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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6QQO

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00900

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245221**
2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 ROSELAWN AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

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 **05/01/2018** (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 **76** (L18)
13.Total Certified Beds **76** (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:

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

* Code: **A*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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):

17. SURVEYOR SIGNATURE — Date :
Susie Haben, Unit Supervisor — 05/03/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 05/03/2018 (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
04/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 245221
May 3, 2018

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

Dear Ms. Jensen:

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

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

Effective May 1, 2018 the above facility is certified for;

76 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 76 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

Electronically delivered
May 3, 2018

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221029

Dear Ms. Jensen:

On April 9, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on March 22, 2018. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On May 1, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on March 22, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of May 1, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on March 22, 2018, effective May 1, 2018 and therefore remedies outlined in our letter to you dated April 9, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Licensing and Certification Program
Minnesota Department of Health
P.O. Box 64900
St. Paul, MN 55164-0900
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 6QQO

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2.STATE VENDOR OR MEDICAID NO.
(L2) **861017700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - MAPLEWOOD**
(L4) **550 ROSELAWN AVENUE EAST**
(L5) **SAINT PAUL, MN** (L6) **55117**

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 **03/22/2018** (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) :

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13.Total Certified Beds **76** (L17)

10.THE FACILITY IS CERTIFIED AS:
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X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	76			
(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):

17. SURVEYOR SIGNATURE Date :
Mary Beth Lacina, NFE-NE II 04/24/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Alison Helm, Enforcement Specialist 04/27/2018 (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:

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2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)
3. Both of the Above :
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22. ORIGINAL DATE OF PARTICIPATION
04/01/1978
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
April 9, 2018

Ms. Susan Jensen, Administrator
Good Samaritan Society - Maplewood
550 Roselawn Avenue East
Saint Paul, MN 55117

RE: Project Number S5221029

Dear Ms. Jensen:

On March 22, 2018, 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 isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the electronically delivered CMS-2567 whereby corrections are required.

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:

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

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

Remedies - 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

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

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

DEPARTMENT CONTACT

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

Susie Haben, Unit Supervisor
Metro A Survey Team
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
85 East Seventh Place, Suite 220
P.O. Box 64900
Saint Paul, Minnesota 55164-0900
Email: susie.haben@state.mn.us
Phone: (651) 201-3794
Fax: (651) 215-9697

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by May 1, 2018, the Department of Health will impose the following remedy:

- State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

An ePoC for the deficiencies must be submitted within **ten calendar days** of your receipt of this letter. Your ePoC 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,

- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

- 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 ePoC 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 ePoC 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 ePoC must meet the criteria listed in the plan of correction section above. You will be notified by the Minnesota Department of Health, Licensing and Certification Program staff and/or the Department of Public Safety, State Fire Marshal Division staff, if your ePoC for the respective deficiencies (if any) is acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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 June 22, 2018 (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 September 22, 2018 (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
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

This request must be sent within the same ten days you have for submitting an ePoC for the cited deficiencies. All requests for an IDR or IIDR of federal deficiencies must be submitted via the web at: 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. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145
St. Paul, Minnesota 55101-5145

Email: tom.linhoff@state.mn.us
Telephone: (651) 430-3012
Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Michaelyn Bruer, Enforcement Specialist
Minnesota Department of Health
Health Regulation Division
Program Assurance Unit
phone 651-201-4117 fax 651-215-9697
email: michaelyn.bruer@state.mn.us

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
	245221	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 On 3/19/18 through 3/22/18, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Because you are enrolled in ePOC, your signature is not required at the bottom of the first page of the CMS-2567 form. Your electronic submission of the POC will be used as verification of compliance. Upon receipt of an acceptable electronic 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		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure accommodation of resident needs for mobility were made for 1 of 1 resident (R4) reviewed for hospice.	F 558	F558 Reasonable Accommodations Needs/Preferences Corrective Action for residents R4 Facility removed R4 immediately from Hospice Broda chair and assisted R4 into	5/1/18

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

Electronically Signed | 04/19/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 558	Continued From page 1 The findings include: During a random observation on 3/19/18 at 5:56 p.m., R4 was observed sitting in a wheelchair being wheeled backward from the dining room to R4's room by nursing assistant (NA)-Z. At 5:58 p.m., NA-Z verified wheeling R4 backward and stated, it was difficult to wheel the wheelchair forward because the wheelchair goes sideways and resident preferred to be wheeled backward. NA-Z added, "[R4] is alert and oriented and chooses to be wheeled backward". At 6:05 p.m., on 3/19/18, R4 confirmed during interview that the wheelchair goes sideways when pushing it forward so he'd requested NA-Z to push him backwards. R4 further stated the wheelchair belonged to a hospice agency. R4's admission record indicated R4 had been admitted to the facility on 12/12/17, and had diagnoses that included: heart failure, hypertension, atherosclerosis heart disease, edema and malignant melanoma of skin. R4's admission Minimum Data Set (MDS) assessment dated 12/12/17, indicated R4 required extensive assist of one staff with locomotion on and off unit, including use of the wheelchair. Several areas of R4's medical record including; progress notes, facility care plan, hospice care plan, and nursing assistant assignment sheets, lacked any documentation indicating the resident's wheelchair malfunctioned, that R4 preffered to be wheeled backward, or that hospice had been informed about the device malfunctioning.	F 558	facility owned Broda chair, while facility ordered Brand New Broda chair from Hospice. Brand new Broda chair was delivered 2 hours and 40 minutes after facility ordered it from Hospice. The resident was assisted into new Broda chair after nap. How to identify other residents with the same issue During the survey, the facility performed a review of all residents in the facility to identify other residents who may have a malfunctioning wheel chair including Broda chairs. No other residents had a Broda chair and no other residents were identified as having a malfunctioning wheel chair. The facility will assess residents for need and proper function of wheel chairs including Broda chairs on admission, quarterly and with change of condition. Recurrence will be prevented by Re-education will be given to all staff regarding use of wheel chairs including Broda chairs. Audits will be completed to ensure that facility staff is using wheel chairs, including Broda chairs, correctly and they are functioning properly. These issues will be monitored in the following manner Director of Nursing and Nurse Managers will complete audits to assure that residents with wheel chairs including Broda chairs are in a fully functioning chair and that staff are using the chairs properly weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance and performance improvement	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING _____ B. WING _____	03/22/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - MAPLEWOOD	550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117

(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 558	Continued From page 2 On 3/21/18 at 8:54 a.m., the environmental director (ED) stated there was no record of nursing staff having filled out a repair requisition for R4's wheelchair, but that he would verify function of R4's wheelchair. On 3/21/18 at 9:08 a.m., registered nurse (RN)-A stated the ED had spoken with her about R4's wheelchair concern and that she would follow up with the hospice agency. RN-A stated, no one had made her aware of this issue previously, and said she'd never seen R4 wheeled backwards. RN-A pointed out where hospice information was kept in the resident's chart, and verified the hospice record lacked any documentation regarding the malfunction of R4's wheelchair. On 3/21/18 at 9:13 a.m., NA-A confirmed when pushing R4's wheelchair that it would go sideways. NA-A said she remembered having reported this to a nurse "awhile ago", but could not remember which nurse she'd reported to. On 3/21/18 at 9:49 a.m., the hospice RN stated during interview she'd not been informed by facility staff that R4's wheelchair was currently not functioning. The hospice RN stated pulling R4 backward was not safe, and if she'd been made aware of the concern, she would have called the hospice's medical supplier to ensure the chair was either repaired or replaced for safety reasons. As a result of the surveyor's questions regarding the wheelchair malfunctioning, a facility REPAIR REQUISITION dated 3/21/18 was provided which indicated: "New chair Delivered from Hospice 3/21/18".	F 558	committee for further review as needed.	

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	245221	A. BUILDING _____ B. WING _____	03/22/2018

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F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) 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 §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care	F 656		5/1/18

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F 656	Continued From page 4 plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure an individualized comprehensive care plan was developed for 1 of 16 residents reviewed (R53) who required staff assistance with activities of daily living (ADLs) including repositioning and assistance with toileting. Findings include: R53's most recent admission MDS (minimum data set) dated 2/8/18, indicated R53 was cognitively intact, and required extensive assistance from staff for bed mobility, transfer, and toilet use. R53's care plan, last revised on 3/22/18, included problem areas: "Needs assistance with ADL's for completion", "The resident has actual impairment to skin integrity", and " The resident has potential for pressure ulcers development." The care plan further indicated R53 required extensive assistance with bed mobility, transfers and toileting. However, the care plan did not include comprehensive resident specific directions such as how frequently R53 should be toileted, or what method he used (e.g. use of incontinence brief, commode/toilet in bathroom). The care plan also failed to indicate the frequency for repositioning R53. On 3/19/18 at 6:43 p.m., R53 stated he had open areas on his buttocks and on his scrotum. R53 reported he had developed the open wound on	F 656	F656 Development/Implement comprehensive Care Plan Corrective Action for resident R53 R53 has had an individualized comprehensive care plan re-developed for activities of daily living including repositioning and assistance with toileting to protect skin integrity, promote hygiene, and provide comfort. R53 has been receiving care for toileting and repositioning per care plan to protect skin integrity, promote hygiene and provide comfort. How to identify other residents with the same issue All residents will be assessed and have an individualized comprehensive care plan developed for activities of daily living for repositioning and assistance with toileting, to protect skin integrity, promote hygiene, and provide comfort, on admission, quarterly, and with change of condition. Residents will receive care, per care plan, for toileting and repositioning to protect skin integrity, promote hygiene, and provide comfort. Recurrence will be prevented by Re-education will be given to all nurses regarding individualized comprehensive care plan development for repositioning and assistance with toileting, and to all nursing staff regarding providing individualized comprehensive care, per	

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F 656	Continued From page 5 his buttocks after admission and stated it hurt when staff helped him with dressing changes. R53 stated this discomfort lasted for quite awhile after the dressing change, and added that he also had multiple small healing blisters all over his body that itched, which had developed from an allergic reaction. During continuous observations on 3/21/18, from 7:46 a.m. to 11:24 a.m., R53 was observed lying in bed, on his back, with the head of the bed elevated. At no time during this observation period was R53 assisted with repositioning, or toileting cares. At 11:13 a.m., R53 stated his bottom was sore from being on it for too long, and stated he felt tired. R53 stated he had last been assisted with toileting and a position change at 7:15 a.m. greater than 3 and a half hours earlier. At 11:24 a.m. on 3/21/18, NA-B assisted R53 with cares. The surveyor asked R53 whether she could view the sores on his bottom, and R53 consented. R53's buttock was observed to have a blister in the crease under the buttock and his scrotum was observed to be swollen. During the observation NA-B was asked how frequently R53 required assistance with toileting and repositioning. NA-B was unable to give a specific time frame. NA-B stated she had changed R53's brief, and helped RN-C with a dressing change earlier that morning, but had not provided any further incontinence care, nor repositioning until 11:24 a.m., greater than 3 and a half hours since the previous cares. On 3/21/18 at 1:57 p.m. RN-B stated R53 required staff assistance to toilet in accordance with a check and change program, and required staff assistance for bed mobility and	F 656	care plan, for toileting and repositioning to protect skin integrity, promote hygiene, and provide comfort. Audits will be completed to ensure that residents care plans are individualized and comprehensive for repositioning and toileting, and that residents are receiving care per care plan to protect skin integrity, promote hygiene, and provide comfort. These issues will be monitored in the following manner Director of Nursing and Nurse Managers will complete audits, regarding repositioning and toileting to protect skin integrity, promote hygiene and provide comfort, weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 656	Continued From page 6 repositioning. RN-B reviewed the care plan with the surveyor. RN-B acknowledged that although it was clear R53 required staff assistance for activities of daily living, such as transfers, bed mobility and toileting, the care plan did not provide clear resident specific directions for frequency of these cares. The facility's Care Plan policy last revised 11/2016, included: "Each resident will have an individualized, person centered, comprehensive plan of care that will include measurable goals and timetables directed towards achieving and maintaining the resident's optimal medical,nursing, physical, functional, spiritual, emotional, psychosocial and educational needs. "	F 656		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to provide grooming care for 2 of 3 residents (R8 and R48) reviewed who were dependent on staff to meet their grooming needs. Findings include: On 3/19/18 at 4:07 p.m., R8 (a female resident), was observed to have several gray/white facial hairs on the upper lip and chin area which were approximately 1 inch long.	F 677	F677 ADL Care Provided For Dependent Residents Corrective Action for residents R8 and R48 R8 and R48 were shaved to remove facial hair as soon as staff was made aware of the resident□s need and preference. R8 and R48 continue to receive grooming care including shaving as needed during ADL care. How to identify other residents with the same issue	5/1/18

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F 677	Continued From page 7 On 3/20/18 at 9:17 a.m., R8 was observed sitting in the dining room. R8 still had the gray/white facial hairs on the upper lip and chin areas. At 3:25 p.m. that day, R8 was observed lying in bed. The resident had still not been shaved and continued ot have the long facial hairs observed on the upper lip and chin areas. R8's admission record identified an admission to facility of 9/18/17, and indicated diagnoses including: mixed receptive-expressive language disorder, cerebral infarction, hypertension, atrial fibrillation and depressive episodes. R8's quarterly Minimum Data Set (MDS) assessment dated 12/18/17, indicated R8 required extensive assist of one staff with personal hygiene needs, including shaving. Review of R8's medical record lacked documentation of the resident having any refusal of cares. The care plan dated 10/2/17 included: "PERSONAL HYGIENE: Resident requires extensive assist of 1 staff." Registered nurse (RN)-A verified on 3/20/18 at 3:35 p.m., that R8 had facial hair that should have been shaved. RN-A stated her expectation was that staff would shave residents daily during morning care. On 3/19/18 at 3:53 p.m., R48 (a female resident), was observed to have several long gray/white facial hairs on the upper lip and chin areas that were approximately an inch long. R48 expressed a preference to be shaved by staff. On 3/20/18 at 9:09 a.m., R48 was again observed to have the long gray/white facial hairs on the	F 677	At the time the facility was made aware of the residents who were not shaved, the facility performed a visual review of all residents in the facility to identify other residents who may have facial hair with a need and preference for removal of facial hair. No other residents were identified as needing or preferring shaving at the time of the review. All residents will be assessed for grooming needs and preferences, including shaving needs and preferences, to remove facial hair, on admission, quarterly, and with change of condition, and all residents who need and prefer shaving to remove facial hair will be shaved during grooming cares as needed. Recurrence will be prevented by Re-education will be given to all nursing staff regarding shaving of facial hairs. Audits will be completed to ensure that residents are shaved that have a need and prefer to be shaved to remove facial hair. These issues will be monitored in the following manner Director of Nursing and Nurse Managers will complete audits, to assure that residents who have need and preference to have facial hair shaved during grooming cares are shaved, weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 677	Continued From page 8 upper lip and chin areas. At 3:17 p.m. on that same day, R48 was observed sitting up in the wheelchair in her room. The facial hair was still present. R8's medical record indicated she'd been admitted to the facility on 12/26/16 with diagnoses including: diabetes type 2, anxiety disorder, hypertension, major depressive disorder and chronic obstructive pulmonary disease. R48's quarterly MDS assessment dated 2/26/17, indicated R48 required extensive assist of one staff with personal hygiene needs, including shaving. Review of R48's medical record lacked documentation that resident refused cares. The care plan dated 1/10/17, revealed, "PERSONAL HYGIENE: Resident requires extensive assist of 1 staff." During an interview with RN-A on 3/20/18 at 3:37 p.m., RN-A verified R48's facial hair should have been shaven during morning cares. At that time, R48 touched the facial hair and stated, "It does not take long to take care of it." The policy and procedure for personal hygiene that include shaving assistance was requested, but not provided.	F 677		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive	F 684		5/1/18

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F 684	Continued From page 9 assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure care was provided for 1 of 16 residents reviewed (R53) to protect skin integrity, promote hygiene and provide comfort. Findings include: R53's most recent admission MDS (minimum data set) dated 2/8/18, indicated R53 was cognitively intact, and required extensive assistance from staff for bed mobility, transfer, and toilet use. R53's care plan, last revised on 3/22/18, identified problem areas including: "Needs assistance with ADL's for completion", "The resident has actual impairment to skin integrity", and " The resident has potential for pressure ulcer development." The care plan further indicated R53 required assistance with bed mobility, transfers, and toilet use. On 3/19/18 at 6:43 p.m., R53 stated he had open areas on his buttocks and on his scrotum. R53 reported he had developed the open wound on his buttocks after admission and stated it hurt when staff helped him with dressing changes. R53 stated this discomfort lasted for quite awhile after the dressing change, and added that he also had multiple small healing blisters all over his body that itched, which had developed from an	F 684	F684 Quality of Care Corrective Action for resident R53 R53 has had an individualized comprehensive care plan re-developed for activities of daily living including repositioning and assistance with toileting to protect skin integrity, promote hygiene, and provide comfort. R53 has been receiving care for toileting and repositioning per care plan to protect skin integrity, promote hygiene and provide comfort. How to identify other residents with the same issue All residents will be assessed and have an individualized comprehensive care plan developed for activities of daily living for repositioning and assistance with toileting, to protect skin integrity, promote hygiene, and provide comfort, on admission, quarterly, and with change of condition. Residents will receive care, per care plan, for toileting and repositioning to protect skin integrity, promote hygiene, and provide comfort. Recurrence will be prevented by Re-education will be given to all nurses regarding individualized comprehensive care plan development for repositioning and assistance with toileting, and to all nursing staff regarding providing individualized comprehensive care, per	

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F 684	Continued From page 10 allergic reaction. On 3/21/18, at 7:31 a.m. registered nurse (RN)-C stated R53 was not feeling well that day and had a cough and fever. RN-C stated she just completed dressing changes to R53's legs and that R53 was resting. RN-C verified R53 had blisters all over his body which were likely from an allergic reaction. During continuous observations on 3/21/18, from 7:46 a.m. to 11:24 a.m., R53 was observed lying in bed, on his back, with the head of the bed elevated. At 8:35 a.m., RN-C entered R53's room to take his temperature. At 9:04 a.m., a nursing assistant (NA)-B entered R53's room to refill his mug of water. At 10:34 a.m., a portable x-ray tech was observed to enter the room and took x-rays while R53 remained on his back. At 10:50 a.m., RN-C entered the room again to take R53's temperature. During none of these observations was R53 assisted with repositioning, or toileting cares. At 11:13 a.m., R53 state his bottom was sore from being on it for too long, and stated he felt tired. R53 stated he had last been assisted with toileting and a position change at 7:15 a.m. greater than 3 and a half hours earlier. At 11:24 a.m. on 3/21/18, NA-B assisted R53 with cares. After NA-B had changed R53's gown, she asked R53 if he wanted to lie on his side to which R53 responded "yes" and pointed to the window. However, NA-B stepped out of the room prior to repositioning R53. When she returned a few minutes later, NA-B straightened out the sheets on R53's bed and asked how R53 was feeling. R53 was heard to respond he was "tired." NA-B asked R53 if he still wanted to lie on his side and R53 replied, "no, I'm fine." The surveyor	F 684	care plan, for toileting and repositioning to protect skin integrity, promote hygiene, and provide comfort. Audits will be completed to ensure that residents care plans are individualized and comprehensive for repositioning and toileting, and that residents are receiving care per care plan to protect skin integrity, promote hygiene, and provide comfort. These issues will be monitored in the following manner Director of Nursing and Nurse Managers will complete audits, regarding repositioning and toileting to protect skin integrity, promote hygiene and provide comfort, weekly for one month, monthly for one quarter, and then quarterly. Audit results will be brought to the quality assurance performance improvement committee for further review as needed.	

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F 684	Continued From page 11	F 684		

asked R53 whether she could view the sores on his bottom, and R53 consented. NA-B removed R53's brief, stating it needed to be changed. NA-B changed the brief and turned R53 on his side facing the window. R53's buttock was observed to have a blister in the crease under the buttock. R53's scrotum was observed to be swollen. NA-B stated she thought the nurse was aware of the blister, but summoned the nurse at the surveyors request. When RN-C observed R53's bottom she reported she had not been aware of the open blister on R53's buttock crease. However, RN-C stated she was aware R53 had multiple blisters over his body from an allergic reaction, and stated he had a swollen scrotum related to a hernia. RN-C reported she would inform her nurse manager, RN-B. Following completion of the cares, and after having been repositioned off his bottom for several minutes, R53 stated his bottom felt better. During the observation NA-B was asked how frequently R53 required assistance with toileting and repositioning. NA-B was unable to give a specific time frame. NA-B stated she had changed R53's brief, and helped RN-C with a dressing change earlier that morning, but had not provided any further incontinence care, nor repositioning until 11:24 a.m., greater than 3 and a half hours since the previous cares. NA-B further stated when she'd just changed the brief for R53, it had not been wet or soiled, but she'd decided to change it because there was drainage from the swollen scrotum and blisters.

On 3/21/18 at 1:57 p.m. RN-C and RN-B reported they'd observed the blister on R53's buttocks crease and said it was similar to other blisters that had developed due to the suspected allergic reaction. RN-B also stated R53 required staff

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F 684	Continued From page 12 assistance to toilet in accordance with a check and change program, and required staff assistance for bed mobility and repositioning. A physician note, dated 3/21/18, revealed "Today he has an area of concern on his left buttock that appears to be a blister that is now open, quite similar to the other multiple ones he has on his body." and "Does have significant scrotal swelling related to hernia."	F 684		

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GOOD SAMARITAN SOCIETY - MAPLEWOOD	**550 ROSELAWN AVENUE EAST SAINT PAUL, MN 55117**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, (Good Samaritan Society) was found in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. Maplewood Good Samaritan Center is a 2-story building with no basement. The building was constructed at three different times. In 1965 the nursing home was built and was determined to be of Type II(111) construction. In 1967 an addition was constructed to the south of the main building, that was determined to be of Type II(111) construction. In 1997 an addition was constructed to the south and west of the 1967 building that was determined to be of Type II(111) construction. Because the original building and the 2 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is fully sprinkler protected and has a fire alarm system with smoke detection in the corridors and spaces open to the corridors that are monitored for automatic fire department notification. Other hazardous areas have either heat detection or smoke detection that are on the fire alarm system in accordance with the Minnesota State Fire Code. The sleeping rooms in the 1997 addition have single smoke detectors that annunciate outside the room and at the nurse's station in accordance with the Minnesota State Fire Code. The facility has a capacity of 96 beds and had a	K 000		

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245221	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**03/21/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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K 000	Continued From page 1 census of 68 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is MET.	K 000		