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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3KOP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00903

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245207**

2.STATE VENDOR OR MEDICAID NO.
(L2) **722519900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/11/2013** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 03/06/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 04/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 4/29/13 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/21/2012
(L33)

DETERMINATION APPROVAL

CCN# 24-5207

A standard OTC survey was completed at this facility on November 20, 2012. The most serious deficiencies were found at a S/S level of F. The LSC survey did not find any deficiencies. A Health PCR was completed on December 27, 2012. One health deficiency was found uncorrected at a S/S level of F.

As a result, we recommended the following to CMS and CMS concurred:

- Mandatory DOPNA effective February 1, 2013.

The facility would also be subject to a loss of NATCEP to be effective February 1, 2013.

A second health PCR was completed on February 11, 2013 and the facility was found in substantial compliance effective February 11, 2013. As a result, we recommended the following action to the CMS RO and CMS concurred:

- Mandatory DOPNA effective February 1, 2013, be discontinued effective February 11, 2013

The facility would also be subject to a loss of NATCEP to be effective February 1, 2013.

See attached CMS-2567B for the February 11, 2013 results.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

CCN # 24-5207 April 8, 2013

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

Dear Mr. Pearson:

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

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

Effective February 11, 2013 the above facility is certified for:

99 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 99 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Shellae Dietrich

Shellae Dietrich, Program Specialist
Program Assurance Unit
Licensing and Certification Program
Division of Compliance Monitoring
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone #: (651) 201-4106 Fax #: (651) 215-9697
cc: Licensing and Certification File

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

March 6, 2013

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

RE: Project Number S5207023

Dear Mr. Pearson:

On January 10, 2013, we informed you that the following enforcement remedy was being imposed:

- Mandatory denial of payment for new Medicare and Medicaid admissions effective February 1, 2013. (42 CFR 488.417 (b))

Also, we notified you in our letter of January 10, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility is prohibited from conducting Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) for two years from February 1, 2013.

This was based on the deficiencies cited by this Department for a standard survey completed on November 1, 2012, and failure to achieve substantial compliance at the Post Certification Revisit (PCR) completed on December 27, 2012. The most serious deficiencies at the time of the revisit were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On February 11, 2013, the Minnesota Department of Health completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a PCR, completed on December 27, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of February 11, 2013. Based on our visit, we have determined that your facility has corrected the deficiencies issued pursuant to our PCR, completed on December 27, 2012, as of February 11, 2013.

As a result of the revisit findings, this Department recommended to the CMS Region V Office the following actions related to the remedies outlined in our letter of January 10, 2013. The CMS Region V Office concurs and has authorized this Department to notify you of these actions:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective February 1, 2013, be discontinued February 11, 2013 (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new Medicare admissions, effective February 1, 2013, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective February 1, 2013, is to be rescinded.

As we notified you in our letter of January 10, 2013, in accordance with Federal law, as specified in the Act at Section 1819(f)(2)(B)(iii)(I)(b) and 1919(f)(2)(B)(iii)(I)(b), your facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from February 1, 2013.

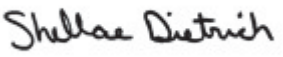
The CMS Region V Office will notify you of their determination regarding the imposed remedies and Nursing Aide Training and/or Competency Evaluation Programs (NATCEP) prohibition.

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

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

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietrich, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5207r213.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245207	A. Building B. Wing	2/11/2013

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

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

(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0371** Reg. # **483.35(i)** LSC	**02/11/2013**	ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By State Agency	**Reviewed By** SR/sd	**Date:** 03/06/13	**Signature of Surveyor:** 30921	**Date:** 02/11/13
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**
Followup to Survey Completed on: 11/1/2012		**Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?**	**YES**	**NO**

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3KOP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00903

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245207**

2.STATE VENDOR OR MEDICAID NO.
(L2) **722519900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **12/27/2012** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Heim HPR Social Work Specialist 01/10/2013 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 03/08/2013 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 3/18/2013
Fixed 2567B see QIS folder

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
12/21/2012
(L33)

DETERMINATION APPROVAL

C&T REMARKS - CMS 1539 FORM STATE AGENCY REMARKS

CCN# 24-5207

A standard OTC survey was completed at this facility on November 20, 2012. The most serious deficiencies were found at a S/S level of F. The LSC survey did not find any deficiencies.

A Health PCR was completed on December 27, 2012. One health deficiency was found uncorrected at a S/S level of F.

As a result, we recommended the following to CMS and CMS concurred:

- Mandatory DOPNA effective February 1, 2013.

The facility would also be subject to a loss of NATCEP to be effective February 1, 2013.

See attached CMS-2567 and CMS-2567B for survey results.

Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7010 2780 0001 8953 7280

January 10, 2013

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

RE: Project Number S5207023

Dear Mr. Pearson:

On November 20, 2012, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on November 1, 2012. This survey found the most serious deficiencies to bewidespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On December 27, 2012, the Minnesota Department of Health completed a revisit to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on November 1, 2012. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of December 31, 2012. Based on our visit, we have determined that your facility has not achieved substantial compliance with the deficiencies issued pursuant to our standard survey, completed on November 1, 2012. The deficiency not corrected is as follows:

F0371 -- S/S: F -- 483.35(i) -- Food Procure, Store/prepare/serve - Sanitary

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

Sections 1819(h)(2)(D) and (E) and 1919(h)(2)(C) and (D) of the Act and 42 CFR 488.417(b) require that, regardless of any other remedies that may be imposed, denial of payment for new admissions must be imposed when the facility is not in substantial compliance 3 months after the last day of the survey identifying noncompliance. Thus, the CMS Region V Office concurs, is imposing the following remedy and has authorized this Department to notify you of the imposition:

- Mandatory Denial of payment for new Medicare and Medicaid admissions effective February 1, 2013. (42 CFR 488.417 (b))

The CMS Region V Office will notify your fiscal intermediary that the denial of payment for new admissions is effective February 1, 2013. They will also notify the State Medicaid Agency that they must also deny payment for new Medicaid admissions effective February 1, 2013. You should notify all Medicare/Medicaid residents admitted on or after this date of the restriction.

Further, Federal law, as specified in the Act at Sections 1819(f)(2)(B), prohibits approval of nurse assistant training programs offered by, or in, a facility which, within the previous two years, has been subject to a denial of payment. Therefore, Good Samaritan Society - Stillwater is prohibited from offering or conducting a Nurse Assistant Training/Competency Evaluation Program or Competency Evaluation Programs for two years effective February 1, 2013. This prohibition is not subject to appeal. Further, this prohibition may be rescinded at a later date if your facility achieves substantial compliance prior to the effective date of denial of payment for new admissions. If this prohibition is not rescinded, under Public Law 105-15 (H.R. 968), you may request a waiver of this prohibition if certain criteria are met. Please contact the Nursing Assistant Registry at (800) 397-6124 for specific information regarding a waiver for these programs from this Department.

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

A copy of the Statement of Deficiencies (CMS-2567) and the Post Certification Revisit Form (CMS-2567B) from this visit are enclosed.

APPEAL RIGHTS

If you disagree with this determination, you or your legal representative may request a hearing before an administrative law judge of the Department of Health and Human Services, Department Appeals Board. Procedures governing this process are set out in Federal regulations at 42 CFR Section 498.40 et seq. A written request for a hearing must be filed no later than 60 days from the date of receipt of this letter. Such a request may be made to the Centers for Medicare and Medicaid Services at the following address:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
Attention: Oliver Potts, Chief
330 Independence Avenue, SE
Cohen Building, Room G-644
Washington, DC 20201

A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree. It should also specify the basis for contending that the findings and conclusions are incorrect. You do not need to submit records or other documents with your hearing request. The Departmental Appeals Board (DAB) will issue instructions regarding the proper submittal of documents for the hearing. The DAB will also set the location for the hearing, which is likely to be in Minnesota or in Chicago, Illinois. You may be represented by counsel at a hearing at your own expense.

DEPARTMENT CONTACT

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

Susanne Reuss
Minnesota Department of Health
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

Upon receipt of an acceptable PoC, a revisit of your facility will be conducted to verify that substantial compliance with the regulations has been attained. The revisit will occur after the date you identified that compliance was achieved in your allegation of compliance and/or plan of correction.

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and we will recommend that the remedies imposed be discontinued effective the date of the on-site verification. Compliance is certified as of the date of the second revisit or the date confirmed by the acceptable evidence, whichever is sooner.

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

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

Nursing Home Informal Dispute Process
Minnesota Department of Health

Division of Compliance Monitoring
P.O. Box 64900
St. Paul, Minnesota 55164-0900

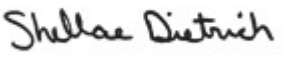
This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

Feel free to contact me if you have questions.

Sincerely,



Shellae Dietric, Program Specialist
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-4106 Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File 5207r113.rtf

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

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction	(Y3) Date of Revisit
245207	A. Building B. Wing	12/27/2012

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

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

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix **F0225** Reg. # **483.13(c)(1)(ii)-(iii), (c)(2) -** LSC	Correction Completed **12/27/2012**	ID Prefix **F0226** Reg. # **483.13(c)** LSC	Correction Completed **12/27/2012**	ID Prefix **F0241** Reg. # **483.15(a)** LSC	Correction Completed **12/27/2012**
ID Prefix **F0253** Reg. # **483.15(h)(2)** LSC	Correction Completed **12/27/2012**	ID Prefix **F0279** Reg. # **483.20(d), 483.20(k)(1)** LSC	Correction Completed **12/27/2012**	ID Prefix **F0280** Reg. # **483.20(d)(3), 483.10(k)(2)** LSC	Correction Completed **12/27/2012**
ID Prefix **F0309** Reg. # **483.25** LSC	Correction Completed **12/27/2012**	ID Prefix **F0322** Reg. # **483.25(g)(2)** LSC	Correction Completed **12/27/2012**	ID Prefix **F0323** Reg. # **483.25(h)** LSC	Correction Completed **12/27/2012**
ID Prefix **F0332** Reg. # **483.25(m)(1)** LSC	Correction Completed **12/27/2012**	ID Prefix **F0431** Reg. # **483.60(b), (d), (e)** LSC	Correction Completed **12/27/2012**	ID Prefix **F0492** Reg. # **483.75(b)** LSC	Correction Completed **12/27/2012**
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	**Reviewed By** SR/sd	**Date:** 01/10/13	**Signature of Surveyor:** 30922	**Date:** 12/27/12
Reviewed By CMS RO	**Reviewed By**	**Date:**	**Signature of Surveyor:**	**Date:**

Followup to Survey Completed on: 11/1/2012

Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? **YES** **NO**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	R 12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	{F 000}	*Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.*	
{F 371} SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review the facility failed to maintain sanitary conditions in the kitchen with cleaning the floor, a wall mounted fan, ceiling light, trash bin cover,and utensils used to prepare food. There was not a manufacturers recommendation for dishwashing rinse cycle. In addition, food items in the freezer were not labeled or dated when opened. Furthermore, the policy for leftovers was not followed to record hot food that is put into the	{F 371}	*Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. All deficiencies will be reviewed by the Quality Assurance Committee on 1/23/2013 for appropriate recommendations.* The facility will continue to follow policies regarding food storage, leftovers procedure and cleaning/ sanitation . All Nutrition Services staff will be re-educated on the policy and procedure for proper food storage and leftover procedure. All refrigerators and	

1/28/13 SER

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kathryn Pearson — TITLE: Administrator — (X6) DATE: 1/22/13

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	R 12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 371}	Continued From page 1 refrigerator to ensure proper cooling temperatures within certain timeframe's. These areas had the potential to affect 80 residents residing in the facility. Findings include: During an observation of the kitchen with dietary supervisor on 12/26/12, at 3:00 p.m. revealed a dirty kitchen floor under the food prep cabinet, the dishwashing area, behind the dry food storage shelves and under the compartment sink. All of these areas had a heavy accumulation of dark brown, black greasy looking substance and an accumulation of crumbs and dust. The fan in the dishwashing area had a heavy accumulation of of black fuzzy dust and grime. The overhead light fixture in the dishwashing area had numerous dead bugs and moths visible. The cabinet under the food prep area holding the measuring spoons in plastic containers revealed black and brown particles in the measuring cups and in the bottom of the two containers. The dishwashing log temp was incomplete with thirty-five documented temperatures for December out of seventy-eight required opportunities to document temperatures. Observation of the dish washing final rinse showed the temperature of the dish machine made it to 180 degrees Fahrenheit (F.) but failed to maintain a specified number of seconds and facility staff were not aware of the number of seconds manufacturer recommendations were for the rinse cycle. A second tour of the kitchen on 12/27/12, at 10:50 a.m. revealed the trash can cover was under the barrel on the floor in the dish washing area. The freezer had an approximate five pound package of a meat substance, what appeared to be10 uncooked	{F 371}	freezers in the kitchen will be monitored for expired food items. All Nutrition Services staff will be re-educated on cleaning and sanitization procedures. An updated cleaning schedule has been implemented to ensure cleaning is being done on a regular basis. Routine audits will be completed by the Director of Nutrition Services, Nutrition Supervisor, or designee to ensure food storage procedures/leftovers are being followed, the cleaning and sanitation procedures are being followed, and that surfaces remain rust-free. Date of Completion	1/30/13

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	R 12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

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{F 371}	Continued From page 2 cinnamon rolls, approximately one pound of what looked like chopped ham in a plastic bag, and a package of what looked like approximately three dozen garlic toasts that were not labeled and dated when opened. Cook (C-A) placed a gallon container of hot chicken broth into the refrigerator at 11:00 a.m. No temperature or time were recorded when the chicken broth was put into the refrigerator. At 1:00 p.m. surveyor asked C-A for the temperature of the chicken broth which after being in the refrigerator for two hours was 92 degrees F. During observation at 2:15 p.m. nursing assistant NA-A donned a hair net and proceeded to walk into the kitchen to the food prep table to obtain a can of soda for a resident. The facility four week cycle menu posted outside of the kitchen was dated September 2012. When interviewed on 12/26/12, at 3:00 p.m. the kitchen supervisor verified all of the findings observed 12/26/12. When interviewed on 12/27/12 at 10:50 a.m. dietary aide (DA-A) verified the trash container lid should not be on the floor and that the number of rinse seconds of the dish machine to be at 180 degrees F. was unknown. When interviewed at 1:15 p.m.C-A revealed food temperature logs were not available in the kitchen. C-A threw out the chicken broth. C-A and C-B were not aware of the undated unlabelled food items in the freezer but verified all food items are to be dated and labeled in the freezer when opened or broken down into smaller packages from the cartons. When interviewed at 2:15 p.m. NA-A thought it was acceptable to go into the kitchen as long as a hair net was worn. When interviewed at 2:20 p.m. the administrator verified the four week menu cycle was dated September 2012.	{F 371}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	R 12/27/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 371}	Continued From page 3 A record of the facility 12/11/12, plan of correction for nutritional services staff education and training in proper food storage, monitoring of expired food items, cleaning and sanitization procedures, and food storage audits were requested but not received. The facility/Food Preparation Leftovers policy and procedure directed #5: Leftover hot food will be cooled to 41 degrees or less per state regulations. First two hours-135 to 70 degrees F. a: Shallow pans will be utilized. (Thick foods such as stew and chili no more than two inches. Thinner liquids such as broth and soup no more than three inches.) Policy and procedures for dating and labeling food items in the freezer, cleaning procedures for floor care, fan care, utensil cleaning, dish machine rinse cycle manufacturer recommendations, light fixture cleaning responsibility, nursing and other non dietary employees allowed in the kitchen and dating of cycle menus were requested but not received.	{F 371}		

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 3KOP

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00903

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245207**

2.STATE VENDOR OR MEDICAID NO.
(L2) **722519900**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - STILLWATER**
(L4) **1119 OWENS STREET NORTH**
(L5) **STILLWATER, MN** (L6) **55082**

4. TYPE OF ACTION: **2** (L8)

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **11/01/2012** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **99** (L18)

13.Total Certified Beds **99** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IMR
	99			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

See Attached Remarks

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, HFE NE II 12/17/2012 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Shellae Dietrich, Program Specialist 12/20/2012 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
05/01/1976
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

VOLUNTARY **00**
01-Merger, Closure
02-Dissatisfaction W/ Reimbursement
03-Risk of Involuntary Termination
04-Other Reason for Withdrawal

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS
Posted 12/21/2012 ML

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

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

CCN# 24-5207

At the time of the standard survey completed November 1, 2012, the facility was not in substantial compliance and the most serious deficiencies were found to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required. The facility has been given an opportunity to correct before remedies are imposed. See attached CMS-2567 for survey results.
Post Certification Revisit to follow.

MINNESOTA
MDH
DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of Minnesotans

Certified Mail # 7011 2000 0002 5148 8908

November 20, 2012

Mr. Nathan Pearson, Administrator
Good Samaritan Society - Stillwater
1119 Owens Street North
Stillwater, Minnesota 55082

RE: Project Number S5207023

Dear Mr. Pearson:

On November 1, 2012, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Suzanne Reuss
Minnesota Department of Health
P.O. BOX 64900
St. Paul, Minnesota 55164-0900

Telephone: (651) 201-3793

Fax: (651) 201-3790

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by December 11, 2012, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by December 11, 2012 the following remedy will be imposed:

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

PLAN OF CORRECTION (PoC)

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

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

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

- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;

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

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

- Include signature of provider and date.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

If substantial compliance has been achieved, certification of your facility in the Medicare and/or Medicaid program(s) will be continued and remedies will not be imposed. Compliance is certified as of the latest correction date on the approved PoC, unless it is determined that either correction actually occurred between the latest correction date on the PoC and the date of the first revisit, or correction occurred sooner than the latest correction date on the PoC.

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by February 1, 2013 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement

of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by May 1, 2013 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

This request must be sent within the same ten days you have for submitting a PoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

You must notify MDH at this website of your request for an IDR or IIDR within the 10 calendar day period allotted for submitting an acceptable plan of correction. A copy of the Department's informal dispute resolution policies are posted on the MDH Information Bulletin website at: http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm

Please note that the failure to complete the informal dispute resolution process will not delay the dates specified for compliance or the imposition of remedies.

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

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

Telephone: (651) 201-7205

Fax: (651) 215-0541

Feel free to contact me if you have questions.

Sincerely,

Suzanne Reuss, Unit Supervisor
Licensing and Certification Program
Division of Compliance Monitoring
Telephone: (651) 201-3793 Fax: (651) 201-3790

Enclosure

cc: Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000	*Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual.*	
F 225 SS=E	483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency). The facility must have evidence that all alleged	F 225 12/17/12 SER	*Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of the federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center's allegation of compliance in accordance with section 7305 of the State Operations Manual. All deficiencies will be reviewed by the Quality Assurance Committee on 12/19/2012 for appropriate recommendations.* F225 The facility will continue to follow State and Federal guidelines as well as their facility policy and procedure regarding VA reporting and investigating. All staff will be re-educated regarding this process with emphasis on timeliness and administrator	

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

Nathan Ramsden Administrator 12/11/12

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245207	A. BUILDING _____ B. WING _____	11/01/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - STILLWATER	1119 OWENS STREET NORTH STILLWATER, MN 55082

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F 225	Continued From page 1 violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on interview and document review the facility failed to immediately report an allegation of abuse for 3 of 7 residents R72, R94 and R95, to the State Agency and did not complete the background check for 1 of 10 employees. Findings include: Allegations of maltreatment made by R72 were not not reported immediately to the facility administrator, were not reported immediately to the state vulnerable adult reporting agency, and were not thoroughly investigated in a timely manner. When interviewed on 10/30/12, at 11:00 a.m. R72 was asked if staff treated her with respect and dignity and she replied that there is a staff person working on the night shift who does not always help her when she asks for help, and also wakes her up for no reason. R72 could not remember the name of this staff member.	F 225	notification. We will also work with residents and families through resident council, care conferences and family council regarding the importance of immediate notification of possible mistreatment. If residents/families chose to notify the facility of alleged mistreatment in writing by using the facility's grievance form, we will indicate on the form the date and time it is received as well as when the administrator is notified. The DNS and/or Social Services (or their designee) will be responsible for auditing the process. Immediately and ongoing the Human Resource Director will complete DHS Background Studies through Net Study online for 100% of the candidates hired to work at the center. HR Director will insure that the study request is entered and that the candidate is permitted to work without direct supervision prior to employee beginning General Orientation. As a secondary verification of completion of above process the Administrative Assistant will verify that each new employee has had a Background Study entered into DHS. Administrative Assistant will monitor the results of said study and report to the Director of HR of any candidates that are unable to work without supervision prior to their arrival. Re-education will be completed by	12/11/12 ~~12/31/12~~

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F 225	Continued From page 2 On 10/30/12, at 11:05 a.m. the unit manager RN-A was informed of these allegations of maltreatment made by R72. On 10/31/12, at 11:45 a.m. RN-A was interviewed regarding her response to the allegations made by R72. RN-A stated that she had interviewed one of the night nurses, but wanted to interview another nurse and nursing assistants soon. When asked by the surveyor if she had told any other facility staff about the allegations, she replied that she thought she may have mentioned it to one of the social workers, but had not talked with the administrator at this point. When asked if an incident report or written investigation, regarding the allegations, would be completed, RN-A replied, "If it is substantiated." RN-A then explained that she would complete an incident report and internal investigation if she thought "the complaints were valid." Allegations of maltreatment made by R94 were not not reported immediately to the facility administrator, were not reported immediately to the state vulnerable adult reporting agency, and were not thoroughly investigated in a timely manner. When interviewed on 10/30/12, at 10:45 a.m. R94 was asked if staff treated her with respect and dignity and she replied that there are times when she puts on her call light for assistance, some staff will come into her room and turn off the call light without talking with her or helping her. She could not remember the names of the staff. On 10/30/12, at 11:05 a.m. the unit manager	F 225		

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F 225	Continued From page 3 RN-A was informed of these allegations of maltreatment made by R94. On 10/31/12, at 11:45 a.m. RN-A was interviewed regarding her response to the allegations made by R94. RN-A stated that she had interviewed one of the night nurses, but wanted to interview another nurse and nursing assistants soon. When asked by the surveyor if she had told any other facility staff about the allegations, she replied that she thought she may have mentioned it to one of the social workers, but had not talked with the administrator at this point. When asked if an incident report or written investigation, regarding the allegations, had been completed, RN-A replied, "If it is substantiated." RN-A then explained that she would complete an incident report and internal investigation if she thought "the complaints were valid." On 10/31/12, at 3 p.m. RN-A told a surveyor that she will be reporting the allegations of maltreatment made by R72 and R94. On 11/1/12, at 10:45 a.m. RN-A stated that she has not yet had a chance to interview R72 regarding her allegations of maltreatment, but planned to do so before the day was over. On 11/1/12, at 1:30 p.m. the facility administrator stated that he was informed by RN-A of the allegations of maltreatment made by R72 and R94 some time during the morning of 10/31/12, but could not recall the exact time. On 11/1/12, RN-A provided the confirmation emails from the Minnesota Department of Health showing that she reported the allegations of	F 225		

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F 225	Continued From page 4 maltreatment to the state agency on 10/31/12, at 4:00 p.m. The facility failed to immediately report to the administrator and state agency allegations of rough treatment and neglect for R95. During interview on 10/30/12, at 9:00 a.m. R95 reported he felt staff treated him roughly and he had been "thrown around like half a beef." He added that one staff member took his call light out of the wall because R95 was "ringing too much." R95 was able to give a general description of the staff person but unable to recall his name. R95 reported the same staff member was assisting him into bed. His legs hurt and so he was going to kick the staff member. However, the staff member "kneed" R95 in the legs. R95 further explained the staff "brought his knee up and banged into legs." R95 stated these two incidents happened about a month and a half ago. R95 further complained that staff was not gentle with his legs when helping him into bed, which caused him pain. R95 reported this happened about once a week. On 10/30/12 at 9:28 a.m. the registered nurse clinical coordinator on the unit, (RN)-B, was informed of R95's allegations of rough treatment, feeling staff were not gentle while moving his legs and call light being taken out of the wall. RN-B was given the general description of the staff member alleged to take the call light out of the wall and "kneed" R95's legs and the time frame R95 reported the incidents occurred. At 10/31/12 at 8:38 a.m. R95 reported RN-B had discussed the allegations with him. He reported	F 225		

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F 225	Continued From page 5 the conversation did not go well because RN-B "didn't do anything" and "blamed me" for the allegations. R95 reported he did not discuss the incident with any other staff member. During interview, on 10/31/12 at 8:49 a.m. the director of nursing (DON), responsible for coordination of reporting abuse allegations to the state agency, reported the facility had made no reports to the state agency since 10/23/12. During interview, on 10/31/12, at 8:53 a.m. the administrator reported he would expect facility staff to notify him immediately of any allegation of rough treatment or any suspected abuse or neglect. The administrator explained staff should fill out an incident report, which included directions to notify the administrator immediately of abuse and neglect concerns. When asked if staff had informed him of R95's allegations the administrator stated "no, not that I can remember." When asked if anything was reported regarding R95 within the past week, the administrator stated "I can definitely say no on that one." On 10/31/12 at approximately 9:05 a.m. RN-B described the conversation she had with R95 about the allegations. RN-B reported R95 reported a nursing assistant "kneed" him. When she asked how that happened RN-B was told by R95 "he raised his leg up on bed and kneed me." RN-B reported R95 told her he had not reported it because "nothing ever got done". When asked if the behavior R95 described was acceptable RN-B stated "well no, but I don't know when it was and can't get their version. The way his bed is raised I don't know they would have done it. I	F 225		

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F 225	Continued From page 6 told him, tell me at the time because we can't go back now and fix it." RN-B reported she did consider that R95's allegation would be considered abuse. RN-B stated she did not fill out an incident report but did document the concern in the interdisciplinary progress notes. RN-B stated she reported the concern to her supervisor, registered nurse manager, (RN)-C. During interview on 10/31/12 at approximately 9:15 a.m. RN-C was asked about R95's recent allegation and RN-C stated she had not been informed recently but said, he has had accusations in the past. He hasn't had any accusations in a long time." When asked if RN-B had informed her of any allegation by R95 in the past week, RN-C stated "no, if it was you'd have to refresh my memory." When asked if there had been any complaints from R95 regarding being "kneed" RN-C stated "nothing that I have heard of recently". RN-C stated she had not been informed of any issues R95 reported regarding call lights. Several minutes later, at approximately 9:25 a.m. RN-C reported to surveyor "I thought you meant kneed in groin. She did tell me. She told me she had already talked to staff and they said they bumped him in bed while they were transferring him." RN-C was unaware about what R95 alleged and stated "I would have to go back and ask her." RN-C was unaware of when RN-B reported R95's allegation to her. When asked if any incident report was completed, RN-C stated the allegation "did not sound crucial, sounded like someone bumped the leg"..."If you feel it is intentional, of course fill out an incident report." At 10:11 a.m. RN-C reported she felt RN-B responded appropriately to R95's allegation.	F 225		

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F 225	Continued From page 7 Document review of Interdisciplinary Progress Notes, dated 10/30/12, indicated a note made by RN-B. The note read" Health Dept (department) Surveyor stated resident had told her he had been handled roughly and been caused pain." The note further indicated "Resident stated he tried to kick him 'because my knees hurt, they always hurt and it hurt when they moved me. When I told him to stop, he raised his leg onto the bed and kneed me, you could even do it if you wanted. I told him to knock it off and he stopped.' States he didn't tell anyone because it wouldn't do any good. Told him we couldn't do anything about his concerns if we're not aware of them." Incident Report, submitted to the state agency, dated 10/31/12, indicated the allegation was reported to the facility on 10/30/12. "[R95] was in bed and the NAR (nursing assistant) bumped his knees, which hurt, so [R95] tried to kick the NAR and that's when the NAR kneed [R95] in the leg." The Abuse and Neglect policy, dated 6/12, directed staff "If a staff member receives an allegation of abuse, neglect or misappropriation of resident property or witnesses suspected abuse, neglect or misappropriation of resident property, the staff member will immediately report this to a supervisor and complete Sections A through D of the "Incident Details" on the Incident Report." "Notify the center administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse and injury of unknown origin, neglect, financial exploitation or involuntary seclusion." "Notify the designated agencies in accordance with state law, including the state survey and certification agency." The Minnesota	F 225		

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F 225	Continued From page 8 Good Samaritan Vulnerable Adult Procedure, dated 8/2009, directed staff "The Director of Social Services, or designated staff, shall immediately make an Online Initial Report to the MN Dept of Health (MDH) and fax on a secure line or email by an encrypted e-mail address a copy of the MDH report to the common entry point. The Minnesota Department of Health (MDH) serves as the state agency for Minnesota. The common entry point is a local agency responsible for receiving and processing reports of abuse and neglect in Minnesota. The facility failed to conduct required background checks for 1 of 10 newly hired employees reviewed. Review of Human Resource Writer Report Request, dated 10/30/12, indicated licensed practical nurse, (LPN)-B was hired on 07/07/12. Review of NETStudy-Request Confirmation, indicated a request for background study for LPN-B was submitted on 10/31/12. On 10/31/12, at 2:42 p.m. the director of human resource director, (HRD), revealed the facility had not requested a background study to be completed until after LPN-B's employee file had been requested by surveyor for review. HRD reported LPN-B had resigned a week and a half ago. On 11/1/12, at 1:04 p.m. the director of nursing (DON) and HRD confirmed LPN-B had worked on the floor as a regularly scheduled nurse and was not under the continuous supervision of another staff person while providing nursing cares to	F 225		

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F 225	Continued From page 9 residents. The Background Investigations policy and procedure, dated 1/2011, directed staff "Minnesota requires that inquiries be done by the state agency." "The conditional employee may not provide direct contact services or have access to the people being served, while he or she is waiting for the study results, unless he or she is under continuous direct supervision."	F 225		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to follow their own vulnerable adult policy instructions to immediately report allegations of abuse to the appropriate state agency for 3 of 7 residents (R72, R94 and R95) who reported an allegation of staff abuse. Findings include: The facility failed to follow the facility policies regarding immediately reporting to the administrator and state agency. The Abuse and Neglect policy, dated 6/12, directed staff "If a staff member receives an	F 226	F226 The facility will continue to follow State and Federal guidelines as well as their facility policy and procedure regarding VA reporting and investigating. All staff will be re-educated regarding this process with emphasis on timeliness and administrator notification. We will also work with residents and families through resident council, care conferences and family council regarding the importance of immediate notification of possible mistreatment. If residents/families chose to notify the facility of alleged mistreatment in writing by using the facility's grievance form, we will indicate on the form the date and time it is received as well as when the administrator is notified. The DNS and/or Social Services (or their designee) will be responsible for auditing the process. Re-education will be completed by	12/11/12 ~~12/31/12~~

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F 226	Continued From page 10 allegation of abuse, neglect or misappropriation of resident property or witnesses suspected abuse, neglect or misappropriation of resident property, the staff member will immediately report this to a supervisor and complete Sections A through D of the "Incident Details" on the Incident Report." "Notify the center administrator immediately of any incidents of resident abuse, misappropriation of resident property, alleged or suspected abuse and injury of unknown origin, neglect, financial exploitation or involuntary seclusion." "Notify the designated agencies in accordance with state law, including the state survey and certification agency." The Minnesota Good Samaritan Vulnerable Adult Procedure, dated 8/2009, directed staff "The Director of Social Services, or designated staff, shall immediately make an Online Initial Report to the MN Dept of Health (MDH) and fax on a secure line or email by an encrypted e-mail address a copy of the MDH report to the common entry point. The Minnesota Department of Health (MDH) serves as the state agency for Minnesota. The common entry point is a local agency responsible for receiving and processing reports of abuse and neglect in Minnesota. During interview on 10/30/12, at 9:00 a.m. R95 reported he felt staff treated him roughly and he had been "thrown around like half a beef." He added that one staff member took his call light out of the wall because R95 was "ringing too much." On 10/30/12, at 9:28 a.m. the registered nurse clinical coordinator on the unit, (RN)-B, was informed of R95's allegations of rough treatment and call light being taken out of the wall.	F 226		

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F 226	Continued From page 11 On 10/31/12, at 8:49 a.m. the director of nursing (DON), responsible for coordination of reporting abuse allegations to the state agency, reported the facility had made no reports to the state agency since 10/23/12. On 10/31/12 at 8:53 a.m. the administrator reported he would expect facility staff to notify him immediately of any allegation of rough treatment or any suspected abuse or neglect. The administrator explained staff should fill out an incident report, which included directions to notify the administrator immediately of abuse and neglect concerns. When asked if staff had informed him of R95's allegations the administrator stated "no, not that I can remember." When asked if anything was reported regarding R95 within the past week, the administrator stated "I can definitely say no on that one." When asked about if the policy regarding reporting of allegations of abuse and neglect was implemented correctly for R95, the administrator stated "I have to touch base." On 10/31/12, at approximately 9:05 a.m. RN-B described the conversation she had with R95 about the allegations. RN-B stated she did not fill out an incident report but did document the concern in the interdisciplinary progress notes. RN-B stated she reported the concern to her supervisor, registered nurse manager (RN)-C. Incident Report, submitted to the state agency, dated 10/31/12, indicated the allegation was reported to the facility on 10/30/12. "[R95] was in bed and the NAR (nursing assistant) bumped his knees, which hurt, so [R95] tried to kick the NAR	F 226		

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F 226	Continued From page 12 and that's when the NAR kneed [R95] in the leg." Allegations of maltreatment made by R72 were not not reported immediately to the facility administrator, were not reported immediately to the state vulnerable adult reporting agency, and were not thoroughly investigated in a timely manner. When interviewed on 10/30/12, at 11:00 a.m. R72 was asked if staff treated her with respect and dignity and she replied that there is a staff person working on the night shift who does not always help her when she asks for help, and also wakes her up for no reason. R72 could not remember the name of this staff member. On 10/30/12, at 11:05 a.m. the unit manager RN-A was informed of the allegations of maltreatment made by R72. On 10/31/12, at 11:45 a.m. RN-A was interviewed regarding her response to the allegations made by R72. RN-A stated that she had interviewed one of the night nurses, but wanted to interview another nurse and nursing assistants soon. When asked if she had told any other facility staff about the allegations, she replied that she thought she may have mentioned it to one of the social workers, but had not talked with the administrator at this point. When asked if she would complete an incident report or written investigation regarding these allegations, RN-A replied, "If it is substantiated." RN-A then explained that she would complete an incident report and internal investigation if she thought "the complaints were valid."	F 226		

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F 226	Continued From page 13 Allegations of maltreatment made by R94 were not not reported immediately to the facility administrator, were not reported immediately to the state vulnerable adult reporting agency, and were not thoroughly investigated in a timely manner. When interviewed on 10/30/12, at 10:45 a.m. R94 was asked if staff treated her with respect and dignity and she replied that there are times when she puts on her call light for assistance, some staff will come into her room and turn off the call light without talking with her or helping her. She could not remember the names of the staff. On 10/30/12, at 11:05 a.m. the unit manager RN-A was informed of the allegations of maltreatment made by R94. On 10/31/12, at 11:45 a.m. RN-A was interviewed regarding her response to the allegations made by R94. RN-A stated that she had interviewed one of the night nurses, but wanted to interview another nurse and nursing assistants soon. When asked by the surveyor if she had told any other facility staff about the allegations, she replied that she thought she may have mentioned it to one of the social workers, but had not talked with the administrator at this point. When asked by a surveyor if she would complete an incident report or written investigation regarding these allegations, RN-A replied, "If it is substantiated." RN-A then explained that she would complete an incident report and internal investigation if she thought "the complaints were valid." On 10/31/12, at 3 p.m. RN-A told a surveyor that she will be reporting the allegations of	F 226		

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F 226	Continued From page 14 maltreatment made by R72 and R94. On 11/1/12, at 10:45 a.m. RN-A stated that she has not yet had a chance to interview R72 regarding her allegations of maltreatment, but planned to do that before the day was over. On 11/1/12, at 1:30 p.m. the facility administrator stated that he was informed by RN-A of the allegations of maltreatment made by R72 and R94 some time during the morning of 10/31/12, but could not recall the exact time.	F 226		
F 241 SS=E	483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to wait until residents were finished eating before scraping dirty dishes in front of residents still eating their meals in 2 of 3 resident dining rooms observed which had the potential to affect approximately 60 of the 86 residents in the facility. Findings include: Tables were being bussed while residents were still present and finishing their meals. On 10/29/12, at 6:55 p.m. observation in the Sleepy Hollow Dining room revealed the clearing	F 241	F241 The facility will continue to ensure the dignity and respect of the residents by following standard bussing procedure. All Nutrition Services staff will be re-educated on proper bussing procedure. DA-A, DA-B, and DA-C will receive 1:1 education regarding proper bussing procedure and the importance of maintaining a sanitary environment for all residents. Routine audits will be done on all Nutrition Services staff to ensure compliance with bussing procedure. The Quality Assurance Committee, Dietary Supervisor, and Staff Development Director will be responsible for completing audits. Re-education of bussing procedure will be completed by	12-11-12 ~~12/31/12~~

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F 241	Continued From page 15 of soiled supper trays from tables. The cart, with an area to pour the liquids and clear off the leftover food was being wheeled from table to table. There were about 12 residents in the dining room. The cart was brought within a foot of the residents and the staff member was observed to clear and scrape food from the plates into a container on the cart. Dining room observations on 10/30/12 at 12:30 p.m., revealed at least 5 tables were in the dining room with residents who were completing their meal. The dietary staff member was bussing tables while residents were still eating. On 10/31/12, at 8:50 a.m. the dietary staff member was observed clearing and wiping tables as residents were still eating or finishing their beverage. The procedure for, Bussing Resident Dining Rooms, dated 11/07 was reviewed and revealed; once a resident has left the table or completed their meal you may remove their dishes even if other residents are still present. The bussing cart receptacle can not be positioned next to the table, where other residents are still eating. On 10/31/12, at 8:55 a.m. dietary assistant (DA-C) was interviewed about bussing tables. She revealed we are able to bus them if we ask the resident but the cart should be away from the tables. On 11/1/12, at 2:55 p.m. dietary supervisor (DS-A) was interviewed about bussing of tables. She revealed staff should not bus tables if residents are still eating. If they are done, staff should ask permission to remove their soiled dishes. Should never have the bussing cart next to the residents. Dining room tables in the memory care unit were	F 241		

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F 241	Continued From page 16 cleared after meals while residents remained at the tables finishing their meals, and the clearing cart was positioned immediately next to the tables. During meal observations on 10/29/12, at 6:55 p.m. and 10/30/12, at 9 a.m. dietary aides (DA) DA-A and DA-B respectively, cleared dining room tables in the memory care unit while residents remained seated and eating at the tables being cleared. The cart used for clearing the tables was positioned next to the table being cleared. The top level of this cart contained an opaque tub into which food and drink was dumped, and the dishes were then stacked on the upper and lower levels of the cart. On 10/31/12, at 9 a.m. DA-B cleared tables where no residents remained, but the clearing cart was positioned next to the tables being cleared, with residents remaining at nearby tables. When interviewed on 10/31/12, at 9 a.m. DA-B stated that he generally starts to clear the tables in that dining room about a half an hour after the meal is served.	F 241		
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility did not maintain sanitary and orderly walls, floors, and heat radiator in 1 of 3 units (Happy Days	F 253	F253 The walls in all common areas have been painted and a painting schedule was created for this to insure the walls are maintained on a regular schedule or sooner if required. We will place a washable surface [wall guard] under sanitizers were this is a problem to reduce any drip marks, splatters, or stains. The flooring in the resident bath room [122] is scheduled to be replaced. The baseboard in the tub room [152] was installed and will be completed by 12-14-12. Also the walls will be patched and painted, this will also be on the painting schedule. Both tub room	

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F 253	Continued From page 17 memory care unit), which had the potential to affect 35 of 86 residents in the facility. Findings include: During observations on 10/29/12, at 5 p.m. the walls in central common area, bathing area, and hallways of the memory care unit contained large areas of dark marks, marring, gouging, and splatter marks. Observations during the environmental tour on 10/31/12, at 1 p.m. revealed the following: Walls in the central common area, the hallway between the tv lounge, and dining room of the memory care unit had many large areas of dark marks, marring, and gouging on the walls. Several large splatter marks on the wall near the sign for the 112 dining room and many large drip marks on the wall under the nearby sanitizer dispenser. Many large areas of dark marks, marring, and gouging on the walls in the hall between room 149 and 153 in the memory care unit. The wall in room 149 (resident toilet) had large areas of peeled paint and large splatter and drip marks near the sink and soap dispenser. The wall in rooms 151 and 152 (both tub rooms) had many large drip marks on the wall near the sink and soap dispensers. The wall across from the room 148 (chart room) doorway had large brownish-red splatter marks. Floors in room 152 (tub room) and 153 (shower room) had many ragged and partially missing black adhesive strips on the floor, with some frayed pieces elevated and loose from the floor. The bathroom floor in room 122 had a large crack near the toilet.	F 253	[152] and shower room [[153] are in the process of having all black adhesive removed and floor cleaned. The radiator in room 136 was Straightened and reinstalled on 12-5-12. The director of Maintenance will monitor all above projects thru completion and will continue to monitor weekly for 3 months and weekly after that for 3 more months after that to insure this becomes and stays part of our weekly routine. Date of completion:	12/11/12 ~~12/21/12~~

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F 253	Continued From page 18 Baseboards were missing in room 152, with many gouges and marred areas on the wall. The heat radiator in room 136 was bent and twisted, with chipped paint. The director of maintenance was present on the tour. When interviewed on 10/31/12, at 2:15 p.m. he stated that his department has been working on some of the baseboard areas in the tub room in recent months. He indicated there was no painting schedule, but that painting is done in the building as needed.	F 253		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).	F 279	F279 The facility will continue to develop and revise resident care plans based upon individual needs. R109's care plan has been updated. We will review care plans of all residents receiving hypnotics or drugs w/ sleep inducing effects for accuracy in identifying sleep disturbances and utilization of non-pharmacological interventions. We will continue to do clinical monitoring w/ all dose increases/reductions to determine effectiveness. All care plan team members will be re-educated on care plan development and the process of updating care plans. An audit tool will be utilized to ensure care plan accuracy and revision at every resident's care conference for 6 mos and then will decrease to random audits yearly. Director of nursing and/or social services or their designee will be responsible for the audits. QA committee will review audits to monitor compliance. Date of Completion	12/11/12 ~~12/31/12~~

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F 279	Continued From page 19 This REQUIREMENT is not met as evidenced by: Based on document review and interview, the facility did not develop a comprehensive plan of care regarding alteration in sleep for 1 of 4 residents (R109) reviewed for the use of sleep-inducing medications. Findings include: R109's record was reviewed on 11/1/12. A physician's order dated 9/20/12, read, "v [decrease] trazodone [an anti-depressant with sleep-inducing effects] to 25mg po [by mouth] q HS [every bed time] sleep disturbance." The Clinical Monitoring form used to monitor sleep revealed R109 continued to experience sleep disturbance and had been awake most of the nights of 9/27/12 and 10/1/12. The current Comprehensive Care Plan, dated 8/22/12, did not contain any problem related to sleep or non-pharmacological interventions for sleep disturbance. When interviewed on 11/1/12, at 10:45 a.m. the unit manager RN-A, stated that any interventions for sleep should be in the current Comprehensive Care Plan, and the interventions for nursing assistants would be generated from the current Comprehensive Care Plan through the facility's computer software system.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to	F 280	F280 The facility will continue to revise resident care plans based upon individual need. R11,R12 and R31's care plans have been updated. We will review all LP progress notes on current residents since Sept 1,	

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F 280	Continued From page 20 participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to revise the care plan related to the licensed psychologist non-pharmological recommendations for 3 of 4 residents (R11, R12, and R31) reviewed for hypnotic, psychotropic and anti-depressant drug use. Findings include: During interview on 10/29/12, at 7:00 p.m. R11 revealed concern with roommate being noisy and affecting sleep at night. The Minimum Data Set (MDS) 4/20/12, identified R11 as having trouble falling or staying asleep. R11 received Melatonin at bedtime for insomnia. The licensed psychologist (LP) note received 5/7/12, read,	F 280	2012 to ensure all recommendations have been addressed on the care plan. The care plan team will be re-educated on the correct procedure for reviewing LP recommendations and updating the care plans accordingly. An audit tool will be utilized to ensure care plan revision re: LP recommendations weekly x 8 weeks, then monthly x 3 months and then random audits at least yearly. Director of Nursing and/or social services or their designee will be responsible for the audits. QA committee will review audits to monitor compliance Date of Completion	12/11/12 ~~12/31/12~~

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F 280	Continued From page 21 "Identifying night time distress with roommate's verbal behavior. It may be helpful for nursing staff to do sleep data for two nights to evaluate her comfort and whether she is sleeping or awake. It may be helpful to have staff check in at the time she goes to bed to evaluate level of noise with her roommate. May benefit from ear plugs or white noise-type device, at least to explore, should her roommate's verbal behavior be disruptive." When Interviewed on 11/1/12, at 10:30 a.m. registered nurse (RN)-B verified R11's trouble falling or staying asleep was not on the care plan, nor the LP recommendations were not addressed in the care plan. During medication review on 10/30/12, at 9:00 a.m. R12 physician order identified Risperidone for dementia with behaviors of yells out at others passing by to stop. Clonazepam for dementia with agitation and for depression is given Zoloft and Remeron. The MDS dated 9/13/12, assessed the communication and psychotropic drug use. The care plan did not address the LP 11/16/11 treatment plan recommendations which read, "To initiate a greeting, a handshake, and offer planned attentional contact, sometimes referred to as "killing the person with kindness," as this becomes validating for her in relation to being recognized, being noticed, and the fact that others do continue to take interest in her. It would be prudent for all staff to go in to greet non-contingent on cares, ultimately reinforcing prosocial behavior, i.e., seeing her for reinforcement value when she is not sitting up, stepping on her alarm pad, or summoning staff through verbal means."	F 280		

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F 280	Continued From page 22 When interviewed on 11/1/12, at 11:00 a.m. RN-A verified R-12's care plan did not reflect the LP recommendations. During medication review on 10/29/12, at 4:44 p.m. R31 physician order identified Seroquil and Aricept for delusional disorder associated with Alzheimers dementia and Effexor for depression. The MDS dated 6/29/12, addresses the cognitive loss and verbal behavioral symptoms directed toward other and other behavioral symptoms not directed toward others. The care plan did not address the LP 5/16/12, treatment plan recommendations which read, "Evidencing presence of marked cognitive dysfunction with severe memory impairment, moderate to severe orientation deficit and moderate deficit in reasoning. There is presence visuospatial constructions as noted on the Clock Drawing Test. Individuals with this profile may benefit from a structured environment where boundaries, assistance and social and sensory stimulating activity are more forthcoming. May benefit from continued prompting and assistance with untoward behaviors at the dining table. Having her bring a discreet container for her dentures, having her use a napkin to cover her mouth, and providing support to her may be beneficial in this regard." R31 June 13, 2012, LP notes read, "Staff to invite care staff to use thought and mood empathy while reminiscing about family travels, her sense of pride in her children as these interactions create optimal mood affect." When interviewed on 11/1/12, at 11:00 a.m. RN-A verified R-31's care plan did not reflect the	F 280		

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F 280	Continued From page 23 LP recommendations.	F 280		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure 1 of 1 resident (R66) was assessed and provided with a properly fitting wheelchair based on the residents height. Findings include: R66 was not provided with a proper fitting wheelchair. R66 was admitted 12/6/11, for rehabilitation due to history of falls, degenerative joint disease of the knees and old cerebral vascular accident (CVA) with hemiparesis. R66 was 6 ft 2 inches, according to medical record. On 10/29/12, at 5:30 p.m. during evening meal observation, R66 was observed sitting at the dining room table in his wheelchair. The back of the wheelchair was noted to cut across the middle of his back. There were no foot pedals on the wheelchair and R66's legs were observed to be slightly elevated with feet touching the floor.	F 309	F309 Per spouse this W/C was fitted and adjusted for R66 in 2006 post CVA. It is R66 personal W/C. R66 has not gotten taller since the CVA. There are no footrests to allow R66 the ability to self propel. Another OT eval for W/C positioning was completed on 11/5/12. W/C height and seat depth were appropriate for proper W/C propulsion w/ feet. OT said R66 might benefit from trial of higher back chair but R66 stated his current W/C was comfortable and did not have any problems. OT approached R66 multiple about height of back of W/C and R66 declined each time. Weekly skin checks and tissue tolerance evals have not revealed any problems w/ redness or rubbing. The facility will attempt to try a higher back W/C for R66, but we will respect R66's right to refuse treatment. The facility will continue to follow the policies and procedures R/T weekly skin checks and tissue tolerance assessments to ensure no problems develop. Director of Nursing or designee and/or therapy representative will continue to monitor all residents @ least quarterly for proper W/C fit. Date of Completion	11/5/12

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F 309	Continued From page 24 The wheelchair seat was short in comparison to R66's upper legs and did not provide full support to the legs. The significant change minimum data set (MDS) dated 8/31/12, indicated R66 had a brief interview for mental status (BIMS) of 14 on a scale of 1-15, however R66 had difficulty communicating his needs due to slurred and mumbled speech. R66 used a walker for ambulation however was spending more time in the wheelchair for mobility purposes. R66 was interviewed on 10/29/12, at 6:00 p.m. and when asked if he was comfortable in his wheelchair he responded, "no/yes" and then nodded yes. On 10/31/12, at 2:15 p.m. interview with occupational therapist (OT-A) revealed he was not aware of any issues with the wheelchair for R66 and had not assessed his height in relationship to the proper fitting of the wheelchair. On 10/31/12, at 2:35 p.m. an interview with R66's family member (FM-A) revealed R66 has had several surgeries on his back and neck. FM-A indicated R66 has had a fusion done on his back. FM-A indicated she was concerned about the wheelchair back being too short, because he is so tall and said he has been spending more time in wheelchair. On 10/31/12, at 3:10 p.m. RN-D was interviewed and indicated during her observations she did not think the wheelchair fit him properly as he was a very tall man. RN-D further revealed that sometimes the back of the seat cuts into the back	F 309		

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F 309	Continued From page 25 of his legs and sometimes red marks are seen on his back from the wheelchair. RN-D was unsure if she had documented that observation.	F 309		
F 322 SS=D	483.25(g)(2) NG TREATMENT/SERVICES - RESTORE EATING SKILLS Based on the comprehensive assessment of a resident, the facility must ensure that a resident who is fed by a naso-gastric or gastrostomy tube receives the appropriate treatment and services to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers and to restore, if possible, normal eating skills. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure gastrostomy tube placement was checked prior to administration of medications and nutrition for 1 of 1 resident (R156) reviewed during medication administration via a gastrostomy tube (GT). Findings include: GT placement was not checked prior to medication and nutrition being provided for R156.. R156's diagnosis included severe multiple sclerosis (MS) and aspiration pneumonia for which a GT was placed in 12/11. On 10/29 /12, at 5:20 p.m. registered nurse (RN-E) was observed to administer medications and then nutrition to R156. RN-E did not check placement of the gastrostomy tube prior to the administration of the	F 322	F322 The facility will continue to follow policies and procedures re: gastrostomy care including checking placement. All nurses will be re-education on correct gastrostomy care procedures. RN-E will receive 1:1 training. An audit tool will be developed to ensure nurses are following correct procedures. A schedule to routinely audit each nurse for gastrostomy procedure compliance will be developed. The director of Nursing or designee will be responsible to monitor results of audits. Date of Completion	12/11/12 ~~12/31/12~~

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F 322	Continued From page 26 medications and administration of nutrition. On 10/29/12, at 5:30 p.m. RN-E was interviewed and verified he had not checked the placement of the GT because he had not been told to do so. The policy and procedure dated 2/2006 revealed that prior to beginning a feeding the feeding tube should be checked for placement and patency. On 10/31/12, at 2:00 p.m. RN-C was interviewed and revealed staff should aspirate contents before medications and feeding to check for stomach contents and placement of the GT. You have to make sure the feeding is going into the correct place.	F 322		
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to minimize potential accident hazards for 4 of 4 residents, (R95, R108, R79, R64) reviewed for bed safety and failed to assess the mattress/bed for potential causative and risk factors for 1 of 1 resident (R95), who fell from the bed.	F 323	F323 4 of 4 beds that were found with mattress's that did not fit properly or that slid easily were replaced with the proper fitting mattress and / or non skid material between the frame and the mattress to keep the mattress in place. The Director of Maintenance will complete a building audit on all beds to insure properly fitting mattress are in place, replaced or a mattress extender is installed as to mitigate accident hazards as is possible. The Director of maintenance will monitor this weekly for 3 months and monthly for 6 after that. The Maintenance staff will also over see the request for new or different mattress going forward to insure the proper fitting mattress are used and non skid materials are used if required or needed. R95 has a DPM because of impulsivity and impatience. The DPM did not slide sideways, therefore was not mentioned as a causative factor in the fall. A DPM is an allowed falls	

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F 323	Continued From page 27 Findings include: R95 fell twice from his bed and the facility failed to assess for potential causes and risk factors related to the use of a loose fitting defined perimeter mattress. On 10/30/12 at 3:31 p.m. R95's bed was observed to have a mattress that was noted to slide easily with a gentle push of the hand, causing a gap at the head board or foot board, depending on which way the mattress was pushed. A gap of five and a half inches was measured between the foot of R79's mattress and the footboard. R79's adjustable bed was flat, not elevated at the foot or head. R95's mattress was noted to have a concave surface. On 10/30/12 at 4:12 p.m. registered nurse clinical coordinator, RN-B measured the gap between the foot of R95's mattress to the footboard as "not quite five" inches. The head of the bed was elevated. R95 was resting in bed with space noted between R95s head of mattress and the headboard. When asked if the mattress fit the bed, RN-B stated, "that's the way they have been, I would say there is room between mattress and foot." RN-B reported that a few days ago, R95 was sitting at the edge of the bed. A nursing assistant, assisting him at the time, told him to stay there. R95 then rolled off the bed. RN-B explained R95 had poor decision making skills, but was cognitively intact. On 10/31/12 at 8:32 a.m. the maintenance supervisor (MS) measured R95's mattress as 80 inches in length. The frame was measured at 80 inches in length, however, from headboard to	F 323	intervention and has worked successfully for this resident except when R95 refuses to wait for assistance. All nursing staff will be re-educated regarding the importance of looking at all potential causative factors contributing to falls. The falls committee will continue to review and discuss falls. Date of Completion:	12/11/12 ~~12/14/12~~

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footboard measured 84 inches in length. The adjustable bed was flat. During interview with R95, when asked if there had been any problems with the mattress and bed, R95 reported it was hard to sit on the edge of the bed because of the raised perimeter.

Document review of R95's Incident Details, dated 6/12/12, indicated resident was found on the floor on his right side. "Res (resident) found lying, head [at] bed insisted scooted self around. Res said slid out of bed, noted bed covers under him and slid off side of bed." No notation was made under Equipment in Use or any other section regarding risk and causative factors related to the bed and mattress. Document review of R95's Incident Details, dated 10/26/12, was reviewed. Document review indicated, "aide found resident lying on right side upon entering room. Aide was in process of getting equipment to transfer resident." Resident was noted as falling during a self transfer from bed to chair. Under Equipment in Use, no indication was made. No notation was made regarding the mattress or bed including consideration of risk or causative factors. Document review of Interdisciplinary Progress Notes, dated 6/12/12 to 10/30/12 were reviewed. No notation was made regarding the bed or mattress regarding possible accident causative and risk factors.

On 10/30/12 at 4:45 p.m. RN-B and registered nurse manager (RN)-C were interviewed regarding R95's falls from bed. RN-B reported that R95 had used the same mattress since his most recent admission to the facility. R95 used a defined parameter mattress due to a stroke because he was rolling off the bed. When asked

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what was assessed after a fall, RN-B reported nursing staff completed an assessment of the resident's body, range of motion, neurological assessment, medications, condition of room and what might have led to the fall. When asked about assessing the possibility of the bed contributing to the fall or causing a potential hazard, RN-B stated, "my assumption is mattresses on the bed are suppose to fit, I don't know what kind of space there is supposed to be between them" RN-B described a fall of R5 occuring on 10/26/12. R95 was sitting on the edge of the bed. The aide asks if R95 could sit there because she was going to get the mechanical lift to help transfer him. R95 fell off the bed. When asked if the mattress was assessed as a potential causative factor, RN-C reported that it had not been assessed as it had "nothing to do with" the falll. RN-C reported the fall was caused by R95 attempting to self transfer out of bed and not being aware of limitations. RN-C added, "if it was an issue, then we would assess." RN-B and RN-C described a fall R95 had in June 2012. R95 used a trapeze above the bed to try and get himself out. He became twisted in the sheets and blankets. R95 fell out of bed and his head was found toward the foot of the bed. When asked if the mattress and bed were assessed as a potential risk or causative factor, RN-C stated, "I can't say we measured the mattress" as there was "no indication it was the cause, it was him trying to self transfer" When asked if the mattress was assessed as a potential hazard, RN-C stated, "no, if mattress was kiddywampus (out of place) or half on half off, we would assess, but it wasn't." RN-B and RN-C reported all relevant documentation regarding post fall follow up would be available in the

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F 323	Continued From page 30 Incident Details and Interdisciplinary Progress Notes. The Fallen or Injured Resident policy and Resident/Visitor Incident Report procedures were reviewed. The Fallen or Injured Resident procedure, dated October 2008 directed staff to Complete a Resident/Visitor Incident Report. The Resident/Visitor Incident Report, dated January 2009, directed staff to fill out a Falls Data Collection Tool and complete an investigation regarding the incident. The facility failed to minimize accident hazards for R108, with a mattress that did not fit the bed. On 10/30/12 at 3:35 p.m. R108's matress was observed to have a gap between the mattress and the bed frame. Measurements were taken to determine R108's fit of the mattress to the bed. From the foot of the mattress to the footboard, a gap was measured at 6 inches. A piece of styrofoam was observed between the foot of the mattress to the footboard. On 10/30/12 at approximately 4:20 p.m., RN-B measured the gap between the foot of R108's mattress and the footboard as 6 inches. When asked if the styrofoam cushion between the mattress and footboard met manufacture recommendations, RN-B reported it did not. R108's daughter brought in the styrofoam cushion because she was worried R108 might slide on the bed and R108 sometimes placed the cushion under her heels. R108 stated "that's to keep blankets from falling down" because the bed is longer than the mattress. When asked if the mattress fit the bed, RN-B stated, "personally, I	F 323		

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F 323	Continued From page 31 would say no." On 10/31/12 at approximately 8:30 a.m. MS measured R108's mattress as 80 inches in length. R108's bed frame was 78 inches in length. From headboard to footboard measured 87 inches in length. The facility failed to minimize accident hazards for R79, with a mattress that did not fit the bed. On 10/31/12 at 3:40 p.m. measurements were taken of R79's fit of the bed. A gap of 5 inches was measured between foot of mattress to footboard. On 10/30/12 at approximately 4:25 p.m., RN-B measured the gap between R79's foot of mattress to footboard as 4 inches. The gap between the quarter side rail to the mattress was 5 and 3/4 inches at the closest part and 7 inches from the farthest point. When asked if the mattress fit the bed frame, RN-B stated, "it's not been an issue." On 10/31/12 at 8:26 a.m. R79's mattress was measured by the maintenance supervisor (MS) at 77 inches in length. From headboard to footboard measured at 84 inches length. The frame was 78 inches in length. The facility failed to minimize the risk of potential accident hazard for R64, with a mattress that did not fit the bed frame. On 11/1/12 at approximately 3:55 p.m. a gap was observed between the mattress and footboard of R64's bed.	F 323		

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F 323	Continued From page 32 On 11/1/12 at 4:05 p.m. MS measured the mattress to be 80 inches. The bed frame was measured at 80 inches. From footboard to headboard was noted as 84 inches. MS confirmed the findings. On 10/31/12, at 8:35 a.m. manufacture recommendations were requested. MS reported he would contact the supply company and corporate offices as he was not sure if they were available. MS reported nursing staff orders beds and mattresses. Manufacture recommendations were again requested at 11:57a.m. MS reported he was still in the process of obtaining them from the corporate offices.	F 323		
F 332 SS=D	483.25(m)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE The facility must ensure that it is free of medication error rates of five percent or greater. This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to administer medication according to the Food and Drug administration recommendations for 2 of 20 resident's (R19 & R156) resulting in a 6% medication administration error rate. Findings include: R19 received omeprazole and levothyroxine sodium after breakfast, both medications were scheduled on the medication administration record to be given before breakfast at 7:00 a.m.,	F 332	F332 This was the second day of our go live date with our new EMR. Nurses/TMA's will continue to administer medications as prescribed. Nurses/TMA's will be re-educated re: medication administration. LPN-A will receive 1:1 education. All nurses will be re-educated on the correct procedure for administering GT meds. RN-E will receive 1:1 retraining. Routine med audits will be done on all nurses/TMA's to ensure compliance w/ GT med administration. Director of Nursing or designee and QA committee will be responsible for reviewing audits and ensuring compliance Date of Completion	12/11/12 ~~12/31/12~~

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F 332	Continued From page 33 and the levothyroxine had a physician's order to be administered before breakfast. During medication administration observation on 10/31/12, at 8:20 a.m. licensed practical nurse (LPN)-A administered 20 mg omeprazole and 112 mcg of levothyroxine sodium to R19. R19 had just finished eating breakfast. Record review on the same date revealed a physician's order, dated 1/12/12, for the levothyroxine sodium that read, "Synthroid (levothyroxine sodium) 112 mcg po [by mouth] before breakfast." Both medications were scheduled for 7:00 a.m. on the electronic medication administration record. When interviewed on 10/31/12, at 8:35 a.m. LPN-A stated these medication were generally given before breakfast, but the night shift was running late because of a new electronic medication system. When interviewed on 10/31/12, at 8:40 a.m. the unit manager, RN-A, stated she thought these medications were given at 6 a.m. and she would check the scheduled administration times on the electronic medication administration record. On 10/31/12, at 9:00 a.m. RN-A stated that both the medications were scheduled to be given before breakfast at 7:00 a.m. and she would complete an administration discrepancy form for this incident. The Food and Drug Administration website advises that omeprazole be taken on an empty stomach with water at least one hour before a meal, and levothyroxine sodium be taken on an empty stomach, one-half to one hour before breakfast. R156's gastrostomy tube (GT) was not flushed	F 332		

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F 332	Continued From page 34 with the prescribed amount of water before and after medication administration and all medications were mixed together and given at once. On 10/29/12, at 5:30 p.m. observation of GT medication administration was completed for R156. During preparation, RN-E took each medication and mixed them all together in a drinking cup. The medications were tussin liquid 5 ml (an expectorant), oxybutin tablets (for neurogenic bladder), magnesium gluconate liquid 7.5cc (for low magnesium), calcium carbonate liquid 5cc (for MS), vitamin D liquid 1 drop, metoprolol liquid 7.5 ml (for hypertension), and baclofen tablets (for MS). The tablets were all crushed and placed in with the liquid medications. After mixing all medications together RN-E attached the syringe to the GT and pushed in the medications. After the medications were pushed in, RN-E pushed in 10cc of water, which was not the prescribed amount. After the medications and the water push the resident was hooked up to gravity feedings and.was given 2 cans of tube feedings (480cc). The policy and procedure dated 2/2006, revealed the extent of the elevation of the syringe would determine the flow rate and should be one medication at a time when there is more than one to administer It also revealed the tube should be flushed before and after administration of each medication. The physicians orders were reviewed, and on 10/9/12, the physician ordered 50 cc water before and after medications and feedings.	F 332		

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F 332	Continued From page 35 On 10/29/12, at 5:45 p.m. RN-E was interviewed and was not aware of giving the medications separately and was not aware of the amount of water to give. On 10/31/12, at 2:00 p.m. RN-C was interviewed and indicated would put one medication in at a time and not mix them all together. That is part of the policy and procedure. Before and after medication flushes should have been completed and done according to the physician orders. That is also part of the policy and procedure.	F 332		
F 371 SS=E	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on observation and interview the facility failed to maintain sanitary conditions in the kitchen with storage and food items used to prepare food. In addition, refrigerator and freezer temperatures were not routinely monitored to ensure proper food storage. This had the potential to affect the 86 residents in the facility. Findings include:	F 371	F371 The facility will continue to follow policies regarding food storage. All Nutrition Services staff will be re-educated on the policy and procedure for proper food storage as well as the importance of retaining accurate documentation of refrigerator and freezer temperatures. All refrigerators and freezers in the kitchen will be monitored daily for expired food items, and twice daily for temperatures. All Nutrition Services staff will be re-educated on cleaning and sanitization procedures. An updated cleaning schedule has been implemented to ensure cleaning is being done on a regular basis. Rust will be removed from storage shelves and the surfaces re-painted. Rust removal and painting will be completed no later than December 31, 2012. The shelves will be monitored weekly for three months, and monthly there after, for the return of rust. Routine audits will be completed by the Quality Assurance Committee, Dietary Supervisor, and Staff Development Director to ensure food storage procedures are being followed, refrigerator and freezer	

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F 371	Continued From page 36 An initial tour of the kitchen area was completed with the dietary supervisor (DS-A) on 10/29/12, at 12:05 p.m. The prep counter refrigerator had soiled floors with food debris and dried on spilled liquid. The storage shelves used for pots, pans, pitchers, and serving trays was very soiled with food particles and rust. The large bag of powered sugar was open and not stored in a covered container. The cover on the flour bin was soiled on top with brown smudge marks and whitish food debris. The refrigerator, which contained the vegetables had a bag of lettuce that was starting to wilt, with a best by use date of 10/19, a bag of unfresh appearing parsley, with a use by date of 10/10, and a whole container of cut up tomatoes not opened, but a use by date of 10/27. In addition, review of the temperature sheets for the refrigerators and the freezers revealed the temperatures were not being checked routinely twice a day, as directed. A return tour of the kitchen completed on 11/1/12, at 11:40 a.m. revealed the following. Two trays of cut up fruit in the refrigerator were not covered after being prepared. Although most of the shelves had been cleaned, rust remained. The DS-A and DM indicated the shelves have to be professionally painted and scraped of rust. The following items in the refrigerator were outdated; two quarts of whipped topping were outdated 10/20/12. Nine quarts of half and half were outdated 10/22/12. The DS-A indicated she wasn't sure when the whipped topping and half and half were last used. On 11/1/12, at 11:55 a.m. the DS-A verified all of the findings.	F 371	temperatures are recorded, and that surfaces remain rust-free. Date of Completion	12/31/12
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

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	245207	A. BUILDING _____ B. WING _____	11/01/2012

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F 431 SS=F	Continued From page 37 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431	F431 The refrigerator was replaced. The facility has developed a routine cleaning schedule for all nursing refrigerators which includes notifying the maintenance director of any problems w/ dripping water, mechanical problems, etc. Nurses/TMAs will be re-educated on correct storage of refrigerated drugs/biologicals and the cleaning schedule guidelines. An audit tool will be developed to ensure compliance. The staff development coordinator and QA committee will be responsible for reviewing audits. Date of Completion	12/15/12

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F 431	Continued From page 38 Based on observation and interview, the facility failed to safely store refrigerated medications in 1 of 3 medication storage rooms (Happy Days memory care unit) in the facility, which had the potential to affect 21 of 35 residents in the unit. Findings include: During observation on 11/1/12, at 11:45 a.m. the refrigerator in medication room 119 contained a large area of dark, crusty material surrounding the perimeter of the bottom shelf and pooled under the bottom drawer. Water was dripping down the back of the inside of the refrigerator. A bottle of omeprazole (a gastroesophageal medication), an uncovered oral medication syringe, lying in an open plastic cup, several boxes of tuberculin solution in a sealed plastic bag, and 20 cardboard boxes of Biscolax (laxative) suppositories were stored in the refrigerator. The boxes of Biscolax were not covered in plastic and were in the bottom drawer of the refrigerator. When interviewed on 11/1/12, at 11:50 a.m. the registered nurse manager of the unit (RN)-A stated that she was unaware of the soiled areas and dripping water in the refrigerator, she believed the dark, crusty material was spilled chocolate-flavored nutritional supplement, and she would notify the maintenance department immediately of the dripping water in the refrigerator. When interviewed on 11/9/12, at 9:30 a.m. the director of nursing stated that there is no written schedule for cleaning this refrigerator, but all nurses on the unit should monitor the refrigerator for cleaning.	F 431		

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F 492 SS=D	483.75(b) COMPLY WITH FEDERAL/STATE/LOCAL LAWS/PROF STD The facility must operate and provide services in compliance with all applicable Federal, State, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to cease billing while a demand bill was in appeals for 1 of 1 resident (R2) reviewed. Findings include: Document review of R2's SNF Determination on Continued Stay form, dated 7/301/12, indicated R2 requested "I do want my bill submitted to the intermediary for a Medicare decision." Review of R2's financial Statements, dated 8/20/12, 9/20/12 and 10/20/12, indicated the amount due and each statement included instructions "For timely and accurate posting of your payment, please include the top remit portion of the statement with your payment each month. Thank you!" The Statement included no explanation regarding the demand bill status of the account and the family and resident not being required to remit payment. The statements were sent to R2's family member. On 11/1/12, at 10:11 a.m. the bookkeeper (BK) explained R2 requested a demand bill on 7/30/12. On 10/5/12, a family member made a payment.	F 492	F492 The facility had just transitioned to the GSS Sioux Falls Service Center for processing accounts receivable at the time of the survey. The account in question was not communicated to the AR specialist by the Medicare special so the statement could be altered to reflect that the charges were being held until the demand bill process was complete. The facility refunded the amount collected with a letter stating that in the event the demand process finds in our favor the amount will be due. The Service center has put a double check in place to prevent this from happening again, however the facility will review the demand log monthly to keep the list of requested names handy to compare to the deposited checks. If a payment is attempted it will be returned to the payor until the process has been completed. The facility accounts service center point person will be responsible for keeping the list up to date and returning the payment if attempted. Date of completion	12/11/12 ~~12/21/12~~

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F 492	Continued From page 40 BK explained the national campus workers handle billing related matters. After calling them, she was made aware R2's financial representative was billed for August and part of September. BK reported her understanding was, "I would assume they should not get billed when in appeal process." and could not explain why R2's family was sent a financial statement requesting payment. On 11/1/12 at 12:27 p.m. the administrator stated "we turn all our billing to someone else. These statements continued to be sent." "...so this payment was done in error, we accepted it and processed it before we caught it." The Statement Checklist-AR Specialist, Revenue Systems, dated 10/1/2012, directed staff "If a resident has requested a demand bill when taken off Medicare Part A or upon admission, we are not allowed to collect full payment from the beneficiary until Medicare has made a decision on the demand bill."	F 492		

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	245207	A. BUILDING **01 - STILLWATER GOOD SAM** B. WING _____	**11/01/2012**

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K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety. At the time of this survey, Good Samaritan Society Stillwater was found to be in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Good Samaritan Society Stillwater is a 1-story building with a partial basement. The building was constructed at 3 different times. The original building was constructed in 1966 and was determined to be of Type II(111) construction. In 1968, an addition was constructed to the South side of the building that was determined to be of Type II(111) construction. In 1995, an addition was constructed to the East side of the building that was determined to be of Type II(111) construction. Because the original building and the additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully fire sprinkler protected. The facility has a complete fire alarm system with smoke detection in the corridors and spaces open to the corridor, that is monitored for automatic fire department notification. The facility has a licensed capacity of 99 beds and had a census of 85 at the time of the survey. The requirement at 42 CFR Subpart 483.70(a) is MET.	K 000		

LABORATORY 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.

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K 000	Continued From page 1 *TEAM COMPOSITION* Tom Linhoff, Life Safety Code Spc.	K 000		