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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7EW4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00078

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245523**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - CLEARBROOK**
(L4) **305 3RD AVENUE SOUTHWEST**
(L5) **CLEARBROOK, MN** (L6) **56634**

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) **04/13/2017**
6. DATE OF SURVEY **07/20/2017** (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 **43** (L18)
13.Total Certified Beds **43** (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
	43			
(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 :
Lyla Burkman, Unit Supervisor 09/05/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 11/13/2017 (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
02/01/1988
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
05/01/2017
(L33)

DETERMINATION APPROVAL

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

CCN: 24 5523

On April 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of their plan of correction and on July 20, 2017, the Minnesota Department of Public Safety completed a PCR to verify that the facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2017 and an FMS completed on March 28, 2017. We presumed, based on their plan of correction, that the facility had corrected these deficiencies as of June 15, 2017. Based on our PCR, we have determined that the facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2017 and FMS completed on March 28, 2017, as of June 15, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of April 7, 2017. The CMS Region V Office concurs and has authorized this Department to notify the facility of these actions:

• Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 24, 2017, be rescinded. (42 CFR 488.417 (b))

In the CMS letter of April 7, 2017, the facility was advised that, 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), the facility was prohibited from conducting a Nursing Aide Training and/or Competency Evaluation Program (NATCEP) for two years from May 24, 2017, due to denial of payment for new admissions. Since the facility attained substantial compliance on June 15, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiencies cited under K311, K161, K351, K225, and K372 at the time of the March 28, 2017, FMS, has not yet been verified. The facility's plan of correction for these deficiencies, including their request for a temporary waiver with a date of completion of September 30, 2017 (for K225 and K372) and November 1, 2017 (for K311, K161 and K351), have been approved.

Effective June 15, 2017, the facility is certfied for 43 skilled nursing facility beds.

CMS Certification Number (CCN): 245523

Electronically delivered
September 5, 2017

Ms. Adriana Peck, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, MN 56634

Dear Ms. Peck:

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 June 15, 2017 the above facility is certified for:

43 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 43 skilled nursing facility beds.

Your request for waivers of K311, K161, K351, K225 and K372 have been approved based on the submitted documentation.

If you are not in compliance with the above requirements at the time of your next survey, you will be required to submit a Plan of Correction for these deficiencies or renew your request for waiver in order to continue your participation in the Medicare Medicaid Program.

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.

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

Electronically delivered
September 5, 2017

Ms. Adriana Peck, Administrator
Good Samaritan Society - Clearbrook
305 3rd Avenue Southwest
Clearbrook, MN 56634

RE: Project Number S5523025, F5523026

Dear Ms. Peck:

On March 9, 2017, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 15, 2017. The most serious deficiencies were found to be a pattern of deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level E), whereby corrections were required.

On March 28, 2017, a surveyor representing the Centers for Medicare & Medicaid Services (CMS) completed a Federal Monitoring Survey (FMS) of your facility. As the surveyor informed you during the exit conference, the FMS revealed that your facility continued to not be in substantial compliance. The FMS found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F).

On April 7, 2017, CMS forwarded the results of the FMS to you and notified you that your facility was not in substantial compliance with the applicable Federal requirements for nursing homes participating in the Medicare and Medicaid programs and imposed the following enforcement remedy:

- Mandatory denial of payment for new Medicare and Medicaid admissions, effective May 24, 2017. (42 CFR 488.417 (b))

Also, the CMS Region V Office notified you in their letter of April 7, 2017, 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 May 24, 2017.

On April 13, 2017, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on July 20, 2017, the Minnesota Department of Public Safety completed a PCR to verify that your facility had achieved and maintained compliance with federal certification deficiencies issued pursuant to a standard survey, completed on February 24, 2017 and an FMS completed on March 28, 2017. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of June 15, 2017. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 24, 2017 and FMS completed on March 28, 2017, as of June 15, 2017.

As a result of the PCR findings, this Department recommended to the Centers for Medicare and Medicaid Services (CMS) Region V Office the following actions related to the remedies outlined in their letter of April 7, 2017. 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 May 24, 2017, be rescinded. (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 May 24, 2017, is to be rescinded. They will also notify the State Medicaid Agency that the denial of payment for all Medicaid admissions, effective May 24, 2017, is to be rescinded.

In the CMS letter of April 7, 2017, you were advised that, 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 May 24, 2017, due to denial of payment for new admissions. Since your facility attained substantial compliance on June 15, 2017, the original triggering remedy, denial of payment for new admissions, did not go into effect. Therefore, the NATCEP prohibition is rescinded.

Correction of the Life Safety Code deficiencies cited under K311, K161, K351, K225, K372 at the time of the March 28, 2017, FMS, has not yet been verified. Your plan of correction for these deficiencies, including your request for a temporary waiver with a date of completion of September 30, 2017 (for K225 and K372) and November 1, 2017 (for K311, K161 and K351), have been approved.

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

Feel free to contact me if you have questions related to this letter.

Sincerely,

Mark Meath

Mark Meath, Enforcement Specialist
Program Assurance Unit
Licensing and Certification Program
Health Regulation Division
Minnesota Department of Health
Email: mark.meath@state.mn.us
Phone: (651) 201-4118 Fax: (651) 215-9697

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 7EW4

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00078

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245523**
2.STATE VENDOR OR MEDICAID NO.
(L2) **017740700**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - CLEARBROOK**
(L4) **305 3RD AVENUE SOUTHWEST**
(L5) **CLEARBROOK, MN** (L6) **56634**

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 **02/24/2017** (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 **43** (L18)
13.Total Certified Beds **43** (L17)

10.THE FACILITY IS CERTIFIED AS:
A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC
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
	43			
(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 :
Rebecca Haberle, HFE NEII 03/19/2017 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Mark Meath, Enforcement Specialist 04/27/2017 (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
02/01/1988
(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

MDH
Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1739

March 9, 2017

Ms. Susan Morgan, Administrator
Accra Home Care Inc.
225 West Cavour Avenue Suite D
Fergus Falls, MN 56537-2103

RE: Project Number S8049023

Dear Ms. Morgan:

A standard survey of your Agency was completed on January 25, 2017 for the purpose of assessing compliance with Federal certification regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division was pleased to find that your agency was in full compliance with Federal certification regulations.

Enclosed is your copy of the Federal Form CMS-2567 indicating your facility's compliance with the Federal regulations.

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

Thank you for your cooperation.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Health Regulation Division
Telephone: (651) 201-4112 Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure
cc: Licensing and Certification

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(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 is enrolled in ePOC and therefore a signature is not required at the bottom of the first page of the CMS-2567 form. Electronic submission of the POC 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		
F 159 SS=D	483.10(f)(10)(i)-(iv) FACILITY MANAGEMENT OF PERSONAL FUNDS (f)(10)(i) …If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section. (f)(10)(ii) Deposit of Funds. (A) In general: Except as set out in paragraph (f)(l0)(ii)(B) of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund. (B) Residents whose care is funded by Medicaid:	F 159		3/30/17

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

Electronically Signed | 03/15/2017

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(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 159	Continued From page 1 The facility must deposit the residents' personal funds in excess of $50 in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a noninterest bearing account, interest-bearing account, or petty cash fund. (f)(10)(iii) Accounting and records. (A) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident's personal funds entrusted to the facility on the resident's behalf. (B) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident. (C)The individual financial record must be available to the resident through quarterly statements and upon request. (f)(10)(iv) Notice of certain balances. The facility must notify each resident that receives Medicaid benefits- (A) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in section 1611(a)(3)(B) of the Act; and (B) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one	F 159		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(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 159	Continued From page 2 person, the resident may lose eligibility for Medicaid or SSI. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents and legal representatives had access to personal funds after business hours and on weekends for 1 of 1 resident (R10) reviewed who had a personal funds account with the facility. This practice had the potential to affect 26 of 32 residents with resident trust accounts with the facility. Findings include: On 2/21/17, at 6:30 p.m. family member (FM)-A stated he/she occasionally purchased items for R10. FM-A stated R10 had a personal trust account, however, the only way to get money from the account was to provide a receipt and proof of purchase to the social service designee (SSD). Once a receipt was provided, the SSD would then reimburse FM-A from R10's trust account. On 2/23/17, at 11:08 a.m. licensed practical nurse (LPN)-A stated the SSD was in charge of the resident trust accounts. She stated if a resident or family member wanted money from the account, they would have to contact the SSD and confirmed resident monies were not available if the SSD was out of the building, which included evenings and weekends. On 2/24/17, at 10:50 a.m. registered nurse	F 159	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 Tag 159- D: 1. R10 family contact notified on 3-10-17 of availability of funds at nurses station if desired after hours. $50.00 was placed in locked box in medication cart on 2/24/17 for resident access after-hours. This money is counted by 2 nurses at shift change to ensure it is accounted for. If a resident chooses to access this money either a nurse and the resident or 2 nurses, if resident unable to sign, will co-sign that it was redeemed by resident and this will be routed to the business office. Per Resident Trust Account Policy and Procedure. 2. Money will remain available in Business office during office hours or in lock box for after-hours. All residents will	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(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 159	Continued From page 3 (RN)-A stated if a resident or legal representative wanted money from the resident trust account, staff would have to call the SSD. RN-A stated they did not have a system in place to obtain monies from the resident trust accounts in the evenings or on weekends. On 2/24/17, at 1:20 p.m. the SSD verfied she was in charge of the resident trust accounts. She stated if the residents' wanted money in the evenings or on the weekends, they were to go to the upper level nurses station where they had access to twenty dollars. The SSD stated it had been "ages" since anybody had requested money after hours. When questioned how family members could obtain money from the resident trust accounts for resident purchases, the SSD stated she encouraged the family members to bring her a receipt for any items purchased and she would reimburse the family members. She stated it was up to her to keep track of the resident funds therefore she preferred to receive a receipt for purchases. When asked if a family member would be able to get money from an account to make a purchase, she explained there was one family in the facility to whom she gave money to, but the family member returned with a receipt and change for any purchases made. The SSD stated each family was treated on a case by case basis and she required receipts for all purchases made with resident funds. -At 1:45 p.m. the SSD and LPN-B entered the upper level medication room. SSD looked on a shelf for the twenty dollars to be given to a resident, if requested. LPN-B stated the facility had not had $20.00 cash in the medication room	F 159	be educated on RTA at next resident council meeting 3/20/17 and letter will be sent to family contact by 3/20/17 notifying them of this information. 3. All residents will be educated on Resident Trust Account information upon admission and with care conferences, and reviewed at resident council quarterly. Business Office will continue to manage Resident Trust Account according to Policy and Procedure. Education was completed 2/24/17 and 3/15/17 with all licensed nurses by DNS and Staff Development, RN on Resident Trust Account Policy and Procedure. 4. Business Office manager or designee will audit that education was completed at care conferences weekly and resident council monthly for 3 months. Audits will be completed weekly x4 weeks, then 2x/month x4 weeks, then monthly x 1 month. All audits results will be reviewed by QAPI Committee for further recommendation. 5. Completion date 3/30/17	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/24/2017

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GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

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F 159	Continued From page 4 for several years. LPN-B stated the facility had a small convenience store so the residents' simply charged their snacks after hours. LPN-B could not recall when the petty cash had been taken out of the medication room. Review of the General Information policy dated 12/2015, regarding resident trust accounts, directed the facility to be able to provide resident requests of less than $50.00 to be honored within the same day. The policy directed staff to ensure a resident signature or if unable, to have two staff members sign their signatures to indicate the withdrawals or deposits of monies to/from the accounts. The policy did not direct staff to refuse to dispense monies without a receipt of purchase. On 2/24/17, at 1:50 p.m. the SSD placed envelopes in the upper and lower medication carts which each contained $25.00 and stated monies were now available for resident requests. The SSD stated stated it had been a long time since she had read the resident trust account policies and confirmed the facility had not been following the policy.	F 159		
F 242 SS=D	483.10(f)(1)-(3) SELF-DETERMINATION - RIGHT TO MAKE CHOICES (f)(1) The resident has a right to choose activities, schedules (including sleeping and waking times), health care and providers of health care services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part. (f)(2) The resident has a right to make choices	F 242		3/30/17

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F 242	Continued From page 5 about aspects of his or her life in the facility that are significant to the resident. (f)(3) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide a resident the opportunity to make choices regarding baths and schedules for 1 of 3 (R14) residents reviewed with concerns regarding these choices. Findings include: R14's quarterly Minimum Data Set (MDS) Dated 1/1/17, indicated R14 was alert and orientated and required extensive assistance of one staff for personal hygiene. On 2/21/17, at 3:30 p.m. R14 stated he was allowed to have one bath a week, everyone received only one bath a week. He stated he had not been given a choice as to how often he would like a bath. R14's care plan dated 2/2/17, directed the staff to provide assistance with a weekly bath. The Nursing Admit Re-admit Data Collection tool dated 4/17/15, indicated R14 preferred a shower/whirlpool bath during the day but did not	F 242	F Tag 242- D: 1. R14 was reevaluated by RN on 2/24/17 for bathing preferences and bathing schedule was updated to reflect 2 baths per week on 2/24/17. Care Plan updated to reflect resident choices. Resident was also educated on his rights to notify staff if there are any changes he would like to have in his care. 2. All residents /family, as needed, have been interviewed as able regarding bathing preferences. Care Plans and schedules updated to reflect resident choices as needed. Upon admission, quarterly, and with significant change residents will be interviewed regarding bathing preferences and Care Plans will be updated to reflect. If residents are unable to be interviewed staff will attempt to contact family for this information at Care conferences. 3. DNS and Staff Development, RN educated Nursing Staff on new interview questions during MDS observation period on 2/27/17 and 3/15/17. 4. DNS or designee will complete audits on completion of bathing preference interviews per MDS schedule weekly x 3 months. All audit results will be reviewed	

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F 242	Continued From page 6 indicate if R14 was asked how frequently he would like a bath. Review of the R14's medical record indicated R14 had not been questioned regarding his bathing preferences since 2015. On 2/24/17, at 9:00 a.m. the social service designee (SSD) stated she did not talk to the residents' about their bathing preferences rather, the nursing staff determined the bathing routines for the residents'. On 2/24/17, at 9:10 a.m. nursing assistant (NA)-A stated she did not know how the bathing schedule was established. NA-A reviewed the bathing schedule and verfied R14 received a weekly bath on Wednesday evenings. On 2/24/17, at 10:30 a.m. registered nurse (RN)-A stated newly admitted residents were asked about their bathing preference upon admission. RN-A confirmed R14 had not been asked about his personal bathing preferences since his admission and to her knowledge had not expressed further concerns regarding additional baths. She confirmed a discussion regarding bathing preferences had not been held since R14's admission to the facility. On 2/24/17, at 11:30 a.m. RN-A reported she had spoken to R14 and he did wish to have two baths a week so she added a second bath to the bathing schedule for R14.	F 242	by QAPI Committee for further recommendations. 5. Completion date 3/30/17	

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F 242	Continued From page 7 On 2/24/17, at 2:10 p.m. the director of nurses (DON) stated the residents' were asked about bathing preference upon admission and at anytime a resident wished, they could request additional baths. However, the DON confirmed R14 was last offered the opportunity for additional baths at admission to the facility two years ago. A policy related to resident choice/ bathing schedule was requested and none was provided.	F 242		
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure a clean bed with linen was provided for 1 of 2 (R38) residents observed to lay on a therapeutic mattress without linen covering it and was soiled. Findings included: On 2/21/17, at 3:00 p.m. R38's bed was observed with an alternating air mattress with raised sides or perimeters at the foot and head of the bed. The sheet on the bed did not cover the mattress and a gray blanket was draped across the middle. The left upper mattress perimeter portion had lines of dried brownish/whitish debris on it.	F 253	F Tag 253- D: 1. R38 mattress was cleaned on 2/23/17 and sheet applied to bed. Housekeeping notified of soiled mattress and started daily cleaning of air specialty mattresses on 2/23/17. 2. All specialty mattresses in facility were evaluated for cleanliness and sheets applied on 2/24/17. Mattresses will be cleaned daily and prn. Sheets will be used unless otherwise directed by manufacturer which facility will then follow manufacturer written recommendations. 3. DNS, Staff Development RN, and Administrator provided education with all Nursing and Housekeeping staff 3/15/17 on Standard Light Cleaning Policy and	3/30/17

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F 253	Continued From page 8 On 2/21/17, at 3:30 p.m. R38 was observed lying in bed on a square lift pad which extended from just above her knees to the lower back and was covered with the gray throw blanket. The rest of R38's body other than her head was touching the bare mattress. The mattress was not covered by a sheet and continued to have lines of dried brownish/white debris on the left built up or raised side of the mattress. On 2/22/17, at 8:52 a.m. R38 was observed lying in bed on a folded lift sheet which extended from her upper thighs to mid back. The rest of R38's body other than her head was touching the bare mattress. The mattress was not covered by a sheet and continued to have lines of dried brownish/white debris on the left built up or raised side of the mattress. On 2/23/17, at 9:12 a.m. the administrative assistant (AA) for ArroAir (mattress manufacturer) stated the manufacturer's recommendation indicated the mattress was be covered entirely with a sheet, and the manufacturer produced sheets that would fit R38's specific therapeutic mattress. AA stated the manufacturer did not have the linen recommendations in writing because it was a "given." AA stated a sheet was more comfortable and cleanly. The Manufacturer's instruction pamphlet was obtained from the facility and the pamphlet's warnings did not advise against utilization of bed linen.	F 253	Procedure. 4. DNS or designee will audit all specialty mattresses for cleanliness and use of sheets weekly x4 weeks, the 2x/month x4 weeks then monthly x 1 month. All audit results will be reviewed by QAPI Committee for further recommendations. 5. Completion date 3/30/17	

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F 253	Continued From page 9 On 2/23/17, at 12:28 p.m. R38 stated it bothered her to not have sheets on her bed and she didn't like it and would prefer to have one. R38 explained the staff had told her they didn't have sheets to fit her bed and stated, "What can one do?" In addition, R38 stated if her mattress was dirty, she would want it to be cleaned. On 2/23/17, at 12:36 p.m. the director of nursing (DON) confirmed R38's mattress needed to be cleaned and indicated housekeeping would now clean it daily. The DON stated a sheet was not put on R38's mattress because the DME (durable medical equipment) supplier representative where the mattresses was purchased from told them not to use sheets because of potential air loss through the micro-holes in the mattress. On 2/23/17, at 12:55 p.m. DME representative (DME)-R stated covering the mattress with a sheet would not reduce the effectiveness, purpose, or functionality of the mattress and further explained not covering the mattress could cause impaired skin integrity related to moisture and warmth. DME-R stated the mattress itself should be kept clean and the cover could be cleaned and easily removed to be laundered. Facility policy for cleaning resident personal care equipment was requested and not received.	F 253		
F 431 SS=D	483.45(b)(2)(3)(g)(h) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must provide routine and emergency drugs and biologicals to its residents, or obtain	F 431		3/30/17

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F 431	Continued From page 10	F 431		

them under an agreement described in §483.70(g) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who--

(2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and

(3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(g) Labeling of Drugs and Biologicals.
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.

(h) Storage of Drugs and Biologicals.
(1) 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.

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F 431	Continued From page 11 (2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely identify and reconcile narcotic count discrepancies that were found in 2 of 2 locked medication cart narcotic boxes. Findings included: During the upper level medication cart narcotic count audit on 2/24/17, at 2:00 p.m., trained medication assistant (TMA)-A opened the locked medication cart and then opened the locked narcotic storage box. The box contained a bottle of Guaifensin-Codeine cough syrup. The prescription label indicated it was for R6, was dispensed on 4/1/16, and expired on 4/1/17. The bottle had metered measuring lines on the side of it; the medication level was slightly above the 20 cc (cubic centimeter) line measuring approximately 22 cc's. TMA-A verified the amount in the bottle. TMA-A referenced the narcotic count book, and stated the book indicated the remaining amount should be 45 cc's. TMA-A stated two nurses counted the narcotics at the end or at the start of each shift.	F 431	F 431- D: 1. R6 Guaifenessin AC was destroyed 2/24/17 and order received from MD to discontinue medication for no use. R19 MS destroyed on 2/24/17 and new bottle ordered from pharmacy. Incident report completed per the Controlled Substance Policy and Procedure. 2. All medications in narcotic boxes counted by DNS and another nurse to ensure accuracy and Expiration dates. No other abnormalities found. 3. DNS and Staff Development, RN educated all licensed nurses on Controlled Substance Policy and Procedure and Medication Rights on 2/24/17 and 3/15/17. All residents will have accurate medication counts completed as per Policy and Procedure and nurses will ensure expiration dates are checked prior to administration. 4. DNS or designee will complete audits on Medication counts and checking expiration dates for all narcotic medications in locked boxes weekly x4 weeks, then 2x/month x4 weeks then monthly x1 month . All audit results will be	

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F 431	Continued From page 12 -At 2:10 p.m. licensed practical nurse (LPN)- B confirmed the amount in the bottle was approximately 22 cc's and verified the recorded amount of 45 cc's in the narcotic count book and also on the nurses shift narcotic count sheet. LPN-B indicated the medication was old and hadn't been used for a long time. LPN-B stated according to the narcotic book the last dose was given on 10/9/16. LPN-B explained the narcotic count was supposed to be done at the end of every shift by two nurses in which one nurse counts the medication and the other nurse verifies in the book and if there was a discrepancy, the DON was supposed to be immediately notified. LPN-B did not offer a reason why the DON had not been notified of the discrepancy for this medication. -At 2:48 p.m. the director of nursing (DON) stated she was not aware of a discrepancy in the narcotic count, and stated staff are were to report immediately if the count was not right, so that she could immediately investigate it. the DON verified the discrepancy of the recorded amount and explained the potential reason for the lost/missing amount was due to administration of the wrong medication. The DON stated the resident also had regular Guaifensin cough syrup with the same dosage during that same period, and doses could've been given that were not counted or recorded. The DON stated the medication should have been discontinued and wasted after 60 days of none use. At 3:07 p.m. DON reported she had measured the cough syrup to be 25 cc's which she then destroyed the rest of the medication.	F 431	reviewed by QAPI Committee for further recommendations. 5. Completion date 3/30/2017	

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F 431	Continued From page 13 During the lower level medication cart narcotic count audit on 2/24/17, at 3:22 p.m. LPN-A opened the locked medication cart and then opened the locked narcotic storage box. The box contained a bottle of Morphine Sulfate Solution 10mg/5ml. the prescription label indicated it was for R19, was dispensed on 6/26/15, and expired 6/26/16, (pharmacy expiration date). The bottle had metered measuring lines on the side of it and the medication level was at the 45 cc line. LPN-A referenced the narcotic log count book and reported the amount recorded to remain was 47 cc's. LPN-A verified the amount in the bottle was 45 cc's and stated the narcotic count was done with two nurses at the end of each shift and if the count was off, the director was notified immediately. -At 3:29 p.m. the DON stated she was not aware of the morphine solution count discrepancy and reiterated she expected to be immediately notified if there was any discrepancy in the narcotic count at all. The DON measured the remaining morphine and reported it was 46 cc's and stated the medication was then destroyed. The DON explained the potential reason for the discrepancy was dropper residual and small amounts of spillage. Facility policy Controlled Substances last revised 5/16, indicated every time the keys which secured medications changed from one nurse to another, the oncoming and off going nurses worked together to count all controlled substances including discontinued controlled substances. The policy explained the procedure for counting as; 1. Working together: one nurse unlocks the controlled substance storage unit and counts	F 431		

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F 431	Continued From page 14 controlled drugs per state regulations, on hand for each resident. 2. At the same time, the other nurse assisted by watching and verifying the count. 3. If the record and actual count are in agreement both nurses initial. 4. If the count is not in agreement with the record, the error must be found or an incident report must be completed and signed in Point Click Care prior to the end of the shift and reported to the director of nursing services or designee before leaving the building.	F 431		
F 441 SS=D	483.80(a)(1)(2)(4)(e)(f) INFECTION CONTROL, PREVENT SPREAD, LINENS (a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: (1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards (facility assessment implementation is Phase 2); (2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;	F 441		3/30/17

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F 441	Continued From page 15 (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv) When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi) The hand hygiene procedures to be followed by staff involved in direct resident contact. (4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. (e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. (f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by:	F 441		

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F 441	Continued From page 16 Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were maintained during blood glucose monitoring for 1 of 1 resident (R47) observed to receive glucose monitoring. Findings include: R47's Physician Order summary dated 2/18/17, indicated R47 had diagnosis including sepsis due to Escherichia coli (e. coli), extended spectrum beta lactamase (ESBL) resistance and hypoglycemia. An order dated 2/18/17, directed staff to monitor R47's blood sugars one time a day every three days. (The orders also indicated R47 was to continue receiving interventions (IV) antibiotic for the treatment of ESBL.) On 2/21/17, at 4:44 p.m. registered nurse (RN)-B was observed to obtain a community use glucometer from the lower level treatment cart. RN-B carried the glucometer into the therapy room where she donned gloves and proceeded to check R47's blood sugar by obtaining a sample of blood from R47's finger. Once the blood sugar reading was obtained, RN-B exited the therapy room, removed her gloves, walked back to the treatment cart which was by the nurses station, wiped the glucometer off with a Sani Wipe (cleaning cloth), threw the wipe in the garbage and returned the glucometer back into the treatment cart. The entire length of cleaning took less than 10 seconds.	F 441	F441- D: 1. R47 glucometer was present in his room, had been issued on admission on 2/18/17. Staff did use R47 personal glucometer until resident discharged on 2/25/17. 2. All residents who have orders for blood glucose monitoring ensured to have individual personal blood glucose meters. Also verified weekly completion of cleaning and disinfecting log for individual blood glucose meters. Residents will be assessed during admission process for need for blood glucose monitoring. If blood glucose monitoring is required a personal blood glucose meter will be issued to them and kept in the residents room. These meters will be cleaned and disinfected weekly and as needed and logged for auditing purposes. 3. DNS and Staff Development, RN have completed education with all nursing staff on Policy and Procedure for Blood Glucose Monitoring Cleaning and Disinfection and Manufacturers Instructions on 2/23/17 and 3/15/17. Community glucometer in treatment carts were discarded and nursing staff educated by DNS on using only resident issued glucometers and no further Community glucometer will be kept in treatment carts, as well as following Super- Sani Cloth product directions on 2/23/17. 4. DNS or designee will complete audits on cleaning/disinfection of blood glucose meters with 2 staff weekly x4 weeks, then 2x/month x 1 month, then monthly x 1	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245523	A. BUILDING _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

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F 441	Continued From page 17 According to the Glucometer manufacture direction manual (undated) the cleaning and disinfection could be completed by using a commercially available EPA registered disinfectant detergent germicide wipe. The direction on the back of the bottle of Sani Wipes directed staff to ensure the surface to be cleaned remained wet for two minutes to ensure full clearing/disinfection purposes. On 2/21/17, at 4:54 p.m. RN-B stated any surface to be cleaned for residents' on isolation precautions was to remain wet with the cleaning solution for up to 10 minutes. She stated for R47, a surface did not need to be wet for any length of time, however, RN-B read the directions on the back of the Sani Wipe bottle and confirmed the directions were to ensure the area remained wet for up to two minutes. She stated she had not been directed to ensure the surface of the glucometer remained wet for two minutes. On 2/22/17, at 1:40 p.m. the director of nurses stated each of the residents who required glucometer readings had their own personal use glucometers. She stated she was not sure why R47 had not used the glucometer in his room but stated if the community glucometer was used, the glucometer surface was to be saturated with the cleaning product and allowed to air dry. The DON reviewed the Saniwipe container directions and confirmed the surface area was to be wet for two minutes. She stated it was the facility policy to have each resident utilize their own glucometers.	F 441	month. Will also complete audits of residents with Blood glucose monitoring orders to ensure they have individual glucometers monthly x3 months. All audit results will be reviewed by QAPI Committee for further recommendations. 5. Completion date 3/30/17	

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F 441	Continued From page 18 The DON confirmed the community glucometer had not been cleaned according to the Saniwipe directions. The Cleaning and Disinfecting policy and procedure dated 5/2016, directed the staff to clean the glucometers with an approved germicidal wipe according to the manufactures directions.	F 441		

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	245523	A. BUILDING **01 - 1953 BUILDING WITH ADDITIONS** B. WING _____	**02/23/2017**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN 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 Life Safety Code Survey was conducted by the Minnesota Department of Public Safety, Fire Marshal Division on February 23, 2017. At the time of this survey Good Samaritan Society Clearbrook was found not 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. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota Street, Suite 145 St. Paul, MN 55101	K 000	EPOC	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		03/15/2017

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 Or by e-mail to: Marian.Whitney@state.mn.us, and Angela.Kappenman@state.mn.us Fax Number 651-215-0525 THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency The Good Samaritan Society Clearbrook is a one story building with a full basement. The main building was built in 1953 and has a wood roof system making this building a Type V (000). The facility has additions built in 1962 and 1966, one to the south and one to the east of the original building, which are one story buildings with basements and are Type II (111) construction. These additions are separated with 2- hour fire barriers. In 1999 a basement laundry addition was added to the west of the north wing and was determined to be Type II(111) construction. The basement level is call 1st floor and the 1st story is called 2nd floor. The facility is completely protected by an automatic sprinkler system installed in accordance with NFPA 13 Standard for the Installation of Sprinkler Systems 1999 edition. The facility has a fire alarm system with smoke	K 000		

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K 000	Continued From page 2 detection in the corridors and spaces open to the corridors that is monitored for automatic fire department notification and installed in accordance with NFPA 72 "The National Fire Alarm Code" 1999 edition. Other hazardous areas have either automatic fire detection, that are on the fire alarm system in accordance with the Minnesota State Fire Code 2007 edition. The sleeping rooms have battery operated smoke detectors in them. The building is divided into 6 smoke zones by 2 hour and 30 minute fire barriers. The facility has a capacity of 43 beds and had a census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 363 SS=E	NFPA 101 Corridor - Doors Corridor - Doors 2012 EXISTING Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas shall be substantial doors, such as those constructed of 1-3/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in fully sprinklered smoke compartments are only required to resist the passage of smoke. Doors shall be provided with a means suitable for keeping the door closed. There is no impediment to the closing of the doors. Clearance between bottom of door and floor covering is not exceeding 1 inch. Roller latches are prohibited by CMS regulations on corridor doors and rooms containing flammable	K 363		3/30/17

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K 363	Continued From page 3 or combustible materials. Powered doors complying with 7.2.1.9 are permissible. Hold open devices that release when the door is pushed or pulled are permitted. Nonrated protective plates of unlimited height are permitted. Dutch doors meeting 19.3.6.3.6 are permitted. Door frames shall be labeled and made of steel or other materials in compliance with 8.3, unless the smoke compartment is sprinklered. Fixed fire window assemblies are allowed per 8.3. In sprinklered compartments there are no restrictions in area or fire resistance of glass or frames in window assemblies. 19.3.6.3, 42 CFR Parts 403, 418, 460, 482, 483, and 485 Show in REMARKS details of doors such as fire protection ratings, automatics closing devices, etc. This STANDARD is not met as evidenced by: Based on observations and staff interview, the facility had a corridor door that did not meet the requirement for resisting the passage of smoke in accordance with 19.3.6.3. This deficient practice could affect 10 residents. Findings include: During the facility tour between the hours of 9:00 AM and 12:30 PM on 2/23/2017, it was observed that resident room 214 door had a 1/2 inch gap at the top of the door not in accordance with 19.3.6.3. The deficient practice was verified by the Maintenance Supervisor.	K 363	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. K 363-E: 1. Maintenance supervisor repaired Room 214 door by installing new door	

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K 363	Continued From page 4	K 363	jamb that filled gap at the top of the door. 2. Maintenance Supervisor checked all resident doors to ensure they are in compliance. Any issues were fixed immediately. 3. Administrator reviewed compliance guidelines with Maintenance supervisor on 3/10/17. 4. Maintenance Supervisor or designee will complete audits on 5 doors weekly x 4 weeks, then 2x/month x 1 month, then monthly x 1 month. All audit findings will be reviewed by QAPI Committee for further recommendations. 5. Completion Date 3/30/17	

Minnesota Department of Health

PROTECTING, MAINTAINING AND IMPROVING THE HEALTH OF ALL MINNESOTANS

Certified Mail # 7013 3020 0001 8869 1739

March 9, 2017

Ms. Susan Morgan, Administrator
Accra Home Care Inc.
225 West Cavour Avenue Suite D
Fergus Falls, MN 56537-2103

Re: Enclosed State Licensing Orders - Project Number S8049023

Dear Ms. Morgan:

A survey of the Home Care Provider named above was completed on January 25, 2017, for the purpose of assessing compliance with State licensing regulations. At the time of survey, the survey team from the Minnesota Department of Health, Health Regulation Division, noted one or more violations of these regulations that are issued in accordance with Minnesota Statutes, sections 144A.43 to 144A.482.

In accordance with Minnesota Statute section 144A.477, for home care providers that are licensed to provide home care services and are also certified for participation in Medicare as a home health agency under Code of Federal Regulations, title 42, part 484, with survey and enforcement by the Minnesota Department of Health as an agent for the United States Department of Health and Human Services, the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) are considered equivalent to the federal requirements. Because Accra Home Care Inc is a certified home health agency, violations of the requirements under Minnesota Statute section 144A.477 subd. 2 (1) to (16) may lead to enforcement actions under Minnesota Statute section 144A.474. The notice of termination from the Medicare program by the Centers for Medicare and Medicaid Services (CMS) or the failure to attain compliance with the federal regulations within the time periods approved by CMS may constitute grounds for the revocation, suspension or nonrenewal of the license.

State licensing orders are delineated on the attached Minnesota Department of Health order form. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes for home care providers. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute number and the corresponding text of the state statute out of compliance is listed in the "Summary Statement of Deficiencies" column. This column also includes the findings that are in violation of the state statute after the statement, "This MN requirement is not met as evidenced by."

We urge you to review these orders carefully. If you have questions, please contact Pam Kerssen at (218) 308-2129 or email: Pam.Kerssen@state.mn.us

DOCUMENTATION OF ACTION TO COMPLY

In accordance with Minnesota Statutes, section 144A.474, subd. 8 (c), by the correction order date, the home care provider must document in the provider's records any action taken to comply with the correction order. The commissioner may request a copy of this documentation and the home care provider's action to respond to the correction orders in future surveys, upon a complaint investigation, and as otherwise needed.

CORRECTION ORDER RECONSIDERATION PROCESS

In accordance with Minnesota Statutes, section 144A.474, subd. 12, you have one opportunity to challenge the correction order issued, including the level and scope, and any fine assessed through the correction order reconsideration process. This written request must be received by the Department within 15 calendar days of the correction order receipt date. You are required to send your written request to the following:

Home Health Agency Correction Order Reconsideration Process
Minnesota Department of Health
Health Regulation Division
P.O. Box 64900
St. Paul, Minnesota 55164-0900

Failure to correct state licensing correction orders may result in enforcement actions in accordance with the provisions of Minnesota Statutes, sections 144A.43 to 144A.482.

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

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing

Kamala Fiske-Downing
Minnesota Department of Health
Licensing and Certification Program
Program Assurance Unit
Health Regulation Division
Telephone: (651) 201-4112

Fax: (651) 215-9697
Email: Kamala.Fiske-Downing@state.mn.us

Enclosure(s)

cc: Licensing and Certification File
Gail Anderson, Unit Supervisor
Pam Kerssen, Assistant Program Manager

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00078	A. BUILDING: _____ B. WING _____	02/24/2017

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm The State licensing orders are delineated on the attached Minnesota	2 000		

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2 000	Continued From page 1 Department of Health orders being submitted to you electronically. Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. On 2/21/17, 2/22/17, 2/23/17, and 2/24/17, surveyors of this Department's staff visited the above provider and the following correction orders are issued. Please indicate in your electronic plan of correction that you have reviewed these orders, and identify the date when they will be completed. Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes. The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings which are in violation of the state statute after the statement, "This Rule is not met as evidence by." Following the surveyors findings are the Suggested Method of Correction and Time period for Correction.	2 000		

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2 000	Continued From page 2 PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE. THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.	2 000		
2 480	MN Rule 4658.0260 Subp. 4 Personal Fund Accounting and Records Subp. 4. Financial record. The resident's financial record must be available through quarterly statements and on request to the resident or the resident's legal guardian, conservator, representative payee, or other person designated in writing by the resident. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to ensure residents and legal representatives had access to personal funds after business hours and on weekends for 1 of 1 resident (R10) reviewed who had a personal funds account with the facility. This practice had the potential to affect 26 of 32 residents with resident trust accounts with the facility. Findings include: On 2/21/17, at 6:30 p.m. family member (FM)-A stated he/she occasionally purchased items for R10. FM-A stated R10 had a personal trust account, however, the only way to get money	2 480	Corrected	3/30/17

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2 480	Continued From page 3 from the account was to provide a receipt and proof of purchase to the social service designee (SSD). Once a receipt was provided, the SSD would then reimburse FM-A from R10's trust account. On 2/23/17, at 11:08 a.m. licensed practical nurse (LPN)-A stated the SSD was in charge of the resident trust accounts. She stated if a resident or family member wanted money from the account, they would have to contact the SSD and confirmed resident monies were not available if the SSD was out of the building, which included evenings and weekends. On 2/24/17, at 10:50 a.m. registered nurse (RN)-A stated if a resident or legal representative wanted money from the resident trust account, staff would have to call the SSD. RN-A stated they did not have a system in place to obtain monies from the resident trust accounts in the evenings or on weekends. On 2/24/17, at 1:20 p.m. the SSD verfied she was in charge of the resident trust accounts. She stated if the residents' wanted money in the evenings or on the weekends, they were to go to the upper level nurses station where they had access to twenty dollars. The SSD stated it had been "ages" since anybody had requested money after hours. When questioned how family members could obtain money from the resident trust accounts for resident purchases, the SSD stated she encouraged the family members to bring her a receipt for any items purchased and she would reimburse the family members. She stated it was up to her to keep track of the	2 480		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(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) COMPLETE DATE
2 480	Continued From page 4 resident funds therefore she preferred to receive a receipt for purchases. When asked if a family member would be able to get money from an account to make a purchase, she explained there was one family in the facility to whom she gave money to, but the family member returned with a receipt and change for any purchases made. The SSD stated each family was treated on a case by case basis and she required receipts for all purchases made with resident funds. -At 1:45 p.m. the SSD and LPN-B entered the upper level medication room. SSD looked on a shelf for the twenty dollars to be given to a resident, if requested. LPN-B stated the facility had not had $20.00 cash in the medication room for several years. LPN-B stated the facility had a small convenience store so the residents' simply charged their snacks after hours. LPN-B could not recall when the petty cash had been taken out of the medication room. Review of the General Information policy dated 12/2015, regarding resident trust accounts, directed the facility to be able to provide resident requests of less than $50.00 to be honored within the same day. The policy directed staff to ensure a resident signature or if unable, to have two staff members sign their signatures to indicate the withdrawals or deposits of monies to/from the accounts. The policy did not direct staff to refuse to dispense monies without a receipt of purchase. On 2/24/17, at 1:50 p.m. the SSD placed envelopes in the upper and lower medication carts which each contained $25.00 and stated monies were now available for resident requests.	2 480		

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2 480	Continued From page 5 The SSD stated stated it had been a long time since she had read the resident trust account policies and confirmed the facility had not been following the policy. Suggested Method of Correction: The social service designee or administrator could review and revise the policies related to residents personal funds and provide education to all involved staff members. The quality assurance committee could develop a system to monitor personal funds and ongoing compliance. Time Period for Correction: Twenty one (21) days.	2 480		
21390	MN Rule 4658.0800 Subp. 4 A-I Infection Control Subp. 4. Policies and procedures. The infection control program must include policies and procedures which provide for the following: A. surveillance based on systematic data collection to identify nosocomial infections in residents; B. a system for detection, investigation, and control of outbreaks of infectious diseases; C. isolation and precautions systems to reduce risk of transmission of infectious agents; D. in-service education in infection prevention and control; E. a resident health program including an immunization program, a tuberculosis program as defined in part 4658.0810, and policies and procedures of resident care practices to assist in the prevention and treatment of infections; F. the development and implementation of	21390		3/30/17

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21390	Continued From page 6 employee health policies and infection control practices, including a tuberculosis program as defined in part 4658.0815; G. a system for reviewing antibiotic use; H. a system for review and evaluation of products which affect infection control, such as disinfectants, antiseptics, gloves, and incontinence products; and I. methods for maintaining awareness of current standards of practice in infection control. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to ensure appropriate infection control measures were maintained during blood glucose monitoring for 1 of 1 resident (R47) observed to receive glucose monitoring. Findings include: R47's Physician Order summary dated 2/18/17, indicated R47 had diagnosis including sepsis due to Escherichia coli (e. coli), extended spectrum beta lactamase (ESBL) resistance and hypoglycemia. An order dated 2/18/17, directed staff to monitor R47's blood sugars one time a day every three days. (The orders also indicated R47 was to continue receiving interventions (IV) antibiotic for the treatment of ESBL.) On 2/21/17, at 4:44 p.m. registered nurse (RN)-B was observed to obtain a community use glucometer from the lower level treatment cart.	21390	Corrected	

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21390	Continued From page 7 RN-B carried the glucometer into the therapy room where she donned gloves and proceeded to check R47's blood sugar by obtaining a sample of blood from R47's finger. Once the blood sugar reading was obtained, RN-B exited the therapy room, removed her gloves, walked back to the treatment cart which was by the nurses station, wiped the glucometer off with a Sani Wipe (cleaning cloth), threw the wipe in the garbage and returned the glucometer back into the treatment cart. The entire length of cleaning took less than 10 seconds. According to the Glucometer manufacture direction manual (undated) the cleaning and disinfection could be completed by using a commercially available EPA registered disinfectant detergent germicide wipe. The direction on the back of the bottle of Sani Wipes directed staff to ensure the surface to be cleaned remained wet for two minutes to ensure full clearing/disinfection purposes. On 2/21/17, at 4:54 p.m. RN-B stated any surface to be cleaned for residents' on isolation precautions was to remain wet with the cleaning solution for up to 10 minutes. She stated for R47, a surface did not need to be wet for any length of time, however, RN-B read the directions on the back of the Sani Wipe bottle and confirmed the directions were to ensure the area remained wet for up to two minutes. She stated she had not been directed to ensure the surface of the glucometer remained wet for two minutes.	21390		

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21390	Continued From page 8 On 2/22/17, at 1:40 p.m. the director of nurses stated each of the residents who required glucometer readings had their own personal use glucometers. She stated she was not sure why R47 had not used the glucometer in his room but stated if the community glucometer was used, the glucometer surface was to be saturated with the cleaning product and allowed to air dry. The DON reviewed the Saniwipe container directions and confirmed the surface area was to be wet for two minutes. She stated it was the facility policy to have each resident utilize their own glucometers. The DON confirmed the community glucometer had not been cleaned according to the Saniwipe directions. The Cleaning and Disinfecting policy and procedure dated 5/2016, directed the staff to clean the glucometers with an approved germicidal wipe according to the manufactures directions. Suggested Method of Correction:: The director of nurses could review and revise the policies related to glucometer cleaning and provide education to all involved staff members. The quality assurance committee could develop a system to monitor glucometer cleaning and ongoing compliance. Time Period for Correction: Twenty one (21) days.	21390		

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21635	Continued From page 9	21635		
21635	MN Rule 4658.1350 Subp. 3 Disposition of Medications; Loss or spillage Subp. 3. Loss or spillage. When a loss or spillage of a prescribed Schedule II drug occurs, an explanatory notation must be made in a Schedule II record. The notation must be signed by the person responsible for the loss or spillage and by one witness who must also observe the destruction of any remaining contaminated drug by flushing into the sewer system or wiping up the spill. This MN Requirement is not met as evidenced by: Based on observation, interview and document review, the facility failed to timely identify and reconcile narcotic count discrepancies that were found in 2 of 2 locked medication cart narcotic boxes. Findings included: During the upper level medication cart narcotic count audit on 2/24/17, at 2:00 p.m., trained medication assistant (TMA)-A opened the locked medication cart and then opened the locked narcotic storage box. The box contained a bottle of Guaifensin-Codeine cough syrup. The prescription label indicated it was for R6, was dispensed on 4/1/16, and expired on 4/1/17. The bottle had metered measuring lines on the side of it; the medication level was slightly above the 20 cc (cubic centimeter) line measuring approximately 22 cc's. TMA-A verified the amount in the bottle. TMA-A referenced the narcotic count book, and stated the book indicated the remaining amount should be 45 cc's. TMA-A	21635	Corrected	3/30/17

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21635	Continued From page 10 stated two nurses counted the narcotics at the end or at the start of each shift. -At 2:10 p.m. licensed practical nurse (LPN)- B confirmed the amount in the bottle was approximately 22 cc's and verified the recorded amount of 45 cc's in the narcotic count book and also on the nurses shift narcotic count sheet. LPN-B indicated the medication was old and hadn't been used for a long time. LPN-B stated according to the narcotic book the last dose was given on 10/9/16. LPN-B explained the narcotic count was supposed to be done at the end of every shift by two nurses in which one nurse counts the medication and the other nurse verifies in the book and if there was a discrepancy, the DON was supposed to be immediately notified. LPN-B did not offer a reason why the DON had not been notified of the discrepancy for this medication. -At 2:48 p.m. the director of nursing (DON) stated she was not aware of a discrepancy in the narcotic count, and stated staff are were to report immediately if the count was not right, so that she could immediately investigate it. the DON verified the discrepancy of the recorded amount and explained the potential reason for the lost/missing amount was due to administration of the wrong medication. The DON stated the resident also had regular Guaifensin cough syrup with the same dosage during that same period, and doses could've been given that were not counted or recorded. The DON stated the medication should have been discontinued and wasted after 60 days of none use. At 3:07 p.m. DON reported she had measured the cough syrup to be 25 cc's which she then destroyed the rest of the medication.	21635		

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21635	Continued From page 11 During the lower level medication cart narcotic count audit on 2/24/17, at 3:22 p.m. LPN-A opened the locked medication cart and then opened the locked narcotic storage box. The box contained a bottle of Morphine Sulfate Solution 10mg/5ml. the prescription label indicated it was for R19, was dispensed on 6/26/15, and expired 6/26/16, (pharmacy expiration date). The bottle had metered measuring lines on the side of it and the medication level was at the 45 cc line. LPN-A referenced the narcotic log count book and reported the amount recorded to remain was 47 cc's. LPN-A verified the amount in the bottle was 45 cc's and stated the narcotic count was done with two nurses at the end of each shift and if the count was off, the director was notified immediately. -At 3:29 p.m. the DON stated she was not aware of the morphine solution count discrepancy and reiterated she expected to be immediately notified if there was any discrepancy in the narcotic count at all. The DON measured the remaining morphine and reported it was 46 cc's and stated the medication was then destroyed. The DON explained the potential reason for the discrepancy was dropper residual and small amounts of spillage. Facility policy Controlled Substances last revised 5/16, indicated every time the keys which secured medications changed from one nurse to another, the oncoming and off going nurses worked together to count all controlled substances including discontinued controlled substances. The policy explained the procedure for counting as; 1. Working together: one nurse unlocks the	21635		

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21635	Continued From page 12 controlled substance storage unit and counts controlled drugs per state regulations, on hand for each resident. 2. At the same time, the other nurse assisted by watching and verifying the count. 3. If the record and actual count are in agreement both nurses initial. 4. If the count is not in agreement with the record, the error must be found or an incident report must be completed and signed in Point Click Care prior to the end of the shift and reported to the director of nursing services or designee before leaving the building. Suggested Method of Correction: The director of nurses could review and revise the policies related to reconciliation of liquid narcotics and provide education to all involved staff members. The quality assurance committee could develop a system to monitor liquid narcotic medication and ongoing compliance. Time Period for Correction: Twenty one (21) days.	21635		
21695	MN Rule 4658.1415 Subp. 4 Plant Housekeeping, Operation, & Maintenance Subp. 4. Housekeeping. A nursing home must provide housekeeping and maintenance services necessary to maintain a clean, orderly, and comfortable interior, including walls, floors, ceilings, registers, fixtures, equipment, lighting, and furnishings. This MN Requirement is not met as evidenced by: Based on observation, interview and document	21695	Corrected	3/30/17

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21695	Continued From page 13 review, the facility failed to ensure a clean bed with linen was provided for 1 of 2 (R38) residents observed to lay on a therapeutic mattress without linen covering it and was soiled. Findings included: On 2/21/17, at 3:00 p.m. R38's bed was observed with an alternating air mattress with raised sides or perimeters at the foot and head of the bed. The sheet on the bed did not cover the mattress and a gray blanket was draped across the middle. The left upper mattress perimeter portion had lines of dried brownish/whitish debris on it. On 2/21/17, at 3:30 p.m. R38 was observed lying in bed on a square lift pad which extended from just above her knees to the lower back and was covered with the gray throw blanket. The rest of R38's body other than her head was touching the bare mattress. The mattress was not covered by a sheet and continued to have lines of dried brownish/white debris on the left built up or raised side of the mattress. On 2/22/17, at 8:52 a.m. R38 was observed lying in bed on a folded lift sheet which extended from her upper thighs to mid back. The rest of R38's body other than her head was touching the bare mattress. The mattress was not covered by a sheet and continued to have lines of dried brownish/white debris on the left built up or raised side of the mattress. On 2/23/17, at 9:12 a.m. the administrative	21695		

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21695	Continued From page 14 assistant (AA) for ArroAir (mattress manufacturer) stated the manufacturer's recommendation indicated the mattress was be covered entirely with a sheet, and the manufacturer produced sheets that would fit R38's specific therapeutic mattress. AA stated the manufacturer did not have the linen recommendations in writing because it was a "given." AA stated a sheet was more comfortable and cleanly. The Manufacturer's instruction pamphlet was obtained from the facility and the pamphlet's warnings did not advise against utilization of bed linen. On 2/23/17, at 12:28 p.m. R38 stated it bothered her to not have sheets on her bed and she didn't like it and would prefer to have one. R38 explained the staff had told her they didn't have sheets to fit her bed and stated, "What can one do?" In addition, R38 stated if her mattress was dirty, she would want it to be cleaned. On 2/23/17, at 12:36 p.m. the director of nursing (DON) confirmed R38's mattress needed to be cleaned and indicated housekeeping would now clean it daily. The DON stated a sheet was not put on R38's mattress because the DME (durable medical equipment) supplier representative where the mattresses was purchased from told them not to use sheets because of potential air loss through the micro-holes in the mattress. On 2/23/17, at 12:55 p.m. DME representative (DME)-R stated covering the mattress with a sheet would not reduce the effectiveness, purpose, or functionality of the mattress and further explained not covering the mattress could	21695		

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21695	Continued From page 15 cause impaired skin integrity related to moisture and warmth. DME-R stated the mattress itself should be kept clean and the cover could be cleaned and easily removed to be laundered. Facility policy for cleaning resident personal care equipment was requested and not received. Suggested Method of Correction: The maintenance director or director of nurses could review and revise the policies related to residents bed clearing schedules and provide education to all involved staff members. The quality assurance committee could develop a system to monitor resident room cleaning and ongoing compliance. Time Period for Correction: Twenty one (21) days.	21695		
21830	MN St. Statute 144.651 Subd. 10 Patients & Residents of HC Fac.Bill of Rights Subd. 10. Participation in planning treatment; notification of family members. (a) Residents shall have the right to participate in the planning of their health care. This right includes the opportunity to discuss treatment and alternatives with individual caregivers, the opportunity to request and participate in formal care conferences, and the right to include a family member or other chosen representative or both. In the event that the resident cannot be present, a family member or other representative chosen by the resident may be included in such	21830		3/30/17

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21830	Continued From page 16	21830		

conferences.

(b) If a resident who enters a facility is unconscious or comatose or is unable to communicate, the facility shall make reasonable efforts as required under paragraph (c) to notify either a family member or a person designated in writing by the resident as the person to contact in an emergency that the resident has been admitted to the facility. The facility shall allow the family member to participate in treatment planning, unless the facility knows or has reason to believe the resident has an effective advance directive to the contrary or knows the resident has specified in writing that they do not want a family member included in treatment planning. After notifying a family member but prior to allowing a family member to participate in treatment planning, the facility must make reasonable efforts, consistent with reasonable medical practice, to determine if the resident has executed an advance directive relative to the esident's health care decisions. For purposes of this paragraph, "reasonable efforts" include:

(1) examining the personal effects of the resident;

(2) examining the medical records of the resident in the possession of the facility;

(3) inquiring of any emergency contact or family member contacted under this section whether the resident has executed an advance directive and whether the resident has a physician to whom the resident normally goes for care; and

(4) inquiring of the physician to whom the resident normally goes for care, if known, whether the resident has executed an advance directive. If a facility notifies a family member or designated emergency contact or allows a family member to participate in treatment planning in

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21830	Continued From page 17 accordance with this paragraph, the facility is not liable to resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. (c) In making reasonable efforts to notify a family member or designated emergency contact, the facility shall attempt to identify family members or a designated emergency contact by examining the personal effects of the resident and the medical records of the resident in the possession of the facility. If the facility is unable to notify a family member or designated emergency contact within 24 hours after the admission, the facility shall notify the county social service agency or local law enforcement agency that the resident has been admitted and the facility has been unable to notify a family member or designated emergency contact. The county social service agency and local law enforcement agency shall assist the facility in identifying and notifying a family member or designated emergency contact. A county social service agency or local law enforcement agency that assists a facility in implementing this subdivision is not liable to the resident for damages on the grounds that the notification of the family member or emergency contact or the participation of the family member was improper or violated the patient's privacy rights. This MN Requirement is not met as evidenced by: Based on interview and document review, the facility failed to provide a resident the opportunity to make choices regarding baths and schedules for 1 of 3 (R14) residents reviewed with concerns	21830	Corrected	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00078	A. BUILDING: _____ B. WING _____	02/24/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - CLEARBROOK	305 3RD AVENUE SOUTHWEST CLEARBROOK, MN 56634

(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) COMPLETE DATE
21830	Continued From page 18 regarding these choices. Findings include: R14's quarterly Minimum Data Set (MDS) Dated 1/1/17, indicated R14 was alert and orientated and required extensive assistance of one staff for personal hygiene. On 2/21/17, at 3:30 p.m. R14 stated he was allowed to have one bath a week, everyone received only one bath a week. He stated he had not been given a choice as to how often he would like a bath. R14's care plan dated 2/2/17, directed the staff to provide assistance with a weekly bath. The Nursing Admit Re-admit Data Collection tool dated 4/17/15, indicated R14 preferred a shower/whirlpool bath during the day but did not indicate if R14 was asked how frequently he would like a bath. Review of the R14's medical record indicated R14 had not been questioned regarding his bathing preferences since 2015. On 2/24/17, at 9:00 a.m. the social service designee (SSD) stated she did not talk to the residents' about their bathing preferences rather, the nursing staff determined the bathing routines for the residents'.	21830		

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21830	Continued From page 19 On 2/24/17, at 9:10 a.m. nursing assistant (NA)-A stated she did not know how the bathing schedule was established. NA-A reviewed the bathing schedule and verfied R14 received a weekly bath on Wednesday evenings. On 2/24/17, at 10:30 a.m. registered nurse (RN)-A stated newly admitted residents were asked about their bathing preference upon admission. RN-A confirmed R14 had not been asked about his personal bathing preferences since his admission and to her knowledge had not expressed further concerns regarding additional baths. She confirmed a discussion regarding bathing preferences had not been held since R14's admission to the facility. On 2/24/17, at 11:30 a.m. RN-A reported she had spoken to R14 and he did wish to have two baths a week so she added a second bath to the bathing schedule for R14. On 2/24/17, at 2:10 p.m. the director of nurses (DON) stated the residents' were asked about bathing preference upon admission and at anytime a resident wished, they could request additional baths. However, the DON confirmed R14 was last offered the opportunity for additional baths at admission to the facility two years ago. A policy related to resident choice/ bathing schedule was requested and none was provided.	21830		

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21830	Continued From page 20 Suggested Method of Correction: The director of nurses could review and revise the policies related to residents bath schedules and provide education to all involved staff members. The quality assurance committee could develop a system to monitor resident baths and ongoing compliance. Time Period for Correction: Twenty one (21) days.	21830		