor, and verified at the vaccination. RN-A stated diministration was "very ibuted it to being short-staffed in the vaccination is subsequent to be ing short-staffed.		883		

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		245317	B. WING				2 <b>8/2023</b>
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE		STREET ADDRESS, CITY, STATE, Z 1201 17TH STREET NE AUSTIN, MN 55912	IP CODE		
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F 883	work the floor adding as a whole, was still were working with a streamline it for the it was important to administration of values [residents]"."  A facility' provided In Residents, Pneumo Other policy, dated admission to the call vaccination Information Inf	constantly being pulled to g the immunization process, I a "work in progress" and they in outside group to help them better. However, RN-A stated ensure the timely accines "to protect them becoccal, Influenza, COVID-19, 3/2022, identified each new re center would be given the ation Statements (VIS) for mococcal vaccines. If they ohysician order and written btained, and the vaccine bolicy outlined a section occal Vaccination," which for adults 65 years or older, ormation on recommendations		383			

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PRINTED: 01/29/2024 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION  12 - BUILT IN 2007	(X3) DATE SURVEY COMPLETED
		245317	B. WING _			12/27/2023
	ROVIDER OR SUPPLIER	MFORCARE		1	STREET ADDRESS, CITY, STATE, ZIP CODE  201 17TH STREET NE  AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	X	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD B  CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	DATE
K 000	INITIAL COMMENTS		K	000		
	FIRE SAFETY					
	by the Minnesota Dep State Fire Marshal Di time of this survey, G COMFORTCARE wa with the requirements Medicare/Medicaid at Life Safety from Fire, National Fire Protecti Life Safety Code (LSC Health Care and the 2 Health Care Facilities THE FACILITY'S POO ALLEGATION OF CO DEPARTMENT'S ACC SIGNATURE AT THE PAGE OF THE CMS- AS VERIFICATION OF ONSITE REVISIT OF CONDUCTED TO VAC COMPLIANCE WITH BEEN ATTAINED IN A VERIFICATION.	and the 2012 edition of on Association (NFPA) 101, C), Chapter 19 Existing 2012 edition of NFPA 99, Code.  C WILL SERVE AS YOUR OMPLIANCE UPON THE CEPTANCE. YOUR BOTTOM OF THE FIRST 2567 FORM WILL BE USED				
	FOR THE FIRE SAFE (K-TAGS) TO:					
A D O D A T O T O T	PAPER COPY OF TH	N THE E-POC PROCESS, A HE PLAN OF CORRECTION			T.T	(VC) DATE
-AROKATORY I	DIRECTOR'S OR PROVIDER/	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE	(X6) DATE

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.

Electronically Signed

01/26/2024

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G <b>02 - BUILT IN 2007</b>	l` '	TE SURVEY MPLETED
		245317	B. WING		1	2/27/2023
	ROVIDER OR SUPPLIER	MFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
K 000	DEFICIENCY MUST FOLLOWING INFOR  1. A detailed descritaken or planned to consume the deficient of the ensure the deficient of the ensure the deficient of the remedy.  3. Indicate how the performance to ensure the deficient of the ensure	ections vision uite 145 5145, OR  RECTION FOR EACH INCLUDE ALL OF THE MATION:  ption of the corrective action orrect the deficiency.  asures that will be put in place acy does not reoccur.  facility plans to monitor future re solutions are sustained.  esponsible for the corrective ag of compliance.  possed date for completion of  SOCIETY COMFORTCARE				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG 02 - BUILT IN 2007	(X3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	MFORCARE		STREET ADDRESS, CITY, STATE, ZIP C 1201 17TH STREET NE AUSTIN, MN 55912	CODE
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K 000	The building is proted system. The facility h full corridor smoke determined the corridors that is madepartment notification. The facility has a capacensus of 36 at the time.	eted by a full fire sprinkler as a fire alarm system with etection and spaces open to nonitored for automatic fire on.  acity of 45 beds and had a me of the survey.  2 CFR, Subpart 483.70(a) is	K		
K 324 SS=D	CFR(s): NFPA 101  Cooking Facilities Cooking equipment is with NFPA 96, Standarfire Protection of Conunless:  * residential cooking appliances such as more toasters) are used for cooking in accordance cooking in accordance cooking facilities op compartments with 30 with the conditions une cooking facilities in or fewer patients compartments	ected according to NFPA 96 uired to be enclosed as shall not be open to the 3.3.2.5.4, 19.3.2.5.1 through		324	1/31/24

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG <b>02 - BUILT IN 2007</b>	(X3) DATE SURVEY COMPLETED
		245317	B. WING _		12/27/2023
	ROVIDER OR SUPPLIER	OMFORCARE		STREET ADDRESS, CITY, STATE, ZIP 1201 17TH STREET NE AUSTIN, MN 55912	CODE
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLÉTION DATE
K 324	Continued From page	e 3	K 3	324	
	Based on observation staff interview, the far safety and security modevice in a resident a accordance with NFF Safety Code, section condition could have residents within the far Findings Include:  On 12/27/2023 between was revealed by observed located in the did not have the properties of the properties. An interview with the	PA 101 (2012 edition), Life 19.3.2.5.3(9). This deficient a isolated impact on the		K324 Cooking Facilities—without proper safety and measures On December 27, 2023 it the cooking device in the troot have a proper safety a measure device installed. The Environmental Service contacted Austin Electric (install a new safety/securic cooking device on January electrician ordered the apparant installed the proper safety and installed the	was found that therapy room did and security  es Director electrician) to ty device on the y 10, 2024. The propriate supplies afety equipment other cooking e to residents nected and will em to notify staff, they are  es Director or g devices twice a then weekly time
K 374 SS=F		ng Spaces - Smoke Barrie	K 3	eight weeks to ensure con	1/31/24
	Doors 2012 EXISTING Doors in smoke barri bonded wood-core deresists fire for 20 min plates of unlimited he	ers are 1-3/4-inch thick solid oors or of construction that utes. Nonrated protective eight are permitted. Doors are ed fire window assemblies per			

	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION 6 02 - BUILT IN 2007	(X3) DATE SURVEY COMPLETED
		245317	B. WING		12/27/2023
	OVIDER OR SUPPLIER	MFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD E  CROSS-REFERENCED TO THE APPROPRI  DEFICIENCY)	SE COMPLÉTION DATE
K 741 SS=C	in the direction of egreprovides a minimum of swinging or horizonta 19.3.7.6, 19.3.7.8, 19. This REQUIREMENT Based on observation facility failed to maintain per NFPA 101 (2012) sections 19.3.7.8 and could have a widesprowithin the facility.  Findings include:  1. On 12/27/2023 beto it was revealed by observation and the sections 19.3.7.8 and could have a widesprowithin the facility.  Findings include:  1. On 12/27/2023 beto it was revealed by observation 1/8 inch. Protect mounted to the doors 2. On 12/27/2023 beto it was revealed by observation 1/8 inch. Protect mounted a final doorsthan 1/8 inch. Protect mounted to the doors 2. An interview with the section of the doors 3.	being or automatic-closing, do and are not required to swing less travel. Door opening clear width of 32 inches for I doors.  3.7.9  is not met as evidenced by: n and staff interview, the ain the smoke barrier doors edition), Life Safety Code, I 8.5.4. This deficient finding lead impact on the residents  ween 9:30 AM and 1:30 PM, servation that the Lodge Wing the doors upon testing leto-door gap opening greater live hardware was incorrectly leto-door gap opening greater live hardware leto-door gap opening greater liv	K 37	K374-Subdivision of Building-Smoke Barrier On December 27, 2023 it was noted the the fire doors on the Lodge and Garde had incorrectly mounted protective hardware on them causing a gap.  The Environmental Services Director mounted protective hardware for smokedoors for both the Lodge and Garden January 10, 2024 so that they were mounted in the correct position. The fawill verify correct hardware mounting it doors are replaced in the future. The Administrator or designee will aud doors two times a week for four weeks then weekly for eight weeks to ensure there is no gap greater than 1/8 of an in while they are closed.	ce on acility fire and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 02 - BUILT IN 2007 245317 B. WING 12/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 741 Continued From page 5 K 741 include not less than the following provisions: (1) Smoking shall be prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area shall be posted with signs that read NO SMOKING or shall be posted with the international symbol for no smoking. (2) In health care occupancies where smoking is prohibited and signs are prominently placed at all major entrances, secondary signs with language that prohibits smoking shall not be required. (3) Smoking by patients classified as not responsible shall be prohibited. (4) The requirement of 18.7.4(3) shall not apply where the patient is under direct supervision. (5) Ashtrays of noncombustible material and safe design shall be provided in all areas where smoking is permitted. (6) Metal containers with self-closing cover devices into which ashtrays can be emptied shall be readily available to all areas where smoking is permitted. 18.7.4, 19.7.4 This REQUIREMENT is not met as evidenced by: K741 Smoking Regulation Based on review of available documentation and On December 27, 2023 it was found that staff interview, the facility failed to implement and the care center did not have a designated maintain proper documentation associated to facility smoking regulations per NFPA 101 (2012) smoking area for staff within its smoking edition), Life Safety Code, section 19.7.4. This policy. deficient finding could have a widespread impact The care center will initiate an addendum on the residents within the facility. to the smoking policy to clearly describe the location of the designated smoking area for the staff to prevent this from Findings include: happening in the future, policy will be On 12/27/2023 between 9:30 AM and 1:30 PM, it reviewed annually to ensure compliance.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 02 - BUILT IN 2007 245317 B. WING 12/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 741 Continued From page 6 K 741 was revealed by review of available documentation On January 24, 2023 the addendum was that the facility smoking policy did not identify printed and placed in the fire safety book location(s) where staff and/or clients are allowed to by the DON and Environmental Services smoke. Director to ensure that it was completed. An interview with the Maintenance Director verified this deficient finding at the time of discovery. K 753 1/31/24 K 753 Combustible Decorations SS=F | CFR(s): NFPA 101 Combustible Decorations Combustible decorations shall be prohibited unless one of the following is met: Flame retardant or treated with approved fire-retardant coating that is listed and labeled for product. Decorations meet NFPA 701. Decorations exhibit heat release less than 100 kilowatts in accordance with NFPA 289. Decorations, such as photographs, paintings and other art are attached to the walls, ceilings and non-fire-rated doors in accordance with 18.7.5.6(4) or 19.7.5.6(4). The decorations in existing occupancies are in such limited quantities that a hazard of fire development or spread is not present. 19.7.5.6 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the K753 Combustible Decorations facility failed to maintain and inspect the facility to On December 27, 2023 it was found that be in accordance with NFPA 101 (2012 edition), two resident rooms had over 90% of their Life Safety Code, section 19.7.5, 19.7.5.6. This doors covered by holiday decorations. These items were removed from the doors deficient finding could have a patterned impact on the residents within the facility. on December 27, 2023. Education about decorations using the Life Safety Code Resource Packet will be Findings include: provided to staff via message using the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 02 - BUILT IN 2007 245317 B. WING 12/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 753 Continued From page 7 K 753 On 12/27/2023 between 9:30 AM and 1:30 PM, it OnShift application on January 24, 2024. was revealed by observation that the following Residents and families will receive resident / client room doors were 90% covered education on decorations upon admission with combustible seasonal decoration(s): RM 413, and annually. The Administrator, RM 419. Environmental Services Director, and DON will provide education to staff, families, and An interview with the Maintenance Director verified residents by January 31, 2024. The Environmental Services Director or this deficient finding at the time of discovery. designee will audit all doors for compliance of decorations two times a week for four weeks and then weekly for eight weeks to ensure facility remains in compliance. The Administrator will ensure correction of deficiency by January 31, 2024. K 920 1/31/24 K 920 Electrical Equipment - Power Cords and Extens SS=E CFR(s): NFPA 101 Electrical Equipment - Power Cords and Extension Cords Power strips in a patient care vicinity are only used for components of movable patient-care-related electrical equipment (PCREE) assembles that have been assembled by qualified personnel and meet the conditions of 10.2.3.6. Power strips in the patient care vicinity may not be used for non-PCREE (e.g., personal electronics), except in long-term care resident rooms that do not use PCREE. Power strips for PCREE meet UL 1363A or UL 60601-1. Power strips for non-PCREE in the patient care rooms (outside of vicinity) meet UL 1363. In non-patient care rooms, power strips meet other UL standards. All power strips are used with general precautions. Extension cords are not used as a substitute for fixed wiring of a structure. Extension cords used temporarily are removed immediately upon completion of the purpose for which it was installed and meets the

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING 02 - BUILT IN 2007 245317 B. WING 12/27/2023 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE **1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912** PROVIDER'S PLAN OF CORRECTION SUMMARY STATEMENT OF DEFICIENCIES (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG **DEFICIENCY**) K 920 Continued From page 8 K 920 conditions of 10.2.4. 10.2.3.6 (NFPA 99), 10.2.4 (NFPA 99), 400-8 (NFPA 70), 590.3(D) (NFPA 70), TIA 12-5 This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the K920 

Electrical Equipment Power Cords facility failed to properly manage the and Extens implementation and usage of power strips in On December 27, 2023 it was found that accordance with NFPA 99 (2012 edition), Health extension cords were being used in Care Facilities Code, section 10.2.3.6, 10.2.4 and Administrator office and Social Services NFPA 70, (2011 edition), National Electrical Code, Office. The extension cords were removed sections 400-8, 590.3(D). These deficient finds on December 31, 2023. Staff education will be provided using the Electrical Systems could have a patterned impact on the residents Resource Packet via the OnShift within the facility. application on January 24, 2024. Findings include: The Environmental Services Director or designee will audit for use of extension 1. On 12/27/2023 between 9:30 AM and 1:30 PM, cords two times a week for four weeks and it was revealed by observation that in the Admin. then weekly for eight weeks. Office that a relocatable power tap was connected The Administrator will ensure correction of to an extension cord deficiency by January 31, 2024. 2. On 12/27/2023 between 9:30 AM and 1:30 PM, it was revealed by observation that in the Social Services Office that a relocatable power tap was connected to an extension cord An interview with the Maintenance Director verified these deficient findings at the time of discovery. K 923 1/31/24 K 923 Gas Equipment - Cylinder and Container Storag SS=F CFR(s): NFPA 101 Gas Equipment - Cylinder and Container Storage Greater than or equal to 3,000 cubic feet Storage locations are designed, constructed, and ventilated in accordance with 5.1.3.3.2 and 5.1.3.3.3. >300 but <3,000 cubic feet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION AND IMPED.		TIPLE CONSTRUCTION NG 02 - BUILT IN 2007	<b>1</b> ` ′	(X3) DATE SURVEY COMPLETED	
		245317	B. WING _		1	2/27/2023	
	ROVIDER OR SUPPLIER	OMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE  AUSTIN, MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
K 923	Storage locations are within an enclosed in combustible construction outdoors) that can be are not stored with flat from combustibles by or enclosed in a cabic construction having a protection rating.  Less than or equal to In a single smoke concylinders available for care areas with an agor equal to 300 cubic stored in an enclosur with precautionary sign each door or gate of where the sign include "CAUTION: OXIDIZIN NO SMOKING."  Storage is planned set of which they are recompty cylinders are softwhen facility employs pressure gauge, a three mpty is established marked to avoid conformation open are protected from 11.3.1, 11.3.2, 11.3.3.  This REQUIREMENT Based on observation facility failed to maint storage and manage edition), Health Care 9.3.7, 9.3.7.5.3, 11.6.	e outdoors in an enclosure or terior space of non- or limitedation, with door (or gates e secured. Oxidizing gases ammables, and are separated 20 feet (5 feet if sprinklered) net of noncombustible a minimum 1/2 hr. fire  300 cubic feet mpartment, individual r immediate use in patient agregate volume of less than feet are not required to be e. Cylinders must be handled pecified in 11.6.2. readable from 5 feet is on a cylinder storage room, les the wording as a minimum NG GAS(ES) STORED WITHIN or cylinders are used in order eived from the supplier. Segregated from full cylinders. It is cylinders with integral reshold pressure considered to Empty cylinders are fusion. Cylinders stored in the		K923-Gas Equipment-Cylinder Container Storage On December 27, 2023 there storage of empty and full cylin Oxygen Supply Room. On De 2023 the cylinders in question	was mixed iders in the ecember 27,		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** A. BUILDING 02 - BUILT IN 2007 245317 B. WING 12/27/2023 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER **1201 17TH STREET NE GOOD SAMARITAN SOCIETY - COMFORCARE AUSTIN, MN 55912** SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) (X4) ID ID COMPLETION (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PREFIX **PREFIX** DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG **DEFICIENCY**) K 923 | Continued From page 10 K 923 into the correct storage rack showing they within the facility. were either empty or full. All staff received education on the Medical Gas Protection, Findings include: Including Oxygen-Life Safety Code Policy and Procedure on January 18, 2024. The 1. On 12/27/2023 between 9:30 AM and 1:30 PM, DON or designee will audit oxygen storage it was revealed by observation in the Healing Grace Wing and the Main - Med Gas (O2) twice a week for four weeks and then Storage Rooms that there was mixed storage of weekly for eight weeks. The DON will empty / full cylinders. correct area of deficiency by January 31, 2024 2. On 12/27/2023 between 9:30 AM and 1:30 PM, On December 27, 2023 it was found that it was revealed by observation in the Main - Med there was combustible materials stored in the Oxygen Storage room. On January 18, Gas (O2) Storage Room that there was storage 2024 combustible materials were removed of combustible materials. from the oxygen storage room. All staff An interview with the Maintenance Director verified received education on the Oxygen Policy these deficient findings at the time of discovery. and Procedure on January 18, 2024. The DON or designee will audit the Oxygen Storage Rooms for combustible items two times a week for four weeks and then weekly for eight weeks. The DON will ensure correction of the area of deficiency by January 31, 2024.

Minnesota Department of Health

AND PLAN OF CORRECTION INTERPRETATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00967	B. WING		12/28/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY	- COMFORCARE 1201 17TH	DRESS, CITY, S I STREET N MN 55912	STATE, ZIP CODE E		
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLET	E
2 000 Initial Comments		2 000			
****ATTEN	NTION*****				
NH LICENSING	CORRECTION ORDER				
144A.10, this correct pursuant to a survey found that the defici herein are not corrected shall be with a schedule of fithe Minnesota Departments of the number and MN Ru When a rule contain comply with any of t lack of compliance. re-inspection with a result in the assessi	nether a violation has been				
that may result from orders provided that the Department with	hearing on any assessments non-compliance with these t a written request is made to nin 15 days of receipt of a nt for non-compliance.				
survey was conduct by surveyors from the Health (MDH) to de	28/23, a standard licensing sed completed at your facility he Minnesota Department of termine compliance with the requirements. In addition, a				

Minnesota Department of Health
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE 01/26/24

Minnesota Department of Health

	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIDENTIFICATION N		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
				A. BUILDING:				
		00967		B. WING		12/2	28/2023	
NAME OF	PROVIDER OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COOD		COMPORCARE	1201 17TH	H STREET N	E			
GOODS	SAMARITAN SOCIETY	- COMFORCARE	AUSTIN, N	MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCE MUST BE PRECEDED B SC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 000	Continued From page	ge 1		2 000				
	The following complaints were reviewed with no licensed orders associated: H53178078C (MN95201)							
	As a result of the such orders are issued. For electronic plan of contractions are reviewed these orders they will be completed.	Please indicate in you have rection that you have ers, and identify the	our ave					
	The MDH 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 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 surveyor 's findings are the Suggested Method of Correction and Time Period for Correction.							
	You have agreed to receipt of State licer the Minnesota Department of Bulleting the State delineated on the at Department of Heal you electronically. A secessary for State enter the word "COI available for text. You electronic State lice heading completion	nsure orders consist artment of Health in 14-01, available a ate.mn.us/divs/fpc/ alicensing orders are though no plan of the Statutes/Rules, part RRECTED" in the based must then indicated	at profinfo/infe correction please ox te in the ler the					

Minnesota Department of Health

Minnesota Department of Health

	ID PLAN OF CORRECTION  IDENTIFICATION NUMBER:		` ′	E CONSTRUCTION (X3)	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/28/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	TH STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION DEFICIENCY)		
2 000	Continued From pa	ge 2	2 000			
	the Minnesota Depa is enrolled in ePOC	electronically submitting to artment of Health. The facility and therefore a signature is oottom of the first page of				
	FOURTH COLUMN "PROVIDER'S PLA APPLIES TO FEDE	RD THE HEADING OF THE WHICH STATES, N OF CORRECTION." THIS RAL DEFICIENCIES ONLY. R ON EACH PAGE.				
2 545 MN Rule 4658.0400 Subp. 3 A-C Comprehensive Resident Assessment; Frequency			2 545		1/31/24	
Subp. 3. Frequency. Comprehensive resident assessments must be conducted:  A. within 14 days after the date of admission;  B. within 14 days after a significant change in the resident's physical or mental condition; and C. at least once every 12 months.						
	Based on interview facility failed to ensustatus Minimum Darcomprehensive asset thorough manner to and depressive synfor 1 of 4 residents accuracy.  Findings include:  The Centers for Me (CMS) Long-Term Comprehensive asset thorough manner to and depressive synfor 1 of 4 residents accuracy.	ent is not met as evidenced and document review, the ure the significant change in ta Set (MDS; i.e., a lessment) was completed in a ensure areas of cognition optoms were fully evaluated (R13) reviewed for MDS  dicare and Medicaid Services Care Facility Resident ment (RAI) 3.0 User's Manual,		□ Comprehensive Assessment After Significant Change Resident R13 had blank MDS Sections from C0200 to C1000, Section was left blank from D0150 to D0600 during a SCSA MDS with an ARD from 11/11/23 to 11/18/23.  1. Resident R13□s MDS was review and noted to have incomplete sections 12/27/2023. The needed assessment were reviewed and competed if reside was able to respond to questions or stavailable for interview.  2. All residents could be affected by	red s on s on int ill	

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Minnesota Department of Health

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	00967	B. WING		12/28/2023	
NAME OF PROVIDER OR SUP	IETY - COMFORCARE 1201 17	ADDRESS, CITY,  TH STREET N  I, MN 55912	STATE, ZIP CODE <b>IE</b>		
PREFIX (EACH DEFI	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROPOLICITION (CORRECTIVE)	D BE COMPLETE	
three basic concare Area Assiguidelines and RAI) was maniful included a sec Assessments change in state assessments to be complete conditions and The manual in "SECTION Conditions and The manual in "SECTION Conditions and the section of the ability to regise "These items care-planning and instruction coding of the another section which outlined address mood adding, "Mood is under diagrant nursing home morbidity," and methods and comprehensive R13's significated identified R13 12/2022 and hincluding renared history of states a completed Equation, the section of the secti	m page 3  , identified the RAI consists of mponents including the MDS, the essment (CAA) and the utilization this process (i.e., use of the entiredated by CMS. The manual tion labeled, "Comprehensive "which included a significant us (SCSA) and outlined such would yield corresponding CAA(s) and which were triggered from a responses marked on the MDS. cluded a section labeled, COGNITIVE PATTERNS," which exit on would be used to help resident's attention, orientation and er or recall information adding, are crucial factors in many decisions;" with provided methods as to ensure accurate, thorough MDS. Further, the manual included in labeled, "SECTION D: MOOD," the section would be used to help distress and social isolation distress is a serious condition that one and under treated in the and is associated with significant diagain, the manual provided instructions to ensure the evaluation of these conditions.  Int change MDS, dated 11/18/23, admitted to the care center in ad several medical diagnoses and several medical diagnoses are several medical diagnoses and several medical diagnoses and several medical diagnoses and several medical diagnoses are several medical diagnoses and several medical diagnoses and several medical diagnoses and several medical diagnoses are several medical diagnoses and several medical diagnoses are several medical diagnoses and several medical diagnoses and several medical diagnoses are several medical diagnoses and several medical diagnoses and several medical diagnoses are several medical diagnoses and several medical diagnoses are several medical diagnoses and several med	e d d d d d d d	deficient practice. Specifically, resimble values and needed to have a new loompleted. All residents who coul affected by this were reviewed by nurse and verified to be completed correctly.  3. To ensure systemic changes a sustained, education was provided MDS Nurse on 12/27/2024 using the 3.0 RAI Policy and Procedure. The provided education to the social was using the MDS 3.0 RAI Policy and Procedure on January 24, 2024. A were notified of this deficiency and education was provided on completed under the procedure on January 18, 20 and all staff meeting. The DON, Sown Worker, Dietary Manager, Activities Director, and MDS nurse will meet to ensure MDS assessments are completed and ready for submissional to ensure MDS assessments will be aud the DON, Administrator, or designal a week for four weeks and weekly eight weeks. Audit results will be a by the QAPI committed with the appropriate follow-up initiated to encompliance is sustained.  5. The correction of this deficiency be conducted the DON and will had date of correction on January 31, 22.	nge in MDS d be the MDS l l l l l l l l l l l l l l l l l l l	

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AND BLAN OF CORRECTION INTERCATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	l ` ′	(X3) DATE SURVEY COMPLETED		
		00967		B. WING		12/	28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE	1201 17TH	DRESS, CITY, S I STREET N IN 55912	STATE, ZIP CODE E		
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2 545	completed. In total, left blank and not composed interview, incompleted and, in a section for the staff resident is rarely or blank and not completed to D0600 was left be addressed.  R13's medical recompleted assessment referent to 11/18/23) to detect complications or issest those corresponding evaluations or issest those corresponding to D0600 was left be assessment referent to 11/18/23) to detect complications or issest those corresponding evaluations or issest those corresponding the SCSA expressed all the annot completed the MDS verified they had resincluding the SCSA expressed all the annot completed. RN-have a social worker result, the assessment worker esult, the assessment worker esult, the assessment worker esult, if at all. RN-lated dash the corresponding if at all. RN-lated dash the corresponding if at all. RN-lated and MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B stated an MD assessments to the either, adding, "I do RN-B assessments to the either, adding, "I do RN-B assessments to the either, adding, "I do RN-B assessments to the either assessments to the ei	was also left blank ar section C0200 to C1 ompleted. The 'Section and the spacing to luding with symptom ression, was left blant addition, the subsequences assessment (also us never understood) woleted. In total, section lank and not completed and not completed and luations (i.e., BIMS, Plant and the SCSA arce date (ARD; from rmine what, if any, sues R13 demonstrated	on D - record a presence k and not ent ed if the ras left n D0150 red or lacked HQ-9) 11/11/23 red with urse RN-B al record, 3), and ed" and ty' did not nd, as a S (i.e., nurse te them they had RN-B f these plete, or not." roughly,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/	28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17	ADDRESS, CITY, S TH STREET N I, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 545	to not trigger adding stated "going forward out" more time to great for the MDS' and exensure MDS(s) were thoroughly so "we know thoroughly so "we know the floor of nursing (RN-B being pulled the floor) was "slow workload, however, just being dashed as a result. DON state as a result such hire who were those full areas on the MD as they help determined.	ould cause various CAA item g, "It might." Further, RN-B rd" they were going to "block et the evaluations completed xpressed it was important to re completed accurately and know where their [resident]				
	(Resident Assessmer Rehab/Skilled & The 6/2023, identified a within the federally policy outlined, "The	O (Minimum Data Set) RAI nent Instrument) - nerapy and Rehab policy, date purpose to complete the RAI mandated timeline(s). The ne designated observation				
	period. The [BIMS] the observation per Assessment are probefore or day of the the interview question and locked." Further discipline is unable RN coordinator will	will be completed during riod. The [PHQ-9] and Pain eferably completed the day ARD. Complete means that ons have been saved, signed or, the policy outlined, "If any to complete its section, the assign another person to on within the time frame."	ł			

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		<b>l</b> `´	E CONSTRUCTION	COMPLETED		
		00967	B. WING		12/28/2023	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	H STREET N MN 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	ION SHOULD BE HE APPROPRIATE	
2 545	Continued From page	ge 6	2 545			
	The director of nurse review applicable per ensure accuracy, exconsulting staff on excompletion of the Mongoing compliance	HOD OF CORRECTION: sing (DON), or designee, could olicies and procedures to ducate floor staff and/or expectations for the timely IDS, and then audit to ensure e.				
2 550	MN Rule 4658.0400 Resident Assessme	Subp. 4 Comprehensive ent; Review	2 550			1/31/24
	home must examine quarterly and must comprehensive ass	assessments. A nursing e each resident at least revise the resident's essment to ensure the of the assessment.				
	This MN Requirements	ent is not met as evidenced				
	Based on interview facility failed to ensure a Data Set (MDS) was manner to ensure a depressive symptom needed, fully evaluate R28) reviewed for North Findings include:  The Centers for Me (CMS) Long-Term Company for the Center of the Cente	dicare and Medicaid Services Care Facility Resident		Quarterly Review Assessment at L Every 3 Months-Residents R3 and were identified to have section C02 C1000 and Section D0150 to D060 on their MDS assessments.  1. These residents MDS sections reviewed by the MDS nurse, the M nurse coordinated the completion of sections in the MDS for residents R R28.  2. All residents have the potential affected by the deficient practice.	R28 200 to 00 blank s were IDS of these R3 and I to be All	
	dated 10/2023, identification three basic components	ment (RAI) 3.0 User's Manual, tified the RAI consists of ents including the MDS, the nent (CAA) and the utilization		resident MDS sections were review the MDS nurse to ensure that they completed in a timely manner.  3. To ensure systemic changes a	are	

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STATEMENT OF DEF AND PLAN OF CORR		(X1) PROVIDER/SUPPI IDENTIFICATION N		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967		B. WING		12/28	8/2023
NAME OF PROVIDER	OR SUPPLIER		STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD SAMARIT	AN SOCIETY	- COMFORCARE		H STREET N MN 55912	E		
· · · · · · · · · · · · · · · · · · ·	CH DEFICIENCY	TEMENT OF DEFICIENC MUST BE PRECEDED E SC IDENTIFYING INFORI	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
2 550 Contin	ued From pa	ge 7		2 550			
guideli RAI) w outline non-co comple resider assess gradua monito labeled which determ ability for "These care-p and inst coding another which address adding is under nursing morbio method compre R3's qual had se blood p strokes review Brief Ir blank a subsec (used in undersic comple left bla	nes and this as mandated a quarterly mprehensive etal every 92 at status between the residence of the MDS are etal medical en en etal etal etal etal etal etal etal etal	process (i.e., use of by CMS. The man assessment was a eassessment whice days and was use ween comprehension ensure critical independent of a resident's status a fanual included a section would be used ent's attention, oriested information a rucial factors in massions;" with provide ensure accurate, the Further, the manual eled, "SECTION Desection would be used and undertreated in sassociated with sections to ensure the factors in conditions including the conditions in addition of the staff assess the condition of the condition of the staff assess the condition of t	h was to be ed to track a ve icators of are ection ATTERNS," sed to help entation and adding, ny d methods for ough al included included included included included endition that in the significant vided enditions.  entified R3 and high tory of terns' was completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the completed S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the sment of the complete S) was left on, the complete S) was left on S) was left		sustained, the DON provided educ MDS Nurse on 12/27/2024 using 3.0 RAI Policy and Procedure. The provided education to the social was using the MDS 3.0 Policy and Procedure on January 24, 2024. All staff we notified of this deficiency and educ was provided on completing UDA ensure completion of the MDS in manner on January 18, 2024. The Social Worker, and MDS nurse with weekly to ensure MDS assessme completed and ready for submission 4. MDS assessments will be auctorated to the DON, Administrator, or design a week for four weeks and weekly eight weeks. Audit results will be by the QAPI committed with the appropriate follow-up initiated to ecompliance is sustained.  5. The correction of this deficient be conducted the DON and will have a conducted the DON and will have a compliance in the properties of the DON and will have a conducted the DON a	the MDS ne DON vorker cedure re cation s to a timely non, ill meet nts are ion. dited by nee twice v for reviewed cy will ave a	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00967	B. WING		12/2	8/2023
	PROVIDER OR SUPPLIER	1201 17TH	I STREET N	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
2 550	of frequency of dep completed and, in a section for the staff resident is rarely or blank and not complete blank and not complete assessment reference to 12/7/23) to determine the complete assessment reference to 12/7/23).	luding with symptom presence ression, was left blank and not addition, the subsequent assessment (also used if the never understood) was left bleted. In total, section D0150 lank and not completed or during the quarterly ace date (ARD; from 12/1/23 mine what, if any, sues R3 demonstrated with	2 550			
	R28 had several mentistory of stroke. The Patterns' was review a completed BIMS of completed and, in a section for the staff blank and not complete to C1000 was left by 'Section D - Mood' of to record a mood in symptom presence was left blank and rethe subsequent section by the	rd was reviewed and lacked				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	E CONSTRUCTION	` '	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/	28/2023
	PROVIDER OR SUPPLIER	STREET AC 1201 17T	DRESS, CITY, S	TATE, ZIP CODE	, —,	
GOODS	SAMARITAN SOCIETY	- COMFORCARE AUSTIN,	MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
2 550	Continued From pa	ge 9	2 550			
	(from 11/22/23 to 11/29/23) to determine what, if any, complications or issues R28 demonstrated with those corresponding areas.					
	(RN)-B was intervied completed the MDS verified they had review record, including the expressed all the air not completed. RN-have a social worker result, the assessments and PHQ-9) was managers who could timely, if at all. RN-have a social worker to dash the corresponding, if at all. RN-have assessments to the either, adding, "I do Further, RN-B state going to "block out" evaluations completed accompleted acco	B4 p.m., registered nurse awed and verified they be solving for the campus. RN-B wiewed R3 and R28 medical explained MDS(s), and reas had been "dashed" and B explained the facility' did not explained the facility' did not explained the facility' did not explained the MDS (i.e., were being left to the nurse led not always complete them B stated, as a result, they had onding MDS areas. RN-B I not delegated any of these for floor nurses' to complete, n't know if we could or not." It was if we could or not." It was if we could or not if they were more time to get the ted for the MDS' and inportant to ensure MDS(s) curately and thoroughly so "we esident] cognitive levels are."				
	director of nursing (RN-B being pulled to the floor) was "slow workload, however, just being dashed a as a result. DON states social worker who whopeful such hire will However, DON states.	DON) stated he was aware to work on other things (i.e., ing [them] down" on MDS' he was unaware they were and not thoroughly completed ated they had recently hired a was "still in training" and were ould improve the situation. ed it was important to ensure S were thoroughly completed				
	as they help determ	nine "how we care for our nelp "develop better care				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		00967	B. WING		12/2	28/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE 1201 17TH	DRESS, CITY, S I STREET N IN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION  (EACH CORRECTIVE ACTION SHOULD BE  CROSS-REFERENCED TO THE APPROPRIATE  DEFICIENCY)  (EACH CORRECTIVE ACTION SHOULD BE  COME OF THE APPROPRIATE  DEFICIENCY		
2 550	(Resident Assessment Rehab/Skilled & The 6/2023, identified a within the federally policy outlined, "The conducted during the period. The [BIMS] the observation per Assessment are present and locked." Further discipline is unable RN coordinator will complete this section.  SUGGESTED MET The director of nurse review applicable per pensure timely and ference to the section of the section.	O (Minimum Data Set) RAI ent Instrument) - erapy and Rehab policy, dated purpose to complete the RAI mandated timeline(s). The enterviews must be the designated observation and the IPHQ-9] and Pain eferably completed the day ARD. Complete means that ons have been saved, signed r, the policy outlined, "If any to complete its section, the assign another person to on within the time frame."  HOD OF CORRECTION: Sing (DON), or designee, could policies and procedures to all MDS completion; then				
	compliance.	udit to ensure ongoing				
2 560	Plan of Care; Contests Subp. 2. Contents comprehensive plan objectives and time long- and short-tern	Subp. 2 Comprehensive ents of plan of care. The nof care must list measurable tables to meet the resident's n goals for medical, nursing, echosocial needs that are	2 560			1/31/24

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING	ì	12/2	8/2023
NAME OF F	PROVIDER OR SUPPLIER	STREE	T ADDRESS, C	ITY, STATE, ZIP CODE	<u> </u>	
GOOD S	AMARITAN SOCIETY	- COMFORCARE	17TH STREE			
		AUS	TIN, MN 559			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		N SHOULD BE	(X5) COMPLETE DATE
2 560	Continued From page 11		2 560			
	assessment. The commust include the inc	nprehensive resident comprehensive plan of care dividual abuse prevention p ota Statutes, section 626.5 agraph (b).	lan			
	This MN Requirements by: Based on interview facility failed to ensemble plan was developed with assessed bowe consumed, high-rist continuity of care are complication for 1 of for care planning.  Findings include:  R95's Medicare - 5 (MDS), dated 11/17 record R95's cognition blank and not complication for 1 of for care planning.	and document review, the ure a comprehensive care to reflect resident' conditional incontinence and k medications to promote and reduce the risk of of 2 residents (R95) reviewed a few points (R95) r	eft ed ed ng,	Develop/Implement Compre Plans-Residents R95 Composite Plan did not show high medication, bowel incontine 1. On 12/27/2023 it was not care plan for resident R95 winformation regarding high-medications and bowel incontine Nurse Manager for R95 revision plan and added section information of side-effects apsychotropic medications us and triggered monitoring quant the electronic medical recomprogram was developed in to provide resident R95 with bowel incontinence care/press. All residents have the paffected by the deficient press.	brehensive h-risk ence. loted that the was lacking risk ontinence. The riewed the care ormation on ding the and e monitoring lestions into rd. A toileting the Care Plan of appropriate evention. lotential to be actice.	
	control over it" so stincontinence productions and the second over it so stincontinence productions and the second over it so stincontinence productions are second over it so stincontinence productions.	Bowel Evaluation, dated R95 had been assessed a	S	Specifically, residents who a high-risk medications and howel/bladder incontinence all residents care plans was the nurse managers and Do these items were in residen	nave A review of S completed by ON to ensure It care plans	
	"months" with a listed control is present." contributing factors and not completed.	tinence which existed for ed frequency, "Daily, but so the sections to record hist, and cognition were left black but he assessment eled, "Care Planning," with	ory,	including interventions and 12/28/2024 The DON provious to the nurse managers usin Comprehensive Care Plan Conference Policy and Province ensure understanding.	ded education g the and Care	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/28/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE AUSTIN, N	I STREET N IN 55912	E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE
2 560	what, if any, probler interventions would for R95's incontiner left blank and not continer left blank and not contined to printed 12/28/23, id period and recorded episodes. This identified R95's had including anemia, of fibrillation, and chrolisted R95's physici included apixaban (lorazepam (an antibumetanide (a diure (an anti-depressant narcotic medication sodium (a laxative of the R95's bowel including anemia, of the R95's physici included apixaban (an anti-depressant narcotic medication sodium (a laxative of the R95's bowel including R95's bowel including R95's bowel including Transcord (TAR), was evidence of ongoing monitoring or how so care planned); in actal acked evidence a final statement of the R95's in actal acked evidence a final statement of the R95's bowel including Transcord (TAR), was evidence of ongoing monitoring or how so care planned); in actal acked evidence a final statement of the R95's in actal acked evidence at the R95's incontinuous acked evidence at th	ons to check to represent in statements or goals or be completed or implemented ace; however, these were all completed.  of Care) Response History, entified a 14-day look back d R95's bowel continence at tified R95 had 10 episodes of recorded during the period.  ary Report, printed 12/28/23, d several medical conditions at tiabetes mellitus, atrial onic kidney disease. The report an-ordered medications which (an anti-coagulant medication), earniety medication) etic medication), mirtazapine at medication), oxycodone (and), and senna-docusate medication).  The plan, dated 12/26/23, and senna-docusate medication interventions on tinence or consumed and interventions on tinence or consumed and lacked g psychotropic medication use such would be completed (i.e., ddition, the medical record paseline care plan had been end upon R95's re-admission	2 560	3. To ensure systemic changes a sustained, all nursing staff were ender comprehensive care plans on 18, 2024 during and all staff meets the Comprehensive Care Plan and Conference Policy and procedure 4. The DON or designee will conduct a week for four weeks and the weekly for eight weeks specifically hazards medications and Bowel incontinence. Audit results will be reviewed by the QAPI committees appropriate follow-up initiated to ecompliance is sustained.  5. The DON will assure correction deficiency by January 31, 2024	ducated January ing using d Care nplete ans hen r for

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00967	B. WING		12/2	8/2023
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17TH	DRESS, CITY, S I STREET N IN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 560	(NA)-B was intervieworked with R95 property most of the time" in so, as a result, wou when he was income R95's stool were "phowever, they never rather "just charted unaware what, if an R95's bowel were be checking and chang incontinence episochad not noticed or stop depressive symptor.  On 12/28/23 at 8:34 manager (RN)-B was they had reviewed Rexplained R95 had in November 2023; re-hospitalized and the bed so, as a resconsidered a new a primary diagnosis of a result of those, we transfusions. RN-B plan was developed included basic information care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done, rather the care with evaluation verified a formal bad done with evaluation verified a formal	is p.m., nursing assistant wed and verified they had for. NA-B explained R95 was a bed and rarely used the toilet ld call for staff assistance tinence of bowel. NA-B stated utty like" most of the time, report that to the nurses it." NA-B stated they were y, other interventions for eing done aside from just ging him with each de. Further, NA-B stated they seen by behavior issues or ms from R95 to their recall.  If a.m., registered nurse unit as interviewed and verified R95's medical record. RN-B originally been admitted back however, he was then the family elected to not hold sult, on 12/20/23 he was dmission adding R95 had a f cancer and anemia and, as fould get routine blood explained a "24 hour" care of upon admission which mation for the NA(s) to use for as are completed. RN-B seline care plan' was not be center just started building care plan right away and sewere evaluated. RN-B eplan and verified it lacked as goals, or interventions for wel incontinence or what, if remonitoring would be				

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AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED		
		00967	B. WING		12/28/2023
			I STREET N	STATE, ZIP CODE E	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICATION (CORRECTION CORRECTION CORREC	D BE COMPLETE
2 560	repeat the bowel eventhe full assessment completed the origin "obviously didn't conacknowledge the impulled to the NA kar cares to provide) and to add certain items monitor for bruising RN-B stated it was plan was developed you're [staff] actually assessment."  A policy on care plant requested, however supplicable presented in the problem of the problem and additional to ensure ongother the director of the problem and additional to ensure ongother the problem and the problem and the problem and the ensure ongother the problem and the problem and the ensure ongother the ensure ongother the problem and the ensure ongother the problem and the ensure ongother the ensure of the ensure o	stated they were going to raluation as they "want to do " since the nurse who hal one (dated 12/20/23) implete everything." RN-B formation on the care planted (tool used to know what had expressed they were going to help guide R95's care (i.e., depression symptoms). important to ensure a care as "it helps address what y doing through your  In development was an annewas received.  THOD OF CORRECTION: Sing (DON), or designee, could policies and procedures to ation and careplanning for areas; then educate staff and			
2 620	MN Rule 4658.0445 Admission Informat	Subp. 4 A-N Clinical Record; ion	2 620		1/31/24
	information must be each resident upon at a minimum:	n information. Identification collected and maintained for admission and must include, legal name and preferred			

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Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			JLTIPLE CONSTRUCTION .DING:	(X3) DATE SURVEY COMPLETED	
		00967	B. WIN	G	12/28/2023
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	- COMFORCARE 120	EET ADDRESS, C 1 17TH STRE STIN, MN 559		-
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAC	ODGGG DEFEDENCED TO THE ADDD	JLD BE COMPLETE
2 620	(DNR) & Do Not Intany; I. name, address designated relative J. name, address person to be notified legal representative, or recepted to the second se	y number; ; e of birth; r of admission; ctives, & Do Not Resuscit ubate (DNI) status, if s, and telephone number or significant other, if any ss, and telephone numbe d in an emergency; ative, designated epresentative payee, if any ntative, designated epresentative payee, if any ation, place of worship, a	of /; r of y; y;		
	Based on interview facility failed to ensign emergency treatments resuscitation) were kept readily-access care would be provinced for advanced for advanced for advanced impaired cognition assessment, dated impaired cognition assessment.	ent is not met as evidence and document review, the ure wishes and directives nt (i.e., cardio-pulmonary obtained upon admissionable to ensure appropriate ded for 1 of 1 resident (Reced directives.  nimum Data Set (MDS) 12/17/23, indicated R96 is and diagnoses included blood pressure), mild cog	for and 96)	1. Resident R96 was identified have documented wishes and directives were entered into the system based on resident wishes clinical documentation from resident out by nursing staff and resident it was submitted to be scannithe residents EMR code status we entered into EMR as soon as resident.	rectives ew of empleted dvanced EMR s and lent s ST was ident. The POLST ed into

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_ `		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/28/2023	
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17TH	DRESS, CITY, S I STREET N MN 55912	STATE, ZIP CODE I <b>E</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTION (EACH CORRECTIO	D BE COMPLETE	
2 620	blood cells), and gableed in the digestive indicated he was incorporated hygiene, a care center on 12/1. Review of R96's phesched evidence of emergent treatment receive if their heart R96. In addition, R9 and his electronic malso lacked evidence heing addressed on EMR had a banner R96's name, date of space which read, space was left bland R96's medical recorporated evidence to ensure were assessed upon evidence the facility determine what, if a implemented during Further, the record information or physical which could be easied emergent situation unable to speak for During interview on registered nurse unthe EMR there is not RN-A stated if a cooffacility would do CPRN-A indicated ther some code status for each cast in the extension of the exten	ess of breath, anemia (low red strointestinal hemorrhage (a ve tract). Further, the MDS dependent with mobility, and eating; and admitted to the 1/23.  ysician orders on 12/26/23, a code status (type of a person would or would not to breathing were to stop) for 26's care plan, dated 12/28/23, nedical record (EMR) both se of R96 health care wishes listed (i.e., code status). The along the top which listed if birth, and age along with a 1 Code Status:," however, this k.  Indicate the control of the	2 620	made wishes know.  2. All residents have the potential affected by the deficient practice. resident medical records were reviby DON or nurse manager on 12/2 and showed that code status/advadirectives were entered into the elimedical record for all other resided 3. To ensure that our systemic control are sustained the DON provided et onurses, nurse managers, social services, and HIM on entry of code status/advance directives using the Advance Directive including Cardiopulmonary Resuscitation (Automated External Defibrillator (Automated External	All iewed 26/2023 inced ectronic ints. hanges education e e e CPR) and AED) ance ure on eeting. esignee le t is k for four s. Audit Pl -up January ator, or	

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION N		A. BUILDING:	E CONSTRUCTION	` ′	E SURVEY PLETED
		00967		B. WING		12/	28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE	1201 17TI	DRESS, CITY, S H STREET N MN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIE  MUST BE PRECEDED BY SC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
2 620	indicated the nurse complete POLST (plife-sustaining treated complete to ensure upheld), question a record it in EMR so RN-C indicated the progress note but do the EMR and reiters should have "conveadmission about the EMR banner and On 12/26/23, at 3:1 and was unable to leverified R96 was concluding R96's, information would check EMR be unresponsive, if the CPR. RN-C stated werify code status, to paperwork placed in RN-C verified R96 and code status remains be". RN-C verified in resuscitate) then we possibly be "agains reviewed hospital prode status.  During interview on	rould start CPR. Regioined the interview who does admission on the property of their healthcare wis resident code statulit shows on banner code status is likely lirectly on banner at ated the "admission ersation with them" of the medical record.  5 p.m., RN-A review locate code status vognitively impaired, as a listed. RN-A then so the had multiple resident or mation within. RN-banner if a resident is banner if a resident is banner if a resident in charting room until admitted 12/11/23, as blank adding "it should get CPR which their wishes". RN-aperwork and unable 12/26/23 at 3:19 p.112/26/23 at 3:1	and n should residents shes are s and . RN-A and not in the top of nurse" on ctly into started to n the lents, -C verified is found ould start gnition to family and I scanned. Indicate the louldn't R (do not could and the louldn't				
	indicated that he "of done if unresponsive the facility asked at son was "so-so" inv	e. R96 was unable bout his wishes. R96	to recall if				

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	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		E SURVEY PLETED
		00967	B. WING		12/	28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17	ADDRESS, CITY, S TH STREET N I, MN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
2 620	to the surveyor and provided a hospital code status. RN-A was doing extensive revand other binders in located in a "typical for a code status are EMR.  During an interview family member (FM not consulted with tor code status of the stated that R96 was code status should stated they are word document (health code status are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign the physician to sign admission. DON stated they are word are sident wish, and representative sign they are word and they are word as a resident wish, and representative sign they are word as a resident wish, and representative sign they are word as a resident wish, and representative sign they are word as a resident wish, and representative sign they are word as a resident wish, and representative sign they are word as a resident wish, and representative sign they are word as a resident wish.	ge 18  1 p.m., RN-A presented back reported they had found and report that listed R96 as a Foverified it was located after iew of the stack of paperwork the office and was not place a nurse would check and verified it should be in the on 12/27/23, at 1:37 p.m., pl-A stated that the facility had hem on health care directive eir family member. They is their own person, and the be what R96 wants. FM-A king on making a legal are directive) with a lawyer of on 12/27/23, at 2:37 p.m., (DON) stated the admission sident's code status, discussed have the resident or a POLST which then goes to a POLST which the policy which the policy which then goes to a POLST which the policy w	all c  I  s c c c d ss			
	The facility policy tit	administering CPR.  led Advance Directive monary Resuscitation (CPR) ernal Defibrillator, dated				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967		B. WING		12/28/2023	
	ROVIDER OR SUPPLIER	- COMFORCARE	1201 17TH	DRESS, CITY, S I STREET N IN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICAL DEFICIENCY)	D BE	(X5) COMPLETE DATE
	purpose is to provid opportunity to make care and select a proto make resident de SUGGESTED MET The director of nurs review applicable poensure code status educate staff and accompliance.	d. The policy indicate e each resident the decisions related to ovide and to define a	medical a process TON: nee, could es to sion; then	2 620			
	Subpart 1. Care in receive nursing care custodial care, and individual needs and the comprehensive plan of care as des 4658.0405. A nursi of bed as much as pwritten order from the comprehensite of t	general. A resident e and treatment, person based of preferences as ide resident assessment of the resident must be attending physicial in in bed or the resident must be attending physicial in the resident must be attended to the resident mus	must sonal and ntified in tand ust be out e is a nthat the	2 830			1/31/24
	by: Based on observation review, the facility fa	ent is not met as evident interview and docailed to comprehension op interventions to p	cument vely		<ol> <li>Cigarettes were removed form resident R96 s room on December 2023 to ensure resident did not sm</li> </ol>	er 27,	

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/28/2023	
	PROVIDER OR SUPPLIER  AMARITAN SOCIETY	1201 17TH	I STREET N	STATE, ZIP CODE	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE COMPLETE	
2 830	residents (R96) after Findings include:  R96's Admission Residented R96 was R96's diagnoses in cognitive impairment hypertension (high R96's admission Missessment dated impaired cognition. wanders daily and prisk of getting into a R96's MDS indicated independent with meating.  A Nursing Admit Resident received endearming and res	ecord printed 12/28/23, admitted on 12/11/23, and cluded tobacco use, mild at, shortness of breath, and		their room. Resident was reminded the care center was a smoke free and that tobacco use was prohibit used by anyone inside the building 2. All residents have potential to affected by the deficient practice. Specifically, those residents who a identified to use tobacco products review of residents who use tobac products was complete by the DO January 24, 2024 and assessment care plans were reviewed to ensuitems were addressed.  3. To ensure systemic changes a sustained all staff were given educt the Smoking and Tobacco Use Porcedure during an all staff meet January 18, 2024. A review of whif a resident is found smoking with care center was completed and in verbal reminder that resident is not allowed to smoke in the building, in nearest nurse that a resident is soft the building, remove smoking item the area (cigarettes, vapes, lighter matches), nurses are to complete tobacco assessment if a resident smoking in the building, and the coshould be updated with appropriatinterventions.  4. The DON or designee will conduct a week for four weeks a weekly for eight weeks. The audit will be reviewed by the QAPI com with appropriate follow-up initiated ensure compliance is sustained.  5. The DON will ensure correction deficiency by January 31, 2024	facility ed to be g. be are . A .co N on ts and re all are cation on olicy and ing on at to do in the cluded: ot notify noking in as from s, a is caught are plan te are resident udit care and then results mittee I to	

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AND PLAN	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AN OF CORRECTION IDENTIFICATION NUMBER:		· /	E CONSTRUCTION	COMPLETED		
		00967		B. WING		12/2	28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE	201 1 <b>7</b> TH	RESS, CITY, S STREET NI IN 55912	STATE, ZIP CODE E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FUL SC IDENTIFYING INFORMATIO		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	to smoking, cigarett interventions.  R96's Order Summ an order for Nicode mg (milligram)/24 h transdermally (via somoking cessation). The order had a state of a state of the order for any non-plasmoking cessation.  A progress note, day was found smoking indicates the cigare educated can't smolighterplaced in lower of the order for any notified of R96's sonexplain facility.  Review of electronic through 12/27/23, lay additional assessmup related to tobact of the order for any notified of R96's sonexplain facility.  Review of electronic through 12/27/23, at 8:2 sitting on the edge of the order for any related to tobact of the order for any sitting an interview R96 indicated that he oxygen and it is a firsmoked for many years.	dence for interventions des, or recent use or ary, dated 12/28/23, income CQ Transdermal Parour: Apply 1 patch kin) one time a day for and remove per schedult date of 12/14/23, which ion. The orders lacked harmalogical intervention ted 12/25/23, indicated in his room. The note of the was put out reside ke in facility confiscated in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room. The note of the was put out reside ke in facility confiscated in his room and the was put out reside ke in facility confiscated in his room and the was put out reside ke in facility	dicated atch 21  ule. ich was any on for  R96 further ated apened tified aer in  of follow ved  y  of a.m., the ated he aten as earing	2 830			

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	MENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA  AN OF CORRECTION IDENTIFICATION NUMBER:		ED.   ` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00967	B. WI	NG		12/	28/2023	
	PROVIDER OR SUPPLIER	- COMFORCARE	TREET ADDRESS 201 17TH STR USTIN, MN 5	EET N				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATION	ILL PR	ID EFIX AG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE	
2 830	During an interview (LPN)-A, they indicated that if a resident was found would immediately contraband, notify roursing and administrated managem with the resident and pulindicated managem with the resident and more cigarettes we sitting on the nursing they were obtained they are not aware matches.  During an interview	as a pack of Marlboro of pocket during the interpocket during the interpocket during the interpocket during the interpolated that a smoking pleted upon admission a facility. If a resident is to be able to independent and smoke safely. They sing cessation is encourse or nicotine inhalers. Hent brings tobacco products and lighter at a consideration drawer. They stated to accidentally burn a fire. They indicated the smoking in the facility, stop the resident, lock management (director of ster), do a tobacco use at in a progress note. The nent would follow up as and family. LPN-A stated are found on R96 as the graph of R96 having a lighter on 12/28/23 at 9:26 a.	nurse , and a ntly raged They ducts in ers are ted it is "we" hat if a they up the of hey well that y are when ated or m., with	30				
	smoke free facility a property to smoke bring tobacco produand cigarettes are I drawer and the adnieviewed. He stated is completed upon a	(DON) indicated it was and residents must leavent the stated that if residents into the facility, the ocked in the medication is a smoking assess a stated if a resident is for	ve the nts lighter n sment					

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	OF DEFICIENCIES OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
		00967		B. WING		12/28/2023	
NAME OF	PROVIDER OR SUPPLIER	STRE	ET ADD	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		STREET N 1N 55912	E		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 830	administer would for immediately address would be notified an would be completed indicated it would be ensure that smoking education provided tobacco assessment R96 after he was for additional progress information/intervent available regarding.  A facility policy titled dated 10/11/23, was indicated all resident.	unds or within the facility, llow up after the issue was sed. He stated the family at a tobacco assessment as soon as possible. He e added to the care plan at g cessation is offered, and DON verified that a follow at had not been completed und smoking. DON verified notes or additional ations in the EMR was tobacco use for R96.  If Smoking and Tobacco uses provided. The policy ats/clients who smoke or use fill be assessed and care paid.	and d v up d for ed no	2 830			
2 960	The director of nurs review applicable persure the timely arreassessment of so smoking; then education on going compliance.  TIME PERIOD FOR (21) days	meone identified to be ate staff and audit to ensu	are -one	2 960			1/31/24
	Food Quality Subpart 1. Food qu	uality. Food must have tas ance that encourages resi	ste,				

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	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA DENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION :	(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/28/2023	
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE	H STREET N MN 55912	IE .		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIES (ENCY)	D BE COMPLETE	
2 960	Continued From pa	ge 24	2 960			
	by: Based on observation review, the facility facility facility of life and not residents (R95, R10 stay (i.e., TCU) unit total 11 of 11 residents (R95/R10 stay (i.e., TCU) unit total 11 of 11 residents (R95/R10 stay (i.e., TCU) unit total 11 of 11 residents (R95/R10 stay (i.e., TCU) unit total 11 of 11 residents (R95/R10 stay (i.e., TCU) unit total of 11 residents (R95/R10 stay (i.e., TCU) unit total of 11 residents (R95/R10 stay (i.e., TCU) unit total 11 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 11 residents (R95/R10 stay (i.e., TCU) unit total 12 of 12 residents (R95/R10 stay (i.e., TCU) unit total 12 residents (R95/R1	t Listing Report, printed all residents and their room are center. This outlined a including R95 and R100,  Note - V2, dated 12/24/23, ections to recorded R95's as or concerns. This note abeled, "Summary of Skilled entified R95 was alert and place, and time.  7 a.m., R95 was interviewed, the care for the meal service at 5 stated he was rarely, if ever, hoice on the meal served and meal he enjoyed was the 5 explained the rest of the ch and supper, were typically the cool when served to him in		1. On 12/26/2023 it was noted the tray food was not seasoned, room temperature and could be warmer 2. All residents have the potential affected by the deficient practice. It staff received education from the I and Food Service Supervisor using Food Preparation-Food and Nutritice Policy and Procedure on January 2024.  3. To ensure systemic changes a sustained the Nutrition and Food Supervisor will have all cooks come the ServSafe Training on January 2024. The Nutrition and Food Serv Supervisor is also going to impleme additional dietary meeting with resmonthly which began on January 2024.  4. The Nutrition and Food Service Supervisor or designee will audit for palatability/temperature two times and then weekly for eight weeks.  5. The Administrator or designee ensure correction of deficiency by 31, 2024.	al to be Dietary Nutrition g the ion 24, are Service plete 29, vice nent an idents 22, se ood a week e will	

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	NT OF DEFICIENCIES I OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/2	8/2023
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17T	DRESS, CITY, S H STREET N MN 55912	STATE, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES  'MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
2 960	dated 12/12/2023, very cognitively intact an after set-up.  On 12/26/23 at 1:19 food is always cold she eats meals her.  On 12/27/23, the formade: -11:36 a.m. steam Unit. The staff set us for the food to be planted in the dining room waiting for lunch to -11:41 a.m. the staff in the dining room wand were served lunch to and two unidentified food trays resident pieces of pieces and plate and then cover plate is then placed -11:52 a.m. the last plated -11:52 a.m. the same nursing assistant (Namuch seasoning) "resident" in the seasoning of the sea	Minimum Data Set (MDS) which indicated she was ad independent with eating  D. p.m., R100 stated that the when it is served. She stated meals in her room.  Ilowing observations were table arrives to Healing Grace up empty trays in preparation lated to be served to rooms. eam table are covered with tin pizza slices (pepperoni and t up lettuce (for salad). idents in the dining room be served if asked both residents sitting what type of pizza they want nch ad was plated onto the trays d nursing staff delivered the rooms. The food items (two d lettuce) are placed onto a ered with a plate cover. The	2 960			

Minnesota Department of Health

STATE FORM 2KDF11 If continuation sheet 26 of 28

Minnesota Department of Health

	NT OF DEFICIENCIES NOF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		00967	B. WING		12/2	28/2023
	PROVIDER OR SUPPLIER	- COMFORCARE 1201 17TH	DRESS, CITY, S I STREET N IN 55912	STATE, ZIP CODE E	-	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPROPRIES (EACH CORRECTIVE ACTION OF CORRECTIVE ACT	ULD BE	(X5) COMPLETE DATE
2 960	stated there have be resident about the transcription and given to the dienursing for follow up.  During interview on dietary manager (Domplaints about flat addressing it. DM stable a couple of we temperatures are horizontal temperatures. DM stable a couple of we temperatures are horizontal to the follow meeting with the restandard stable and the follow up when need provides education a health concern or A facility policy titled Standard-Food and date of 7/21/23 was residents will be pronourishing, attractive served at a safe and SUGGESTED MET. The director of nutritions are sidents of the food and the director of the food and the f	12/27/23, at 12:27 p.m., NA-A een "some" complaints from temperature, flavor, and e complaints are written down etary manager and director of p.  12/27/23, at 12:36 p.m., M) stated he had received avoring about food and is tated they got a new steam eeks ago to help ensure olding as he had received ed they are monitoring food etated that when he receives a vs up on the complaint by sident to see how it can be stary and the administrator will ded. DON indicated he when needed if it is related to impacting a resident's health.	2 960			
	to ensure timely ser	rving of prepared food items to then educate staff and audit to				

Minnesota Department of Health

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00967 B. WING 12/2	28/2023	
12/2	12/28/2023	
NAME OF PROVIDER OR SUPPLIER  GOOD SAMARITAN SOCIETY - COMFORCARE  STREET ADDRESS, CITY, STATE, ZIP CODE  1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
2 960 Continued From page 27 TIME PERIOD FOR CORRECTION: Twenty-one (21) days		

Minnesota Department of Health



## Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically Delivered February 14, 2024

Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, MN 55912

RE: CCN: 245317

Cycle Start Date: December 28, 2023

## Dear Administrator:

On February 8, 2024, the Minnesota Departments of Health and Public Safety completed a revisit to verify that your facility had achieved and maintained compliance. Based on our review, we have determined that your facility has achieved substantial compliance; therefore no remedies will be imposed.

Feel free to contact me if you have questions.

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us



## Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered

February 14, 2024

Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, MN 55912

Re: Reinspection Results

Event ID: 2KDF12

Dear Administrator:

On February 8, 2024 survey staff of the Minnesota Department of Health - Health Regulation Division completed a reinspection of your facility, to determine correction of orders found on the survey completed on December 28, 2023. At this time these correction orders were found corrected.

Please feel free to call me with any questions.

Sincerely,

Melissa Poepping, Compliance Analyst

Federal Enforcement | Health Regulation Division

Minnesota Department of Health

P.O. Box 64900

Saint Paul, Minnesota 55164-0970

Phone: 651-201-4117

Email: Melissa.Poepping@state.mn.us