DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

May 7, 2018

Ms. Jennifer Rowinski, Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, MN 55912

Subject: Good Samaritan Society - Comforcare - IDR CMS Certification Number (CCN) 245317 Project # S5317030

Dear Ms. Rowinski:

This is in response to your letter of March 12, 2018, in regard to your request for an informal dispute resolution (IDR) for the federal deficiencies at tag F684, F867, issued pursuant to the survey event 9GS811, completed on February 8, 2018.

The information presented with your letter and conversation during a phone conference, the CMS 2567 dated February 8, 2018 and corresponding Plan of Correction, as well as survey documents, documents submitted and discussion with representatives of L&C staff have been carefully considered and the following determination has been made:

F684 S/S – (D) 42 CFR § 483.25: Quality of Care

Summary of the facility's reason for IDR of this tag.

Good Samaritan Society-Comforcare is requesting the citation be removed because they are in compliance with the regulatory language of 483.25. The facility feels that while it is good practice to document leading up to a resident's death, there is no regulation that requires this. R42 and R192 had no change in condition prior to the time of their deaths that would warrant nursing progress note documentation. All care and medications were given and documented appropriately.

Summary of facts:

At the time of survey, the surveyor had difficulty accessing the Electronic Health Record so had asked for copies of documentation regarding R42 and R192's care. During the IDR conference call, the facility alleged the information was available during survey and for IDR review submitted additional documentation including the Medication Administration Record (MAR), Treatment Administration Record (TAR) and Discharge Summary which indicated treatments and medications had been provided for R42 and R192. Although the facility did not have narrative notes documents, based on the additional information provided, it was apparent care had been provided.

Good Samaritan Society - Comforcare May 7, 2018 Page 2

Summary of findings:

This is not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

F867 S/S – (F) 42 CFR § 483.75(g)(2)(ii): QAPI/QAA Improvement Activities

Summary of the facility's reason for IDR of this tag:

Good Samaritan Society-Comforcare requests that this citation be removed because the facility asserts they were in compliance with the regulatory language of 483.75(g)(2) and 42 CFR § 483.25: Quality of Care.

Summary of facts:

At the time of survey, the surveyor had difficulty accessing the Electronic Health Record so had asked for copies of documentation regarding R42 and R192's care. During the IDR conference call, the facility alleged the information was available during survey and for IDR review submitted additional documentation including the Medication Administration Record (MAR), Treatment Administration Record (TAR) and Discharge Summary which indicated treatments and medications had been provided for R42 and R192. Although the facility did not have narrative notes documented, based on the additional information provided, it was apparent care had been provided.

Summary of findings:

This in not a valid example of a deficient practice under this regulation and will be removed from the Statement of Deficiencies.

The revised Statement of Deficiencies is attached.

This concludes the Minnesota Department of Health informal dispute resolution process.

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

Sincerely,

Susanne Reuss

Susanne Reuss, Unit Supervisor Licensing and Certification Program Health Regulation Division Telephone: 651-201-3793

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cc: Office of Ombudsman for Long Term Care Pam Kerssen, Assistant Program Manager Maria King, Assistant Program Manager Gary Nederhoff, Rochester District Office Supervisor

							APPROVED
						OMB NO. 0938-0391 (X3) DATE SURVEY	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY IPLETED
		245317	B. WING				C 08/2018
NAME OF F	PROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2010
					01 17TH STREET NE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		A	USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
E 000	Initial Comments		EC	000			
5 000	Emergency Prepare conducted February recertification surver with the Appendix Z Requirements.	iance with CMS Appendix Z edness Requirements, was y 5, 6, 7, & 8, 2018, during a ey. The facility is in compliance Z Emergency Preparedness					
F 000	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483 Requirements for L The facility's plan o as your allegation o Department's accep	7, & 8, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements	FC				
F 550 SS=D	be used as verificat Upon receipt of an revisit of your facilit validate that substa	tion of compliance. acceptable POC an on-site y may be conducted to untial compliance with the en attained in accordance with ercise of Rights	F 5	550			3/16/18
	self-determination, access to persons a outside the facility, this section.	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in sility must treat each resident					
LABORATORY	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	NATURE		TITLE		(X6) DATE
Electron	ically Signed						03/09/2018

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.

DEDADTMENT OF LIEALTH AND LIUMANN CEDVICES

STATEMENT	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DATE	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:		G	`́сом	PLETED
		245317	B. WING			C 0 8/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	02/	00/2010
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
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F 550	resident in a manner promotes maintena her quality of life, re- individuality. The fa promote the rights of §483.10(a)(2) The fa access to quality ca severity of condition must establish and practices regarding provision of service residents regardless §483.10(b) Exercis The resident has the rights as a resident or resident of the U §483.10(b)(1) The resident can exerci interference, coerci from the facility. §483.10(b)(2) The free of interference reprisal from the fa- rights and to be sup exercise of his or h subpart. This REQUIREMEN	gnity and care for each er and in an environment that ince or enhancement of his or ecognizing each resident's icility must protect and of the resident. facility must provide equal are regardless of diagnosis, n, or payment source. A facility maintain identical policies and transfer, discharge, and the es under the State plan for all as of payment source. e of Rights. he right to exercise his or her of the facility and as a citizen inited States. facility must ensure that the se his or her rights without ion, discrimination, or reprisal resident has the right to be , coercion, discrimination, and cility in exercising his or her oported by the facility in the er rights as required under this NT is not met as evidenced	F 55			
	Based on observat document review, t 1 resident (R145) re	tion, interviews, and he facility failed to ensure 1 of eviewed for dignity was treated anner during a therapy		Preparation and execution of this response and plan of correction of constitute an admission or agreed the provider of the truth of the face alleged or conclusions set forth in statement of deficiencies. The pla	loes not nent by ts i the	

Facility ID: 00967

If continuation sheet Page 2 of 27

		AND HUMAN SERVICES			FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION	(X3) DATI COM	E SURVEY PLETED
		245317	B. WING			C 08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STA	-	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
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F 550	with diagnosis of publockage in lung arrehabilitation therap form. During initial intervi R145 stated in regat (RN)-B, "Well, first job." I think she [RN something, it was F girls were in here a in and plopped dow happens again I'm [RN-B] then contin statements that did she did not want to burden." While talk looked at door, doo and then quickly clo identification of self During interview on Family Member (FN was upset with a nut to long ago. FM-A s facility when this ind During follow-up int 2:09 p.m., R145 sta anyone about the ir was asked if comfo services in the futur want her near me."	acility on 2/1/18, from hospital ulmonary embolism (a sudden tery) for short-term by according to the admission ew on 2/6/18, at 12:52 p.m., ards to registered nurse of all she [RN-B] hates her N-B] was called in or Friday, morning. The therapy t the time. She [RN-B] came <i>n</i> on the bed and said, 'If this just going to have to leave.' ue with other stupid not pertain to me. "I felt like be here and that I was a king R145 stopped talking and or had opened about 2 inches beed. No knock on the door or opening door was heard. 2/7/18, at 1:06 p.m. with M)-A who had confirmed R145 urse who come into room not said she had not been at cident occurred. terview on 2/7/18, with R145 at ated that he had not told hoident with RN-B. When R145 with don't view with occupational		 50 correction is preparers solely because it is reprovisions of federal the purposes of any center is not in subsimit federal requirem this response and pl constitutes the center compliance in accord 7305 of the State Op 1. R145 and family 2/8/2018 by social wincident. Resident remental distress relat Social worker encoureport concerns to si RN-B was provided reducation by the DO by surveyors regardidignity. R145 is now 2. All interview able interviewed to ensurrin a respectful mann 3. All staff will be peducation by the Social society pfor ensuring resident Education was giver 2/12/2018 regarding dignity and reporting 4. Audits will be co Worker or designee interview able resider resident dignity is be X4, monthly X3, with reported to Quality Context and the provided of the social worker or designee interview able resident dignity is be X4, monthly X3, with reported to Quality Context and Social worker or designee interview able resident dignity is be X4, monthly X3, with reported to Quality Context and Social worker or designee interview able resident dignity is be X4, monthly X3, with reported to Quality Context and Social worker or designee interview able resident dignity is be X4, monthly X3, with reported to Quality Context and Social worker or designee interview able resident dignity is be X4, monthly X3, with reported to Quality Context and Social Worker or Context and Social Worke	ed and/or executed equired by the and state law. For allegation that the tantial compliance nents of participation, an of correction er s allegation of dance with section berations Manual. were interviewed on orker regarding the ports no emotional or ed to the incident. raged resident to taff in the future. with immediate N upon being notified ng facility policy on deceased. e residents have been e that they are treated er. rovided with cial Worker or 18 regarding Good olicy and procedure t dignity and reporting. to therapy staff on ensuring resident nducted by Social on 5 random ints to ensure their ing upheld, weekly	
		OTR)-A, on 2/7/18, at 3:03		reported to Quality C recommendations.	If continuation sheet	

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		AND HUMAN SERVICES				FORM	APPROVED
		& MEDICAID SERVICES		TIDI			0938-0391
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NAME OF F	PROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			201 17TH STREET NE		
				Α	USTIN, MN 55912		
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ind	,				DEFICIENCY)		
		0					
F 550	Continued From pa	-	F 5	550			
		med that during her initial on 2/2/18 around 9:00 a.m. a					
	nurse came into the	e room and was a little					
		made the comments that "I'm					
		working now, and wanting to so stated that it was the nurse,					
	R145, and herself in	n the room during this incident.					
		ppropriate for the nurse to say					
	the things she said	10 1 1 4 3.					
		2/8/18, at 1:06 p.m., with					
		(DON) who said, "My ide care that is respectful and					
		ered, according to the resident					
	performances. This	should not have been a					
	conservation in from	nt of resident."					
	Review of policy ar	nd procedure "Resident					
	Dignity" revision da	te 2/2017 included:					
		omote resident care in a environment that maintains or					
		ident's dignity and respect in					
	full recognition of hi	s or her individuality.					
	Procedure:	dent's social status by					
		lly, listening carefully and					
	treating residents w	/ith respect.					
		nt as individuals when nem and addressing them as					
		oviding cares and services.					
F 578	Request/Refuse/Ds	contrue Trmnt;FormIte Adv Dir	F 5	578			3/16/18
SS=D	CFR(s): 483.10(c)(6	6)(8)(g)(12)(i)-(v)					
	§483.10(c)(6) The r	ight to request, refuse, and/or					
	discontinue treatme	ent, to participate in or refuse					
	to participate in exp formulate an advan	erimental research, and to					
	ionnulate an auvan						

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		& MEDICAID SERVICES				. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				E SURVEY	
			A. DOILDING	A	С		
		245317	B. WING			08/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C			
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 578	Continued From pa	ige 4	F 578	3			
	§483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.						
	requirements speci subpart I (Advance (i) These requirements inform and provide residents concernin medical or surgical resident's option, for (ii) This includes a vertice facility's policies to and applicable Statt (iii) Facilities are per- entities to furnish the legally responsible requirements of this (iv) If an adult indivi- time of admission at information or article has executed an ad- may give advance of individual's resident with State Law. (v) The facility is not provide this information or she is able to recor- Follow-up procedur the information to the appropriate time. This REQUIREMENt	ents include provisions to written information to all adult ng the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives e law. ermitted to contract with other his information but are still for ensuring that the					
	facility failed to ider	v and document review, the htify the preference for Health 1 of 1 resident (R4) reviewed		1. R4 s code status was i entered into the electronic n on 2/5/2018. R4 expired on	nedical record		

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TATEMENT	OF DEFICIENCIES OF CORRECTION	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY IPLETED	
		245317				C / 08/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD		00/2010	
good s	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE	
F 578	Continued From pa	-	F 578	3			
	for advanced direct	tives.		2. All resident s electronic m			
	Findings include:			records were reviewed on 2/5/ ensure a code status was door per the resident s choice.			
	according to the ac obtained from the e (EMR) which includ pulmonary disease congestive heart fa and gastrointestina R4's quarterly Minin an assessment dat brief interview for n	d to the facility on 2/2/18 Imission form, with diagnoses electronic medical record ded chronic obstructive with acute exacerbation, ilure, pulmonary hypertension I bleeding. mum Data Assessment (MDS) red 11/7/17, included R4 had a nental status (BIMS) score of I R4, had intact cognition.	\ (All nurses will be provided education on GSS policy and p for advanced care planning an status documentation by DON designee on 3/16/2018. Audits will conducted by H designee to ensure all resident status are documented in the e medical record, weekly X4, mo with results being reported to C Committee for further recomm 	orocedure d code or IM or t s code electronic onthly X3, Quality		
	R4's EMR was revi no code status had return from the hos nurse (RN)-A and t	ewed on 2/5/18, and identified been identified upon R4's pital on 2/2/18. Registered he director of nursing (DON), d not have an identified code					
	director of nursing printed the POLST hospitalization, and discussed this with back to the facility I stated she explained of the admission pr was concerned it w obtain a POLST ba was trying to provice education prior to F The DON stated sh	on 2/7/18, at 2:36 p.m. the (DON) stated she had actually R4 had on file prior to R4's I printed a blank POLST and the nurse prior to R4 coming Friday afternoon. The DON ed to the nurse this was a part rocess. The DON stated she rould be difficult based to used on the history of R4, so I le her with the information and R4's return from the hospital. the followed up with the nurse 4 and stated the nurse that					

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		AND HUMAN SERVICES & MEDICAID SERVICES		FOR	D: 04/26/2018 M APPROVED D. 0938-0391	
STATEMEN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION (X3) D/	(X3) DATE SURVEY COMPLETED C	
		245317	B. WING	0	2/08/2018	
NAME OF	PROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 578 F 689 SS=D	her code status and clear indication of fu The DON stated the she did not provide would have to resus [cardiopulmonary re cardiac arrest. The attempt to call the F status and stated sl message. The DON document the educ R4 or the attempt to DON stated the nur was full code in the because of this I did and provided educa procedures. Policy regarding ad requested and none Free of Accident Ha CFR(s): 483.25(d) (1) §483.25(d) Accident The facility must en §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa assess the risk for e	d R4 did not want to provide a all code or do not resuscitate. e nurse did educate R4 that if a code status that meant she scitate her and perform CPR esuscitation] if she had a DON stated the nurse did R4's daughter to discuss code he left the daughter a N stated the nurse did not ation and discussion held with o contact the daughter. The se should have indicated R4 EMR. The DON stated d put out a memo to all staff ation on advanced directive vanced directives was e provided. azards/Supervision/Devices 1)(2) tts. sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview, and document ailed to comprehensively elopement for 2 of 2 resident had a history of leaving the	F 578	 The Social Worker has assessed an care planned appropriate interventions for R12 and R14 for elopement risk. All residents at risk of elopement has been reviewed by the Social Worker and 	e ve	

Facility ID: 00967

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		245317	B. WING				C 08/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 7	F 6	89			
	Findings include:				DON to ensure their elopement risk been assessed and care plans upd appropriately with interventions to p	ated	
	facility 6/3/14. Diag obstructive pulmona disease; major dep bone; unspecified of hypertension; heart dementia with beha R14 had been obse dining room on unit On 2/7/18, at 10:00 devotions activity in 2:40 p.m. attending dining room. On 2/8/18, at 10:25 wheelchair still in pa belongings. At 10:3	a.m. R14 attending a the chapel. In addition, at BINGO in the lodge unit a.m. R14 in room in ajamas, looking though her 8 a.m. R14 in room visiting M)-A & B, who were leaving,			 appropriately with interventions to perform a composition of the provided with education on GSS policy and process of the elopement risk including assess upon admission, re-admission, and any onset of exit seeking behavior, as care planning appropriate interventions. 4. Audits of all residents at risk of elopement will be conducted by Qui Coordinator or designee to ensure assessments have been completed care plans reflect appropriate interventions, weekly x4, monthly x results being reported to Quality Committee for further recommendations. 	edure sing with as well ality d and 3, with	
	wandering behavior independent with tra- monitored for mood care sheet (Kardex) Behavior of Agitatio leave: Attempt to re- activities and snack root beer float or de monitor and ensure Behavior of agitatio intervention: Appro- wheeling around the	luded a has history of r. In addition, that she is ansfers. I/behavior per nursing assist). Care plan also included: on/talking about wanting to edirect thought process, offer as resident prefers such as ecaf coffee. Continue to resident is in a safe place. n and starting to wander each R14 right when starting to e hallway and offer things float, glass of root beer, decaf					

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		AND HUMAN SERVICES				FORM /	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		245317	B. WING			(02/0) 8/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,	ZIP CODE		
		001/2020122		1201 17TH STREET NE			
GOOD S	AMARITAN SOCIETY	- COMFORCARE		AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		CTION SHOULD THE APPROPE	BE	(X5) COMPLETION DATE
F 689	unit, to help reduce unable to keep on u hallways. Attempt to she appears to dee and being combata resident in safe pos later time. Also, ask that she has in her Review of incident to R14 had eloped fro 6/9/17, and again o R14's electronic me reviewed and revea elopement risk ass completed for R14 facility on 6/3/14, ev elopement behavio R14's incident repo 5:45 p.m. certified r received a report fro was out the front do R14's investigation report dated 6/2/17 Complaints include exited her neighbor on her ankle. Alarr neighborhood. Floo resident's room with came and notified a neighborhood that a door in between the get resident to retur and when he got to	time music on DVD player on any escalation of behavior. If unit, one staff to follow R14 in o divert her to chapel where escalate. Behavior of yelling tive intervention: Leave sition and re-approach at a k resident to show her "bike" room. reports for R14 revealed that in the facility on 5/27/17, on 7/12/17. edical record (EMR) was aled a comprehensive essment had not been since her admission to the ven though she had exhibited r in the past year. of for elopement on 5/27/17, at nursing assistant (CNA) om another CNA that resident for in the parking lot. summary vulnerable adult , to the Office of Health facility d the following: resident had shood with a wander bracelet ns did sound on her or staff were in another h an emergency. A visitor a CNA from another a resident was at the front e double doors. CNA went to rn her to her neighborhood the front door, R14 had got	F	589			
FORM CMS-25	OUT INTO THE PARKING	tot by the parked cars looking Obsolete Event ID:9GS81	1	Facility ID: 00967	lf continua	tion sheet	Page 9 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	COM	E SURVEY IPLETED C
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GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 689	for vehicle to go hol alarming and locked reoccurrence: Imm was brought back for minute checks were hours. Double door were closed until m determine if in good Long-term action pl doors to determine and wander bracele was sent to all nurs they need to assess is going off and not immediately. R14's incident repo 9:21 a.m., unable to R14 outside in encl R14's investigation report dated 6/15/1' facility Complaints i investigation it was exterior doors alarn appropriately. Mair nursing (DON) teste alarm systems imm were not alarming v residents who have put on 15-minute ch system could not co On 6/12/17, a techr company) had com wander-guard door checked each door only a few minor ad He made all annung	me. CNA stated front door was d. Action taken to prevent hediate action taken was R14 or safety. 15 min checks e care planned for the next 48 rs to resident's neighborhood aintenance could assess to d working condition. an is in place to audit exit they are working appropriately ets daily for function. A memo ing staff to re-educate that s the area when a door alarm being turned off by staff rt for elopement on 6/9/17, at o locate resident, CNA found	F 689			

If continuation sheet Page 10 of 27

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245317	B. WING	Э			08/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG	FIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	needed it. There are fixing on the doors elopement but shout technician, these are on the another wall detect the wander-op until that unit can be patio door in the Ga piece replaced. The had eloped from are The technician will make these repairs remain locked until reoccurrence: Ware assessed and being recommendations f R14's incident repo 10:00 p.m., CNA re break around 8:30 p building, in front, un resident said, "I wate R14's investigation report dated 7/20/11 facility Complaints if was found sitting ou the kids off her port working that evenin resident does like to her wheelchair. Sta neighborhood doorn around facility. Staff every 5-10 minutes resident to come ba R14 possibly follow had pushed the door get it open. R14 for	ge 10 re few adjustments that need that will not cause an uld get done per the re a key box needs to be place on the Garden to accurately guard. This is door is locked e moved. The door to the arden needs a new magnetic is is the same door resident nd why it happened so easily. be back to facility on 6/20/17, and that patio door will then. Action taken to prevent nder-guard alarm system g fixed and updated per rom technician from IFC. rt for elopement on 7/12/17, at ported the when she went on p.m. resident was outside the nder canopy. CNA reports in those kids out of my house." summary vulnerable adult 7, to the Office of Health ncluded the following: R14 ut front of the facility wanting ch. After interviewing staff ig it has been discovered that o wheel around the facility in aff had shut off alarm to the way as R14 was wheeling f then did not go check on R14 and had not tried to redirect ack to R14's neighborhood. ed a visitor out of the door or or for 15 seconds or more to und by another staff member rhood and that staff person	F	689			

If continuation sheet Page 11 of 27

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		245317	B. WING	à) 08/2018
NAME OF	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	-	
GOOD S	AMARITAN SOCIETY	- COMFORCARE			1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	brought resident ba nor is there a chang Action taken to prey was done with staff a door alarm goes of alarm and let reside place continue to w Review of progress showed R14 contin wandering on R14's up and down hallwa resident rooms, and doors, by following note dated 1/30/18, follow family memb of facility. During interview on assistant (NA)-B sta with most of care th will go assist R14 w R14 has not allowe During interview on nurse (RN)-A states assistance and will reproached and hel R14 is perfectly fine refuse and if attemp R14, can become of hitting, or yelling at During interview on maintenance-A stat guard alarm on the (healing grace, the front door, and all p	ge 11 ack to her unit. R14 not injured ge in her functional status. vent reoccurrence: Education on her unit stating that when off they cannot shut of the ent with a wander guard in the ander the building alone. a notes from 11/8/17-2/8/17, ues to have behaviors of a neighborhood by wandering ays; in and out of other d attempting to exit the front visitors. With the last progress were R14 had attempted to er (FM)-A out the front doors 2/8/18, at 10:28 a.m., nursing ated that R14 is independent hough B14 is declining and I when allows due to refusal. d me to help yet today. 2/8/18, 11:10 a.m., register s, R14 will not call for refuse care. Staff will p R14 as allows. Some days with help, the next time will ots to encourage continue combative, by kicking, or staff to get out of here. 2/8/18, at 11:15 a.m., red the he checks the wander all neighborhood doors lodge, the garden), along with vatio doors weekly, every will check each resident's	F	685			

If continuation sheet Page 12 of 27

	MENT OF HEALTH							FORM A	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUP IDENTIFICATION	PLIER/CLIA			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		24531	7	B. WING			C 02/08/2018		
NAME OF I	PROVIDER OR SUPPLIER					REET ADDRESS, CITY, STATE, Z	IP CODE	•	
GOOD S	AMARITAN SOCIETY	- COMFORCARE				D1 17TH STREET NE JSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIEN / MUST BE PRECEDEL SC IDENTIFYING INFO	BY FULL	ID PREFI TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD	BE	(X5) COMPLETION DATE
F 689	Continued From pa wanderguard brace doors and ensuring logs showed no cor During interview on director of nursing v document for elope However, everyone evaluatated, with th each elopement we scan into the reside checklist it is not pa R12 was observed wheeling around th was looking for her R12's admission re diagnoses of deme Data Set (MDS) da severely impaired of living. Review of incident the eloped from the fact R12's electronic me reviewed and revea elopement risk assis completed for R12 wandering behaviou facility on 9/17/17. R12's Incident Rep Elopement. Activity back to the Garden in the parking lot. R to a wedding. R12's investigation	elet by bringing the that alarm sound acerns. 2/8/18 at 2:42 p. who stated there is ment risk assess with a elopemen e quarterly asses e do a checklist, the medical chart. art of the resident on 2/05/18, at 9:5 e unit in her whee mother. cord identified R1 ntia. R12's apnue ted 11/28/18, india lecision-making s reports revealed R fillity on 9/17/17. edical record (EM aled a comprehen essment had not even though she r and had eloped ort dated 9/17/17, Director brought s. Stated resident tesident stated sh summary vulnera	 As. Review of m., with is no specific ment. trisk is sments, after nat we do not As it is a chart. As a.m. And thinimum cated kills for daily R12 had R) was sive been had from the , indicated: resident t was found e was going 	F	589				
FORM CMS-2	567(02-99) Previous Versions	Obsolete	Event ID:9GS811		Facil	ity ID: 00967	If continuati	on sheet P	age 13 of 27

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED	
		245317	B. WING	i		C 02/08/2018		
NAME OF	PROVIDER OR SUPPLIER							
GOOD S	AMARITAN SOCIETY	- COMFORCARE			201 17TH STREET NE USTIN, MN 55912			
(X4) ID PREFIX TAG	IX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 689	report dated 9/22/1 facility Complaints i had wheeled herse facility and went our member saw R12 of staff member that the outside that should come back inside we then went and saw building pillars in a approached R12 ar and the R12 stated did come back into with the staff member reoccurrence: R12 behavior in the pass long-term side of the come to the front de declined and so a we R12's Elopement C to be completed after the elopement police provided. During an interviewe quality director (QD elopement risk assessment co on 9/17/17. During an interviewe director of nursing (assessments were and readmission to addressed at care of	ge 13 7, to the Office of Health ncluded the following: R12 If to the front door of the t onto the sidewalk. A family but there and reported to a hey believed a resident was not be and that R12 would not with them. The staff member R12 out front between two wheelchair. The staff member nd asked what R12 was doing , "I'm going to a wedding." R12 the facility without any incident ber. Action taken to prevent did not exhibit elopement t. R12 would wheel around the e facility but would rarely bor. R12's dementia has wander guard was placed on vention of elopement. Thecklist Worksheet that was er R12 eloped on 9/17/17 per cy was requested and not f on 2/8/18, at 9:10 a.m. the there was no elopement impleted after resident eloped for 2/8/18, at 11:24 a.m. the (DON) stated elopement risk completed upon admission the facility and were conferences. The DON stated opement risk assessment to	F	589				

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		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DATE COM	E SURVEY PLETED	
		245317	B. WING		C 02/08/2018		
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 689	stated an elopemer completed if a resid behaviors that woul risk for eloping or if from the facility. The create a form that w checklist binder to b an elopement or wh increase their flight facility would also c elopement risk, the guard and if the inte DON stated she felt assessed R12's risk measures to minim after R12 eloped. T the facility did follow During an interview director of nursing (elopement did not p how to document at in one comprehens stated in the progre specific comprehen R12's elopement risk stated I personally w story (regarding R1 to tell by the docum residents' elopement at care conferences documentation did to The Elopement polit 4/2016 included, "T for maintaining a sy mechanisms and pure	an elopement. The DON th risk assessment should be lent started to display d indicate they would be at a resident had an elopement e DON stated she planned to vould be kept with the nurses' be completed when there was nen behaviors were noted that risk. The DON stated the ontinue to review residents' continued need for a wander erventions were effective. The t like they (facility staff) k for elopement and placed ize the risk of the elopement he DON stated she felt like v their policy for elopement. on 2/8/18, at 2:05 p.m. the DON) said the policy for provide a clear indication of n elopement risk assessment ive assessment. The DON ss notes there was not a isive summary analysis of sk assessment. The DON would like to know the whole 2's elopement) and am unable entation. The DON stated nt risk was reviewed quarterly s, but R12's care conference not reflect this. Expand procedure revised he location will be responsible ystem that clearly defines the procedures for monitoring and	F 68				
	stated I personally v story (regarding R1 to tell by the docum residents' elopemen at care conferences documentation did The Elopement poli 4/2016 included, "T for maintaining a sy mechanisms and p	would like to know the whole 2's elopement) and am unable entation. The DON stated nt risk was reviewed quarterly s, but R12's care conference not reflect this. The location will be responsible responsible responsible responsible responsible					

If continuation sheet Page 15 of 27

		& MEDICAID SERVICES	1		<u>1B NO. 0938-0</u>
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDI		С
		245317	B. WING _		02/08/2018
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	
F 689	include identifying e resident risk; evalu- risks; implementing monitoring/modifyir residents will be as through the pre-adu process and as nee occurred, use the E Worksheet that foll all required steps w	environmental hazards and ating/analyzing hazard and		39	
F 695 SS=D	Respiratory/Trache CFR(s): 483.25(i) § 483.25(i) Respirat tracheostomy care The facility must er needs respiratory of care and tracheal s care, consistent with practice, the compri- care plan, the reside and 483.65 of this s This REQUIREMENT	and tracheal suctioning. sure that a resident who are, including tracheostomy uctioning, is provided such h professional standards of ehensive person-centered ents' goals and preferences,	F 69	95	3/16/18
	review, the facility f order was in place (R2) reviewed for re Findings include: R4 was observed of chapel participating oxygen in place.	tion, interview and record ailed ensure a physician's for oxygen for 1 of 2 residents espiratory care. n 2/5/18, at 10:13 a.m. in the i n a coloring activity. R4 had I to the facility on 2/2/18		 An oxygen order was obtained f the physician for R4 and added to th electronic medical record on 2/6/20 All residents records who utiliz oxygen were reviewed to ensure an oxygen order was in place on 2/6/20 Re-education will be provided to nurses on 3/16/2018 regarding the process of ensuring a physician s o is in place for resident s requiring respiratory care. Audits will be conducted by DOI 	ne 18. :e 018. 0 0 rder

Event ID:9GS811

Facility ID: 00967

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TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA			E CONSTRUCTION	(X3) DATI	0938-039
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			PLETED
		245317	B. WING				
	PROVIDER OR SUPPLIER	245317	D. WING		TREET ADDRESS, CITY, STATE, ZIP CODE	02/	08/2018
	noviden on our der elen				201 17TH STREET NE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 695	Continued From pa	ne 16	F 6	95			
1 000	 Gontinued From page 16 according to the admission form, with diagnoses obtained from the electronic medical record (EMR) which included chronic obstructive pulmonary disease with acute exacerbation, congestive heart failure, pulmonary hypertension and gastrointestinal bleeding. 		FO	95	designee on residents requiring respiratory care to ensure orders a present, weekly X4, monthly X3, w results being reported to Quality Committee for further recommend	<i>v</i> ith	
	R4's quarterly Minimum Data Set (MDS) an assessment dated 11/7/17, included R4 had a brief interview for mental status (BIMS) score of 15, which indicated R4, had intact cognition.						
	record (EMR) were	ers in the electronic medical reviewed and revealed R4 ers for oxygen therapy.	10		EV		
	respiratory status/d chronic obstructive	ed 10/2/17, included R4 altered ifficulty breathing related to culinary disease. Interventions erapy per medical doctor					
	licensed practical n orders for oxygen s computer. LPN-B v	on 2/6/18, at 6:46 p.m. urse (LPN)-B stated R4's should be in the orders in the erified the orders in the EMR order for oxygen. LPN-B stated					
	hospitalized and sta on 3 liters of oxygen previous order prior	ers of oxygen prior to being ated she just assumed R4 was n as that had been her r to being in the hospital. vas her first night working on					
	this unit since R4's when she came in a had been set to 3 li	hospital return. LPN-B stated on her shift the concentrator ters and she has not made B looked through the hospital					
	discharge summary order for oxygen. L	y and was not able to locate an PN-B stated she would need rder for R4's oxygen right					

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		AND HUMAN SERVICES			FORM	: 04/26/2018 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245317	B. WING		02	C / 08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	X (EACH CORRECT CROSS-REFERENC	PLAN OF CORRECTION TIVE ACTION SHOULD BE CED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE
F 695 F 756 SS=D	from the hospital or oxygen order upon gotten an order for one of her main iss During an interview director of nursing (R4 was readmitted nurse should have the doctor if R4 retu oxygen and there w the hospital dismiss During an interview director of nursing (dismissal summary oxygen. The DON w orders in place for L after it was brought through the survey Drug Regimen Rev CFR(s): 483.45(c)(1) \$483.45(c)(1) The of must be reviewed a licensed pharmacis \$483.45(c)(4) The p irregularities to the facility's medical dir and these reports m (i) Irregularities inc	d when a resident returned n oxygen and there was not an readmission she would have oxygen, especially for her as ues is being short of breath. To n 2/6/18, at 7:10 p.m., the (DON) stated absolutely when from the hospital the admitting obtained an oxygen order from urned from the hospital on vas not an order for oxygen in sal summary. To n 2/7/18, at 2:25 p.m. the (DON) stated the hospital did not include orders for verified there were no oxygen R4 from 2/2/18 until 2/6/18, to the facilities attention process. iew, Report Irregular, Act On 1)(2)(4)(5) egimen Review. drug regimen of each resident at least once a month by a st.	F 7	595		3/16/18
	67(02-99) Previous Versions	Obsolete Event ID:9GS81	r	Facility ID: 00967	If continuation sheet	

ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE CONSTRUCTION	(X3) DAT	0938-039	
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING			
		245317	B. WING			C 08/2018	
IAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		00/2010	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		HOULD BE	(X5) COMPLETIO DATE	
F 756	Continued From pa	ige 18 or an unnecessary drug.	F7	756			
	during this review n separate, written re attending physician director and director minimum, the resid and the irregularity (iii) The attending p resident's medical irregularity has bee action has been tak be no change in the physician should do the resident's medi §483.45(c)(5) The f maintain policies and drug regimen revie limited to, time fran the process and ste when he or she ide requires urgent act This REQUIREMEN by: Based on interview facility failed to ens regimen recommen	s noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical or of nursing and lists, at a lent's name, the relevant drug, the pharmacist identified. obysician must document in the record that the identified n reviewed and what, if any, ken to address it. If there is to e medication, the attending boument his or her rationale in cal record. facility must develop and nd procedures for the monthly w that include, but are not ness for the different steps in eps the pharmacist must take ntifies an irregularity that ion to protect the resident. NT is not met as evidenced w and document reviews, the ure that pharmacist drug ndations were evaluated and ician and that a sleep		1. A sleep study and assess completed on 2/20/2018 for F 2. All pharmacy recommend the past 2 months will be revi	R14. dations for		
	assessment was completed for 1 of 5 residents (R14) reviewed for unnecessary medications. Findings include: R14 admitted to the facility 6/3/14 according to the admission form also included chronic obstructive pulmonary disease; chronic kidney disease; major depressive disorder; disorder of bone; unspecified osteoarthritis; unspecified			ensure they have been addresappropriately.3. All nurses will be provideeducation on the center proce	d with ess that has		
				been developed and put in pl ensure pharmacy recommen addressed appropriately and pharmacist will communicate the recommendations to the now delegate completion to r	dations are timely. The and route DON who will		

Facility ID: 00967

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TATEMENT	OF DEFICIENCIES	A MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DAT CON	<u>. 0938-039</u> E SURVEY MPLETED C
		245317	B. WING			/08/2018
	PROVIDER OR SUPPLIER	- COMFORCARE	1	BTREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIC DATE
F 756	hypertension; hear dementia with beha R14's Care plan increlated to interrupted Intervention includer respond due to slor skills. Adjust enviror follow R14's usual bed between 7-9 p lights off, keeping r with door slightly cl health care provider reduction when clir as needed. Pharmacy consulta 12/30/17, indicated month drug reevalt medications: Zoloff depression /demer With the following r of Benadryl must b ordered for sleep. Per electronic reco completed on 12/3. Physician ordered Benadryl Tablet 25 time a day related to behavioral disturba mouth one time a c Zoloft Tablet 50 MC time a day related to	t failure; insomnia; unspecific avioral disturbance. dicates sleep disturbance ed sleep during the night. e allow resident time to wer processing of cognition onment to promote sleep, bedtime routine, likes to be in m. Resident prefers room nightlight or bathroom light on osed. Consult with pharmacy, er, etc. to consider dosage nically appropriate. Sleep study ant recommendation dated t that R14 was due for a six uation for the following t 50 milligrams (MG) in a.m. for ntia: Benadryl 50 mg for sleep. recommendations: dose hold e attempted since this was And sleep assessment. and sleep assessment was /16. medications are: MG Give 25 mg by mouth one to unspecified dementia with unce, and Give 50 mg by day related to insomnia. G Give 50 mg by mouth one to depression visit note dated 1/18/18 had		and will track responses to ens appropriate and timely complet nurses will be provided educati process related to pharmacy cor recommendations on 3/16/201 4. Audits will be conducted by Coordinator or designee on the completion of pharmacy consu recommendations monthly X3, X3, with results being reported Committee for further recommendations	ion. All on on the onsultant 3. v Quality Itant quarterly to Quality	

STATEMENT OF DERIGENCIES [XI] PROVIDERSUPPLIERCIAL IDENTIFICATION NUMBER: PAILAUTIFIC CONSTRUCTION A. BUILDING (XI) PROVIDERS UPPLIER (XI) PROVIDERS (XIII) (XIII) PROVIDERS (XIIII) (XIIIII) PROVIDERS (XIIIII) (XIIIIIIIIIIII) (XIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII			AND HUMAN SERVICES			FORM	D: 04/26/2018 MAPPROVED D. 0938-0391
245317 B. WING 02/08/2018 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2/P CODE 1201 17TH STREET NE 2020 5 GOOD SAMARITAN SOCIETY - COMFORCARE International provider of supplication of the supplic	-						MPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE GOOD SAMARITAN SOCIETY - COMFORCARE 1201171W STREET NE AUSTIN, MN 55912 IVAL ID PHETIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST ER PREVENCE OB SY FLUL REGULATORY OR LSC DENTIFYING INFORMATION) ID PROVIDERS OF AUTON OF CORRECTION (EACH OPERICIENCY MIST ER PREVENCE OB SY FLUL REGULATORY OR LSC DENTIFYING INFORMATION) PROVIDERS OF AUTON OF CORRECTION (EACH CORRECTIVE ACTION SHOLD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) F 756 Continued From page 20 pharmacists recommendations as written by the pharmacist on 12/30/17. F 756 When asked if sleep assessment for R14 was completed after 12/20017, per pharmacist recommendation, Received monthly nursing documentation and highlighted areas: c. trouble fail or staying asleep, or sleeping too much, not checked, and j. none of the above, checked. However, it lacked a comprehensive assessment of Current sleep pattern. During interview on 2/8/18, at 4:04 p.m. with Director of Nursing (DON) regarding the monthly nursing documentation and highlighted aftes. DON stated, "That is all can find of sleep alter 12/30/17." When asked, DON is have would consider the documentation given a complete sleep assessment. DON stated, "No." F 757 Drug Regimen is Free frem Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d)(1) he excessive dose (including duplicate drug therapy); or \$483.45(d)(2) For excessive duration; or \$483.45(d)(2) Without adequate monitoring; or \$483.45(d)(4) Without adequate indications for its			245317	B. WING		02	
GOOD SAMARITAN SOCIETY - COMPORCARE AUSTIN, MN 55912 (K4)10 PHEFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST BE PHACEDED BY FULL) REQUERTED AT CONFECTION REQUERTED AT CONFECTION RECUERTED AT CONFECTION REQUERTED AT CONFECTION REQUERTED AT CONFECTION REQUERTED AT CONFECTION REQUERTED AT CONFECTION RECUERTED AT THE RECUERTED AT THE RECUERTED AT THE RECUERTED AT RECUERTED AT THE RECUERTED AT THE RECUERTED AT THE RECUERTED	NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD		<u> </u>
PREFIX TAG (EACH DEFICIENCY ALLS LIBENTEYING INFORMATION) PRECULATORY OR LSC IDENTEYING INFORMATION) PRECULATORY OR LSC IDENTIFYING INFORMATION F756 F756 F757 Info IDENTIFYING INFORMATION INTEGERS IN DIAGONAL IDENTIFY INFORMATION INFORMATION INFORMATION F757 F757 F757 SS=D CFR(s): 483.45(d)(1)-(6) F757 F757 S760(1) S483.45(d)(1) Info IDENTIFY INFORMATION INFOR	GOOD S	AMARITAN SOCIETY	- COMFORCARE				
 pharmacists recommendations as written by the pharmacist on 12/30/17. When asked if sleep assessment for R14 was completed after 12/30/17, per pharmacist recommendations. Received monthly nursing documentation, dated 1/12/18, under section for behavioral symptoms or moods with highlighted areas: c. trouble fall or staying asleep, or sleeping too much, not checked, and j. none of the above, checked. Howver, it lacked a comprehensive assessment of current sleep pattern. During interview on 2/8/18, at 4:04 p.m. with Director of Nursing (DON) regarding the monthly nursing documentation and highlighted areas. DON stated, "That is all I can find tor sleep asters. DON stated, "That is all I can find tor sleep asters ment. DON stated, "No." F 757 Drug Regimen is Free from Unnecessary Drugs Ceneral. Each resident's drug regimen must be free from unnecessary drug. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(4) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its 	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP	HOULD BE	COMPLETION
• • • • • • • • • • • • • • • • • • • •	F 757	pharmacists recompleted after 12/3 When asked if slee completed after 12/3 recommendations. documentation, dat behavioral symptor areas: c. trouble fa sleeping too much, the above, checked comprehensive assist pattern. During interview on Director of Nursing nursing documenta DON stated, "That 12/30/17." When a consider the docum sleep assessment. Drug Regimen is F CFR(s): 483.45(d)(§483.45(d) Unnece Each resident's dru unnecessary drugs drug when used- §483.45(d)(1) In ex duplicate drug thera §483.45(d)(2) For ex §483.45(d)(3) With	mendations as written by the a0/17. p assessment for R14 was 30/17, per pharmacist Received monthly nursing ted 1/12/18, under section for ns or moods with highlighted all or staying asleep, or not checked, and j. none of d. However, it lacked a sessment of current sleep 2/8/18, at 4:04 p.m. with (DON) regarding the monthly tion and highlighted areas. is all I can find for sleep after asked, DON if she would nentation given a complete DON stated, "No." ree from Unnecessary Drugs 1)-(6) essary Drugs-General. Ig regimen must be free from . An unnecessary drug is any cessive dose (including apy); or excessive duration; or out adequate monitoring; or		56		3/16/18
		-	out adequate indications for its				

If continuation sheet Page 21 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391			
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED				
		245317	B. WING		C 02/08/2018				
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE					
GOOD SAMARITAN SOCIETY - COMFORCARE				1201 17TH STREET NE AUSTIN, MN 55912					
(X4) ID PREFIX TAG			ID PREFIX TAG	X (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)					
	REGULATORY OR LS Continued From pa §483.45(d)(5) In the consequences which reduced or discontin §483.45(d)(6) Any of stated in paragraph section. This REQUIREMEN by: Based on interview facility failed to provide attempt nonpharmation for 3 of 5 residents unnecessary medic Findings include: According to the face the facility 6/3/14. If obstructive pulmonation disease; major depul- bone; unspecified of hypertension; heart dementia with behar R14's care plan include: alteration in comform non-pharmacologication encourage R14 to whas pain. R14 is ab independently. Obs irritation when using According to R14's	ge 21 e presence of adverse ch indicate the dose should be nued; or combinations of the reasons s (d)(1) through (5) of this NT is not met as evidenced and document review, the vide adequate parameters and cological pain interventions (R14, R40, R15) reviewed for ations. ce sheet R14 was admitted to Diagnoses included chronic ary disease) chronic kidney ressive disorder; disorder of osteoarthritis; unspecified failure, insomnia; unspecific vioral disturbance. Iuded the potential for t related to osteoarthritis, al interventions included, wear left wrist brace when she le to on /off brace erve skin for redness or g brace. current physician orders, the		CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	ations and ns urses and ding and N or utilized ers are h	COMPLETION DATE			
	ordered; Ultram 50 rate of 1-5 out of a worst pain ever. R4 10 times in Decemb 2018, and 2 times F	d pain medication were mg for Pain-Moderate pain 1 to 10 scale with 10 being 0 received as needed Ultram ber 2017, 8 times in January February 1 to 6, 2018. No al attempts had been							

Facility ID: 00967

If continuation sheet Page 22 of 27

					0(0) = -	D. 0938-039	
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245317	B. WING _		C 02/08/2018		
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
GOOD S	SAMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETIO DATE	
F 757	documented prior t pain medication. According to the fa facility on 1/15/18, spine, after a fall a R40's care plan ind pain/discomfort rel fracture of thoracid L4 back pain, wear (Thoracolumbosad left knee swelling s osteoarthritis. Appr non-pharmacologid lay down and use p According to the m (MAR) R40 had an medications: Oxycodone 5 mg ta moderated pain; to 1/16/18, for 7 days moderate pain sco pain of score of 7- received oxycodom 1/16/18. No docum non-pharmacologid administrating as n Percocet 5-325 mg needed for moderate on 1/26/18, for 10 d times in the 10 day of any non-pharmac prior to administratin noted.	to administration of as needed ace sheet, R40 admitted to with diagnosis of fracture to t home. dicated R40 has ated to wedge compression c (T) T11 -T12 and lumbar (L) rs a TLSO cral Orthosis) back brace. and secondary to advanced roaches to try for pain: attempt cal inventions: R40 prefers to billows on her sides. nedication administration record norders for the following pain ablet every 8 hours for severe pain started on one table as needed for re of 4-6 out of 10 or severe 10 out 10 for 7 days. R40 ne 11 times since ordered on nentation of any cal attempted prior to needed oxycodone were noted. g tablet give 1 tablet 8 hours as ate to severe pain was started days. R40 received Percocet 8 /s ordered. No documentation acological intervention attempts ting as needed Percocet were	F 75				
	(MAR) R40 had an medications: Oxycodone 5 mg ta moderated pain; to 1/16/18, for 7 days moderate pain sco pain of score of 7- received oxycodon 1/16/18. No docum non-pharmacologid administrating as n Percocet 5-325 mg needed for modera on 1/26/18, for 10 d times in the 10 day of any non-pharma prior to administrat noted. Tylenol (Acetamino by mouth every for	a orders for the following pain ablet every 8 hours for o severe pain started on o one table as needed for ore of 4-6 out of 10 or severe 10 out 10 for 7 days. R40 the 11 times since ordered on neetation of any cal attempted prior to needed oxycodone were noted. g tablet give 1 tablet 8 hours as ate to severe pain was started days. R40 received Percocet 8 vs ordered. No documentation acological intervention attempts					

If continuation sheet Page 23 of 27

		AND HUMAN SERVICES					FORM A	04/26/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			DNSTRUCTION		(X3) DATE COMF	SURVEY PLETED
		245317	B. WING	i		C 02/08/2018		
NAME OF I	PROVIDER OR SUPPLIER	•			ET ADDRESS, CITY, STATE, ZI	IP CODE	-	
GOOD S	AMARITAN SOCIETY	- COMFORCARE			17TH STREET NE TIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD	BE	(X5) COMPLETION DATE
F 757	prior administrating noted. R15's admission fa the facility on 9/22/ fracture, back pain The quarterly Minin an assessment, inc pain. According to the me (MAR) dated 2/201 Tramadol 50 mg ev Tylenol 1000 mg by needed for pain. N the MAR as to whe given. During an interview (LPN)-A on 2/7/18, were nonpharmaco would be document although she stated them even when th In an interview with 2/7/18 at 2:04 p.m. documentation has addressed this with which was held 1/2 facility has been hit and documenting n interventions. A facility policy revision nonpharmacological prior to or in conjunt	cological intervention attempts as needed Tylenol were ce sheet included admitted to 15, including diagnosis of a hip and dementia with behaviors. num Data Set dated 12/12/17 dicated R15 had occasional edication administration record 8, R15 had an order for very 6 hours for pain and y mouth every 8 hours as to parameters were noted on n each medication should be with licensed practical nurse at 1,31 p.m.stated if there blogical interventions done they ted in the medical record, d they do not always document ey are done. the director of nurses on , she acknowledged that been an issue and she had the nurses at the last meeting 3/18. She verified that the and miss with parameters, ionpharmacological sed on 5/2017, indicated that al interventions should be tried action with pain medication.		757				
FORM CMS-25	567(02-99) Previous Versions	Obsolete Event ID:9GS81	1	Facility I	D: 00967	If continuati	on sheet F	Page 24 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245317	B. WING _		C 02/08/2018	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	MARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758 SS=D	Management, Data and Non-Pharmaco with revision date or Non-pharmacologic attempt first, howev successful, they map pharmacological reg Free from Unnec PS CFR(s): 483.45(c)(3 §483.45(e) Psychot §483.45(c)(3) A psy affects brain activiti- processes and beha but are not limited to categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a compre resident, the facility §483.45(e)(1) Resid psychotropic drugs unless the medicati specific condition as in the clinical record §483.45(e)(2) Resid drugs receive gradu behavioral intervent contraindicated, in a drugs;	d Procedure for "Pain Collection and Assessment logical Pain Interventions" f 5/17. Procedure: al interventions should be er, in the event they are not aybe combined with a gimen. sychotropic Meds/PRN Use B)(e)(1)-(5) ropic Drugs. rchotropic drug is any drug that es associated with mental avior. These drugs include, o, drugs in the following d thensive assessment of a must ensure that dents who have not used are not given these drugs on is necessary to treat a s diagnosed and documented	F 75			3/16/18

If continuation sheet Page 25 of 27

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	04/26/2018 APPROVED 0938-0391	
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			TIPLE CONSTRUCTION	COM	(X3) DATE SURVEY COMPLETED C		
		245317	B. WING			02/08/2018	
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODI	E		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PROVIDER'S PLAN OF CORRE X (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 758	AMARITAN SOCIETY - COMFORCARE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL		F7		e reviewed ey are ed within 14 maritan egarding s will be and nurses y Social nt s with ekly X4,		
	R1 received this me	edication on 12/16/17,		Quality Committee for further	•		

Facility ID: 00967

If continuation sheet Page 26 of 27

		AND HUMAN SERVICES				FORM	04/26/2018 APPROVED 0938-0391
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		245317	B. WING			C 02/08/2018	
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			201 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
TAG F 758	Continued From pa 12/17/17, 12/29/17, 1/27/18, 1/28/18, 1/ As needed antipsyc limited to fourteen of order a provider mu In an interview with on 2/7/18 at 2:35 p. been ordered the m being admitted to h was intended for er meet the criteria for remained. The DO had face to face co fourteen days and s discontinuing the m family. In a facility policy re antipsychotic drugs	age 26 , 1/5/18, 1/10/18, 1/13/18, /31/18, 2/1/18, and 2/3/18. chotic medications are to be days. In order to continue the ust first evaluate the resident. the director of nursing (DON) , she verified that R1 had nedication in anticipation of ospice and the medication nd of life agitation. R1 did not r hospice and the medication N verified that R1 should have ntact with the physician after stated she will work on nedication after speaking with evised 6/2017, prn are limited to fourteen days eved without the prescribing es the resident for	F 7	758			

Facility ID: 00967

If continuation sheet Page 27 of 27

DEPARTMENT OF HEAL						DICARE & MEDICAID SERVICES		
					AND TRANSMITTAL	ID: 9GS8		
					FE SURVEY AGENCY	Facility ID: 00967		
1. MEDICARE/MEDICAID PROVID (L1) 245317	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - COMFORCARE			OMFORCARE	4. TYPE OF ACTION: $\underline{7}$ (L8)			
2.STATE VENDOR OR MEDICAID	(L4) 1201 17TH STREET NE (L5) AUSTIN, MN				1. Initial2. Recertification3. Termination4. CHOW			
(L2) 692515400				(L6) 55912	5. Validation 6. Complaint			
5. EFFECTIVE DATE CHANGE OF	7. PROVIDER/SUPPLIER CATEGORY			<u>02</u> (L7)	7. On-Site Visit 9. Other			
(L9)		01 Hospital 05 HHA 09 ESRD			13 PTIP 22 CLIA	8. Full Survey After Complaint		
6. DATE OF SURVEY 04/	02 SNF/NF/Dual	06 PRTF	10 NF	14 CORF	FISCAL YEAR ENDING DATE: (L35)			
8. ACCREDITATION STATUS:	(L10)	03 SNF/NF/Distinct	07 X-Ray	11 ICF/IIE		12/31		
0 Unaccredited 1 TJC 2 AOA 3 Other		04 SNF	08 OPT/SP	12 RHC	16 HOSPICE	12/51		
11LTC PERIOD OF CERTIFICATION	ON	10.THE FACILITY		AS:				
From (a):		x ^{A.} In Complia			And/Or Approved Waivers Of The Following Requirements:			
To (b):			equirements e Based On:		2. Technical Personnel6. Scope of Services Limit			
			cceptable POC		3. 24 Hour RN 4. 7-Day RN (Rural S	7. Medical Director NF) 8. Patient Room Size		
12. Total Facility Beds	45 (L18)	1. A	cceptable FOC			· _		
13.Total Certified Beds	45 (L17)	B. Not in Comp	0		5. Life Safety Code	9. Beds/Room		
		Requirements	and/or Applied V	Waivers:	* Code: A	(L12)		
14. LTC CERTIFIED BED BREAKD					15. FACILITY MEETS			
18 SNF 18/19 SNF 45	F 19 SNF	ICF	IID		1861 (e) (1) or 1861 (j) (1):	(L15)		
(L37) (L38)	(L39)	(L42)	(L43)					
16. STATE SURVEY AGENCY RE	MARKS (IF APPLIC)	BLE SHOW LTC CA	NCELLATION I	DATE).				
10. SIME SORVET AGENCT KE				Dratt).				
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:			
Danette Bakken, HFE N	4/11/2018			Kamala Fiske-Downing, Enforcement Specialist 4/11/2018				
P/	ART II - TO BE	COMPLETED I	RY HCFA RE	(L19)	L OFFICE OR SINGLE S	(L20)		
19. DETERMINATION OF ELIGIB			IPLIANCE WITH			ancial Solvency (HCFA-2572)		
			ITS ACT:	I CI VIL	2. Ownership/Control Interest Disclosure Stmt (HCFA-1513)			
1. Facility is Eligible to				3. Both of the Above :				
2. Facility is not Eligib	(L21)							
22. ORIGINAL DATE	23. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION ACTION	I: (L30)		
OF PARTICIPATION	BEGINNING	G DATE	ENDING DA	ТЕ	VOLUNTARY 0	0 INVOLUNTARY		
06/01/1986					01-Merger, Closure	05-Fail to Meet Health/Safety		
(L24)	(L41)	(L25)			02-Dissatisfaction W/ Reimburg			
25. LTC EXTENSION DATE:	27. ALTERNATI	VE SANCTIONS			03-Risk of Involuntary Terminati	OTHER		
	A. Suspension	n of Admissions:			04-Other Reason for Withdrawal	07-1 lovider Status Change		
(L27)	Deter	(L44)			00-Active			
	B. Rescind S	uspension Date:	(L45)					
28. TERMINATION DATE:	20	9. INTERMEDIARY			30. REMARKS			
	2,	03401						
	(L28)	JUTU1		(L31)				
31. RO RECEIPT OF CMS-1539	32	2. DETERMINATION	OF APPROVAL	L DATE				
	(L32)			(L33)	DETERMINATION APP	ROVAL		



CMS Certification Number (CCN): 245317 April 11, 2018

Ms. Jennifer Rowinski, Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, MN 55912

Dear Ms. Rowinski:

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 March 16, 2018 the above facility is certified for:

45 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 45 skilled nursing facility beds.

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

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

Please contact me if you have any questions.

Sincerely,

Kumalu 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: <u>kamala.fiske-downing@state.mn.us</u>



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered April 11, 2018

Ms. Jennifer Rowinski, Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, MN 55912

RE: Project Number S5317030

Dear Ms. Rowinski:

On February 28, 2018, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on February 8, 2018. This survey found the most serious deficiencies to be widespread deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level F) whereby corrections were required.

On April 4, 2018, the Minnesota Department of Health completed a Post Certification Revisit (PCR) and on March 19, 2018 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 8, 2018. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 16, 2018. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on February 8, 2018, effective March 16, 2018 and therefore remedies outlined in our letter to you dated February 28, 2018, will not be imposed.

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

Feel free to contact me if you have questions.

Sincerely,

Kumalu 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: <u>kamala.fiske-downing@state.mn.us</u>

cc: Licensing and Certification File

DEPARTMENT OF HEALTH A	MEDICA	ARE/MEDICAI			CENTERS FO AND TRANSMITT FE SURVEY AGE	FAL	ICARE & MED	ICAID SERVICI ID: 9GS8 Facility ID: 00967	ES
1. MEDICARE/MEDICAID PROVIDER N (L1) 245317 2.STATE VENDOR OR MEDICAID NO. (L2) 692515400	3. NAME AND ADDRESS OF FACILITY (L3) GOOD SAMARITAN SOCIETY - CO (L4) 1201 17TH STREET NE (L5) AUSTIN, MN					 TYPE OF AC Initial Termination Validation 	•	D n	
5. EFFECTIVE DATE CHANGE OF OW (L9)	NERSHIP	7. PROVIDER/SUPPLIER CATEGORY01 Hospital05 HHA09 ESRD			<u>02</u> (L7) 13 PTIP 22 CLIA		 7. On-Site Visit 8. Full Survey A 		
6. DATE OF SURVEY 02/08/20 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	18 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/IID 12 RHC	14 CORF		FISCAL YEAR EN 12/31	IDING DATE: (L3	5)
 11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds 	45 (L18) 45 (L17)	X B. Not in Con	nce With equirements e Based On: cceptable POC	gram	And/Or Approved Wi 2. Technical I 3. 24 Hour RI 4. 7-Day RN 1 5. Life Safety * Code: B *	Personnel N (Rural SNF ⁷ Code	6. Scope of 7. Medical	f Services Limit Director Room Size	
14. LTC CERTIFIED BED BREAKDOWN 18 SNF 18/19 SNF	ICF IID			15. FACILITY MEETS 1861 (e) (1) or 1861 (j) (1): (L15)					
45	19 SNF	ICT.	liD		1801 (e) (1) 01 1801	())(1).	(213)		
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMARK	KS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SURVEY AGENCY APPROVAL Date:				
Jodie Fox, HFE NE II		03/15/2018 (L19)		Amy Johnson, Enforcement Specialist 03/23/2018			(L20)		
PART	II - TO BE	COMPLETED I	BY HCFA RI	. /	OFFICE OR SIN	GLE ST	TATE AGENCY		(L20)
 DETERMINATION OF ELIGIBILITY 1. Facility is Eligible to Partia 2. Facility is not Eligible 	20. COMPLIANCE WITH CIVIL RIGHTS ACT:			 1. Statement of Financial Solvency (HCFA-2572) 2. Ownership/Control Interest Disclosure Stmt (HCFA-1513) 3. Both of the Above : 					
22. ORIGINAL DATE 2	3. LTC AGREE	MENT 24	4. LTC AGREEN	MENT	26. TERMINATION	ACTION:		(L30)	
OF PARTICIPATION 06/01/1986	BEGINNINC	G DATE ENDING DATE		VOLUNTARY 00 01-Merger, Closure 02-Dissatisfaction W/ Reimburse		05-Fail to Meet Health/Safety			
(L24)			(L25)						
25. LTC EXTENSION DATE: 2 (L27)	VE SANCTIONS n of Admissions: (L44) Ispension Date:		04-Other Reason for Withdrawal			<u>OTHER</u> 07-Provider Status Change 00-Active			
			(L45)						
28. TERMINATION DATE: 29. INTERMEDIARY/CARRIER NO. 03401 (L28) (L31)					30. REMARKS				
31. RO RECEIPT OF CMS-1539 32. DETERMINATION OF APPROVAL DATE									

(L33)

DETERMINATION APPROVAL

(L32)

_



Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered February 28, 2018

Ms. Jennifer Rowinski, Administrator Good Samaritan Society - Comforcare 1201 17th Street NE Austin, MN 55912

RE: Project Number S5317030

Dear Ms.. Rowinski:

On February 8, 2018, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs.

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

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Gary Nederhoff, Unit Supervisor Rochester Survey Team Licensing and Certification Program Health Regulation Division Minnesota Department of Health 18 Wood Lake Drive Southeast Rochester, Minnesota 55904-5506 Email: gary.nederhoff@state.mn.us Phone: (507) 206-2731 Fax: (507) 206-2711

OPPORTUNITY TO CORRECT - DATE OF CORRECTION - REMEDIES

As of January 14, 2000, CMS policy requires that facilities will not be given an opportunity to correct before remedies will be imposed when actual harm was cited at the last standard or intervening survey and also cited at the current survey. Your facility does not meet this criterion. Therefore, if your facility has not achieved substantial compliance by March 20, 2018, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

In addition, the Department of Health is recommending to the CMS Region V Office that if your facility has not achieved substantial compliance by March 20, 2018 the following remedy will be imposed:

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

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur;
- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

- Optional denial of payment for new Medicare and Medicaid admissions (42 CFR 488.417 (a));
- Per day civil money penalty (42 CFR 488.430 through 488.444).

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

Good Samaritan Society - Comforcare February 28, 2018 Page 4

acceptable.

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by May 8, 2018 (three months after the identification of noncompliance), the CMS Region V Office must deny payment for new admissions as mandated by the Social Security Act (the Act) at Sections 1819(h)(2)(D) and 1919(h)(2)(C) and Federal regulations at 42 CFR Section 488.417(b). This mandatory denial of payments will be based on the

Good Samaritan Society - Comforcare February 28, 2018 Page 5

failure to comply with deficiencies originally contained in the Statement of Deficiencies, upon the identification of new deficiencies at the time of the revisit, or if deficiencies have been issued as the result of a complaint visit or other survey conducted after the original statement of deficiencies was issued. This mandatory denial of payment is in addition to any remedies that may still be in effect as of this date.

We will also recommend to the CMS Region V Office and/or the Minnesota Department of Human Services that your provider agreement be terminated by August 8, 2018 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor Health Care Fire Inspections Minnesota Department of Public Safety State Fire Marshal Division 445 Minnesota Street, Suite 145 Good Samaritan Society - Comforcare February 28, 2018 Page 6

> St. Paul, Minnesota 55101-5145 Email: tom.linhoff@state.mn.us Telephone: (651) 430-3012 Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kumala Fiske Downing

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

cc: Licensing and Certification File

DEPART	MENT OF HEALTH	AND HUMAN SERVICES					APPROVED
CENTER	RS FOR MEDICARE	& MEDICAID SERVICES			C	MB NO	. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245317	B. WING			02/	08/2018
NAME OF F	PROVIDER OR SUPPLIER	L		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			01 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 0	00			
F 000	Emergency Prepare conducted Februar recertification surve	iance with CMS Appendix Z edness Requirements, was y 5, 6, 7, & 8, 2018, during a ey. The facility is in compliance Z Emergency Preparedness	F 0	00			
	survey was comple Minnesota Departm your facility was in o of 42 CFR Part 483	7, & 8, 2018, a standard ted at your facility by the nent of Health to determine if compliance with requirements 5, Subpart B, and ong Term Care Facilities.	3/9/18 GPN	V			
	as your allegation o Department's accept	f correction (POC) will serve of compliance upon the otance. Your signature at the age of the CMS-2567 form will tion of compliance.	0				
F 550 SS=D	revisit of your facilit validate that substa regulations has bee your verification. Resident Rights/Ex	0	F 5	50			3/16/18
	self-determination, access to persons a	nt Rights. right to a dignified existence, and communication with and and services inside and including those specified in					
	§483.10(a)(1) A fac	ility must treat each resident					
	IRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	IATURE		TITLE		(X6) DATE 03/09/2018

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.

	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	TIPLE CONSTRUCTION	(X3) DA	. 0938-039 TE SURVEY
ND PLAN C	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG	COI	MPLETED
		245317	B. WING _		02	/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	DDE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 550	Continued From pa	ige 1	F 55	50		
		gnity and care for each				
		er and in an environment that				
		nce or enhancement of his or ecognizing each resident's				
		cility must protect and				
	promote the rights	of the resident.				
	8483 10(a)(2) The	facility must provide equal				
		are regardless of diagnosis,				
		n, or payment source. A facility				
		maintain identical policies and transfer, discharge, and the				
		es under the State plan for all				
	residents regardles	s of payment source.				
	§483.10(b) Exercis	e of Rights.				
	The resident has th	e right to exercise his or her				
	rights as a resident or resident of the U	of the facility and as a citizen nited States.				
	§483.10(b)(1) The	facility must ensure that the				
		se his or her rights without				
	from the facility.	ion, discrimination, or reprisal				
		resident has the right to be				
		, coercion, discrimination, and				
		cility in exercising his or her ported by the facility in the				
		er rights as required under this				
		NT is not met as evidenced				
	by: Based on observat	tion, interviews, and		Preparation and execution	of this	
		he facility failed to ensure 1 of		response and plan of correct		
	1 resident (R145) r	eviewed for dignity was treated		constitute an admission or a	greement by	
	in a respectable ma session.	anner during a therapy		the provider of the truth of the alleged or conclusions set for		
	35331011.			statement of deficiencies. T		

Facility ID: 00967

If continuation sheet Page 2 of 31

					OMB NO.	E SURVEY
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION		E SURVEY PLETED
		245317	B. WING		02/	08/2018
NAME OF	PROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CODE	-	
good s	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 550	Continued From pa	ae 2	F 550)		
	Findings include:	5		correction is prepared and/or exe	ecuted	
	·			solely because it is required by t		
		acility on 2/1/18, from hospital		provisions of federal and state la		
		ulmonary embolism (a sudden		the purposes of any allegation th		
	blockage in lung ar			center is not in substantial comp		
		by according to the admission		with federal requirements of part		
	form.			this response and plan of correc constitutes the center⊡s allegation		
	During initial intervi	ew on 2/6/18, at 12:52 p.m.,		compliance in accordance with s		
		ards to registered nurse		7305 of the State Operations Ma		
		of all she [RN-B] hates her				
	job." I think she [RN	N-B] was called in or		1. R145 and family were intervi		
		riday, morning. The therapy		2/8/2018 by social worker regard		
		t the time. She [RN-B] came		incident. Resident reports no em		
		n on the bed and said, 'If this		mental distress related to the inc		
		just going to have to leave.' ue with other stupid		Social worker encouraged reside report concerns to staff in the fut		
		not pertain to me. "I felt like		RN-B was provided with immedia		
		be here and that I was a		education by the DON upon bein		
		king R145 stopped talking and		by surveyors regarding facility po		
		r had opened about 2 inches		dignity. R145 is now deceased.	-	
		osed. No knock on the door or		2. All interview able residents h		
	identification of self	opening door was heard.		interviewed to ensure that they a	re treated	
	During interview or	2/7/10 at 1:00 a m with		in a respectful manner.		
		2/7/18, at 1:06 p.m. with M)-A who had confirmed R145		3. All staff will be provided with education by the Social Worker	h.	
		urse who come into room not		designee on 3/13/2018 regarding		
		said she had not been at		Samaritan Society policy and pro		
	facility when this in			for ensuring resident dignity and		
				Education was given to therapy s		
		terview on 2/7/18, with R145 at		2/12/2018 regarding ensuring re-	sident	
		ated that he had not told		dignity and reporting.		
		ncident with RN-B. When R145		4. Audits will be conducted by S		
		ortable with RN-B providing		Worker or designee on 5 randon interview able residents to ensur		
	want her near me."	re. R145 stated, "No, I don't		resident dignity is being upheld,		
				X4, monthly X3, with results being		
	During phone interv	view with occupational		reported to Quality Committee for		
		OTR)-A, on 2/7/18, at 3:03		recommendations.		

Facility ID: 00967

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STATEMEN	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		IPLE CONSTRUCTION	(X3) DAT	. 0938-039 E SURVEY
IND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	IG	CON	1PLETED
		245317	B. WING _		02/	08/2018
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT	LD BE	(X5) COMPLETIOI DATE
F 550 F 578 SS=D	p.m., OTR-A confir evaluation of R145 nurse came into the disgruntled. RN-B not supposed to be go home." OTR als R145, and herself in OTR said it was inat the things she said During interview on director of nursing, exception is to provi in a dignified manne performances. This conservation in from Review of policy ar Dignity" revision dat The location will pro- manner and in an e enhances each res full recognition of hi Procedure: Respecting the resis speaking respectful treating residents w Focusing on reside employees talk to the individuals when pro- Request/Refuse/Ds CFR(s): 483.10(c)(6) The re-	med that during her initial for 2/2/18 around 9:00 a.m. a e room and was a little made the comments that "I'm working now, and wanting to so stated that it was the nurse, in the room during this incident. appropriate for the nurse to say to R145. 2/8/18, at 1:06 p.m., with (DON) who said, "My ride care that is respectful and ered, according to the resident a should not have been a at of resident." and procedure "Resident te 2/2017 included: pmote resident care in a environment that maintains or ident's dignity and respect in is or her individuality. dent's social status by Ily, listening carefully and <i>r</i> ith respect. Int as individuals when hem and addressing them as oviding cares and services. scntnue Trmnt;FormIte Adv Dir 6)(8)(g)(12)(i)-(v) right to request, refuse, and/or ent, to participate in or refuse perimental research, and to	F 55			3/16/18

Facility ID: 00967

If continuation sheet Page 4 of 31

TATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO	E SURVEY
	F CORRECTION	IDENTIFICATION NUMBER:	. ,	G		IPLETED
		245317	B. WING		02/	08/2018
NAME OF F	PROVIDER OR SUPPLIER	-		STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETIO DATE
F 578	Continued From pa	age 4	F 578	8		
	§483.10(c)(8) Noth construed as the ri the provision of me	ing in this paragraph should be ght of the resident to receive edical treatment or medical nedically unnecessary or				
	requirements spec subpart I (Advance (i) These requirem inform and provide residents concernin medical or surgical resident's option, fe (ii) This includes a facility's policies to and applicable Sta (iii) Facilities are pe entities to furnish th legally responsible requirements of this (iv) If an adult indivi- time of admission a information or artice has executed an a may give advance individual's residen with State Law. (v) The facility is no provide this inform	ents include provisions to written information to all adult ng the right to accept or refuse treatment and, at the ormulate an advance directive. written description of the implement advance directives te law. ermitted to contract with other his information but are still for ensuring that the				
	Follow-up procedu the information to t appropriate time. This REQUIREME by: Based on interview	res must be in place to provide he individual directly at the NT is not met as evidenced v and document review, the ntify the preference for Health		 R4□s code status was identi entered into the electronic medic 		

If continuation sheet Page 5 of 31

CENTER	RS FOR MEDICARE	& MEDICAID SERVICES					. 0938-039	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED	
		245317	B. WING _			02	/08/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- COMFORCARE	1201 17TH STREET NE AUSTIN, MN 55912					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 578	Continued From pa	age 5	F 57	8				
	for advanced direct	tives.			All resident s electronic me			
	Findings include:	-			ords were reviewed on 2/5/20 sure a code status was docun the resident⊡s choice.			
	 R4 was re-admitted to the facility on 2/2/18 according to the admission form, with diagnoses obtained from the electronic medical record (EMR) which included chronic obstructive pulmonary disease with acute exacerbation, congestive heart failure, pulmonary hypertension and gastrointestinal bleeding. R4's quarterly Minimum Data Assessment (MDS) an assessment dated 11/7/17, included R4 had a brief interview for mental status (BIMS) score of 15, which indicated R4, had intact cognition. R4's EMR was reviewed on 2/5/18, and identified no code status had been identified upon R4's return from the hospital on 2/2/18. Registered nurse (RN)-A and the director of nursing (DON), verified the EMR did not have an identified code status at 12:08 p.m. on 2/5/18. 			3. edu for stat des 4. des stat me with	All nurses will be provided w acation on GSS policy and pro- advanced care planning and tus documentation by DON o signee on 3/16/2018. Audits will conducted by HIM signee to ensure all resident tus are documented in the ele dical record, weekly X4, mon n results being reported to Qu mmittee for further recommen	ocedure code r 1 or s code ectronic thly X3, iality		
	director of nursing printed the POLST hospitalization, and discussed this with back to the facility I stated she explained of the admission pr was concerned it w obtain a POLST bat was trying to provide education prior to F The DON stated she who re-admitted R4	y on 2/7/18, at 2:36 p.m. the (DON) stated she had actually R4 had on file prior to R4's I printed a blank POLST and the nurse prior to R4 coming Friday afternoon. The DON ed to the nurse this was a part rocess. The DON stated she yould be difficult based to ased on the history of R4, so I de her with the information and R4's return from the hospital. he followed up with the nurse 4 and stated the nurse that dmission did talk to R4 about						

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY
ID PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G	COM	PLETED
		245317	B. WING		02/	08/2018
IAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETIO DATE
F 578	Continued From pa	ge 6	F 57	8		
	her code status and	d R4 did not want to provide a	_			
		ull code or do not resuscitate.				
		e nurse did educate R4 that if a code status that meant she				
	would have to resu	scitate her and perform CPR				
		esuscitation] if she had a				
		DON stated the nurse did R4's daughter to discuss code				
		he left the daughter a				
		N stated the nurse did not				
		ation and discussion held with o contact the daughter. The				
		rse should have indicated R4				
		EMR. The DON stated				
		d put out a memo to all staff ation on advanced directive				
	procedures.					
		vanced directives was				
F 684	requested and none Quality of Care	e provided.	F 68	Δ		3/16/18
	CFR(s): 483.25		1 00	-		5/10/10
	§ 483.25 Quality of					
		fundamental principle that nent and care provided to				
		ased on the comprehensive				
	assessment of a re	sident, the facility must ensure				
		ve treatment and care in ofessional standards of				
	•	ehensive person-centered				
	care plan, and the					
	by: Based on interview	and record review the facility		1 P42 and P102 are evaluated		
		and record review the facility curate and complete		 R42 and R192 are expired. The center will review the n 		
		s maintained in health records		records of all residents decease		
		ons/services provided for 2 of				

Facility ID: 00967

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CENTE	RS FOR MEDICARE	& MEDICAID SERVICES	1			APPROVE . 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED	
		245317	B. WING		02/	08/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETIO DATE	
F 684	Continued From pa	ge 7	F 6	84			
	2 residents (R42, R	(192) reviewed for death.		is adequate documentation lea	ding up to		
	Findings include:			the resident death.3. Education will be provided on 3/16/2018 regarding GSS p			
	R42 admission form included they had been admitted on 3/17/17, with admitting diagnosis of heart failure. R42 died on 11/10/17.			procedure for documentation requirements. 4. Audits will be conducted by designee for any resident deat	/ DON or		
	had a scratch on lo	d 11/9/17, included that R42 wer back, stating it had		center to ensure adequate documentation, weekly X4, mo	nthly X3,		
	notes regarding res 11/10/17, at 2:00 p. ceased. At 2:49 p.n	atching. The next progress sident health status was on m. family present when vitals n. regarding call from funeral . medical doctor to release		with results being reported to G Committee for further recommo			
	body to mortician. documentation of w	There was a lack of /hen R42 began to decline in erventions including any					
	pain, if physician wa was roommate pre	ventions, comfort cares, in as contacted prior to passing, esent and what given, who took personal					
	items, disposition o						
	regarding circumsta ongoing assessme licensed practical n working, but they to	2/7/18, at 9:20 a.m., ances leading up to and nts done prior to death with urse (LPN)-A "I was not old me, she was fine at lunch, on her and she had passed."					
	Administrator, state be doing fine at lun wheelchair in room the afternoon. Whe went into room with	2/7/18, at 2:25 p.m. with e from want I know, R42 had ch, R42 normal was to nap in and family would come visit in on R42's daughter came, she a nursing assistant and responsive at that time. They					

		AND HUMAN SERVICES & MEDICAID SERVICES			FORM	APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG	(X3) DATI	E SURVEY PLETED
		245317	B. WING _		02/	08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 684	Continued From pa	ge 8	F 68	84		
	director of nursing (them to chart what tell the story of exact someone reading it know what happene also stated that she 1/23/18, regarding of resident died includ include death. R192 had admitted according to admiss diagnosis of malign	2/8/18, at 12:30 p.m., with DON) stated, "I would expect they had done." For them to ctly what happened so that would be able to follow and ed and what was done." DON had a nursing meeting on documentation when a ing a checklists tool that to the facility on 1/26/18 sion form with admitting ant neoplasm of colon and ctive pulmonary disease. Also				
	Progress notes data indicating that resid given pain medicati out of a pain scale of pain ever. At 5:40 p ceased at 5:30 p.m notify of R192 pass that daughter-in-law However, there was regarding pain cont changes, any interv 4:29 a.m. until deat During follow-up int with DON, confirme showed no notes pr comfortable. When met the death chec 1/23/18, at nurse's	erview on 2/8/18 at 1:25 p.m., d documentation for R192 for to R192 passing asked if the documentation klist education presented on meeting. DON stated "No, the not tell the story of him having				

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		AND HUMAN SERVICES			FORM	03/09/201 APPROVE 0938-039	
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	TIPLE CONSTRUCTION		E SURVEY IPLETED	
		245317	B. WING		02/	08/2018	
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STAT			
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	PROVIDER'S PLAN X (EACH CORRECTIVE CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIOI DATE	
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2)		F 6	89		3/16/18	
	as free of accident §483.25(d)(2)Each supervision and ass accidents. This REQUIREMEN by: Based on observat review, the facility fa assess the risk for of (R14 and R12) who facility without author Findings include: According to face s facility 6/3/14. Diag obstructive pulmona disease; major dep bone; unspecified of hypertension; heart dementia with beha R14 had been obsec dining room on unit On 2/7/18, at 10:00 devotions activity in 2:40 p.m. attending dining room. On 2/8/18, at 10:25 wheelchair still in pa	sure that - resident environment remains hazards as is possible; and resident receives adequate sistance devices to prevent NT is not met as evidenced tion, interview, and document ailed to comprehensively elopement for 2 of 2 resident o had a history of leaving the orization. heet R14 admitted to the gnoses include: chronic ary disease; chronic kidney ressive disorder; disorder of osteoarthritis; unspecified failure; insomnia; unspecific avioral disturbance. erved on 2/6/18, at 6:29 p.m. in		 The Social Worke care planned appropr R12 and R14 for elop All residents at ris been reviewed by the DON to ensure their eleven assessed and cappropriately with interelopement. All staff will be pro- education on GSS po- for elopement risk incoupon admission, re-ar- any onset of exit seek as care planning apprinterventions. Audits of all resid elopement will be con Coordinator or design assessments have be care plans reflect apprinterventions, weekly results being reported Committee for further 	iate interventions for ement risk. sk of elopement have Social Worker and elopement risk has are plans updated erventions to prevent ovided with licy and procedure cluding assessing dmission, and with king behavior, as well ropriate ents at risk of nducted by Quality nee to ensure een completed and oropriate x4, monthly x3, with d to Quality		

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		I AND HUMAN SERVICES E & MEDICAID SERVICES				FC	ED: 03/09/2018 RM APPROVED NO: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		PLE CONSTRUCTION		DATE SURVEY COMPLETED
		245317	B. WING				02/08/2018
NAME OF F	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP (CODE	
GOOD SA	AMARITAN SOCIETY	- COMFORCARE			1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 689	Continued From pa	age 10	F 6	589)		
	family members (F R14 stating not fee	M)-A&B, who were leaving, ling well.					
	wandering behavio independent with tr monitored for moor care sheet (Kardex Behavior of Agitati leave: Attempt to re activities and snach root beer float or de monitor and ensure Behavior of agitatio intervention: Approved wheeling around th such as a root beer coffee, turn on old unit, to help reduce unable to keep on thallways. Attempt to she appears to dee and being combata resident in safe pos later time. Also, ast that she has in her	d/behavior per nursing assist c). Care plan also included: on/talking about wanting to edirect thought process, offer ks resident prefers such as ecaf coffee. Continue to e resident is in a safe place. on and starting to wander bach R14 right when starting to e hallway and offer things r float, glass of root beer, decaf time music on DVD player on e any escalation of behavior. If unit, one staff to follow R14 in o divert her to chapel where escalate. Behavior of yelling tive intervention: Leave sition and re-approach at a k resident to show her "bike" room.					
	R14 had eloped fro 6/9/17, and again of R14's electronic me	reports for R14 revealed that om the facility on 5/27/17, on 7/12/17. edical record (EMR) was aled a comprehensive					
	elopement risk ass completed for R14	essment had not been since her admission to the ven though she had exhibited					
	R14's incident repo	ort for elopement on 5/27/17, at					

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ATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	PLE CONSTRUCTION	(X3) DA	D. 0938-039 TE SURVEY
ID PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	G		MPLETED
		245317	B. WING		02	2/08/2018
IAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 689	received a report fr was out the front do R14's investigation report dated 6/2/17 Complaints include exited her neighbor on her ankle. Alarr neighborhood. Floo resident's room with came and notified a neighborhood that a door in between the get resident to retur and when he got to out into the parking for vehicle to go ho alarming and locke reoccurrence: Imm was brought back f minute checks were hours. Double doo were closed until m determine if in good Long-term action pl doors to determine and wander bracele was sent to all nurs they need to assess is going off and not immediately. R14's incident repo	hursing assistant (CNA) om another CNA that resident bor in the parking lot. summary vulnerable adult , to the Office of Health facility d the following: resident had hood with a wander bracelet ns did sound on her or staff were in another h an emergency. A visitor a CNA from another a resident was at the front e double doors. CNA went to rn her to her neighborhood the front door, R14 had got lot by the parked cars looking me. CNA stated front door was d. Action taken to prevent hediate action taken was R14 or safety. 15 min checks e care planned for the next 48 rs to resident's neighborhood anintenance could assess to d working condition. Ian is in place to audit exit they are working appropriately ets daily for function. A memo sing staff to re-educate that s the area when a door alarm being turned off by staff	F 68	9		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	· · ·	TE SURVEY
ND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	CO	MPLETED
		245317	B. WING _		02	2/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE
F 689	facility Complaints investigation it was exterior doors alarr appropriately. Main nursing (DON) test alarm systems imm were not alarming y residents who have put on 15-minute c system could not c On 6/12/17, a tech company) had com wander-guard door checked each door only a few minor ac He made all annun adjusted a few mag needed it. There a fixing on the doors elopement but show technician, these a on the another wall detect the wander- until that unit can b	included the following: upon determined that some of the n boxes were not working ntenance and director of ed all doors with wander-guard nediately and determined some when they should be. All e a wander guard in place were hecks, as the company for the ome to the facility until 612/17. nician from IFC (the alarm e to facility to assess and fix alarms. The technician and all were working well with djustments needing to be done. ciator panels alarm louder and gnetic holds on the doors that re few adjustments that need that will not cause an uld get done per the re a key box needs to be place on the Garden to accurately guard. This is door is locked e moved. The door to the arden needs a new magnetic	F 68	39		
	had eloped from a The technician will make these repairs remain locked until reoccurrence: Wat assessed and bein recommendations R14's incident repo 10:00 p.m., CNA re break around 8:30 building, in front, un	is is the same door resident nd why it happened so easily. be back to facility on 6/20/17, and that patio door will then. Action taken to prevent nder-guard alarm system g fixed and updated per from technician from IFC. ort for elopement on 7/12/17, at ported the when she went on p.m. resident was outside the nder canopy. CNA reports nt those kids out of my house."				

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		AND HUMAN SERVICES & MEDICAID SERVICES				FORM	03/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245317	B. WING			02/	08/2018
NAME OF F	PROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- COMFORCARE			201 17TH STREET NE \USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 689	Continued From pa	ge 13	F 6	89			
	R14's investigation report dated 7/20/1 facility Complaints i was found sitting out the kids off her pore working that evenin resident does like to her wheelchair. Stan eighborhood doorn around facility. Staff every 5-10 minutes resident to come bar R14 possibly follow had pushed the door get it open. R14 for of another neighbor brought resident bar nor is there a chang Action taken to prev was done with staff a door alarm goes of alarm and let reside place continue to w Review of progress showed R14 contin wandering on R14's up and down hallwar resident rooms, and doors, by following note dated 1/30/18, follow family memb of facility. During interview on assistant (NA)-B sta with most of care th	summary vulnerable adult 7, to the Office of Health ncluded the following: R14 ut front of the facility wanting ch. After interviewing staff g it has been discovered that o wheel around the facility in aff had shut off alarm to the way as R14 was wheeling f then did not go check on R14 and had not tried to redirect ack to R14's neighborhood. ed a visitor out of the door or or for 15 seconds or more to und by another staff member hood and that staff person ck to her unit. R14 not injured ge in her functional status. vent reoccurrence: Education on her unit stating that when off they cannot shut of the ent with a wander guard in the ander the building alone. notes from 11/8/17-2/8/17, ues to have behaviors of a neighborhood by wandering ays; in and out of other d attempting to exit the front visitors. With the last progress were R14 had attempted to er (FM)-A out the front doors					

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DEPARTMENT OF HEALTH A					FORM	APPROVED 0938-0391
	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE	E SURVEY PLETED
	245317	B. WING			02/	08/2018
NAME OF PROVIDER OR SUPPLIER				IREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SAMARITAN SOCIETY -	COMFORCARE			201 17TH STREET NE USTIN, MN 55912		
PREFIX (EACH DEFICIENCY I	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL IC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
During interview on 2 nurse (RN)-A states, assistance and will r reproached and help R14 is perfectly fine refuse and if attempt R14, can become co hitting, or yelling at s During interview on 2 maintenance-A state guard alarm on the a (healing grace, the lo front door, and all pa Friday. In addition, w wanderguard bracele doors and ensuring t logs showed no cond During interview on 2 director of nursing w document for elopen However, everyone w evaluatated, with the each elopement we scan into the resider checklist it is not par R12 was observed o wheeling around the was looking for her r R12's admission rec diagnoses of demen Data Set (MDS) date	d me to help yet today. 2/8/18, 11:10 a.m., register , R14 will not call for refuse care. Staff will b R14 as allows. Some days with help, the next time will ts to encourage continue ombative, by kicking, or staff to get out of here. 2/8/18, at 11:15 a.m., ed the he checks the wander all neighborhood doors odge, the garden), along with atio doors weekly, every vill check each resident's et by bringing them to the that alarm sounds. Review of cerns. 2/8/18 at 2:42 p.m., with /ho stated there is no specific ment risk assessment. with a elopement risk is e quarterly assessments, after do a checklist, that we do not nt medical chart. As it is a rt of the resident chart. on 2/05/18, at 9:58 a.m. e unit in her wheelchair and	F 6	89			

		E & MEDICAID SERVICES	L			<u>). 0938-039</u>	
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245317	B. WING _		- 02	2/08/2018	
NAME OF F	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STA	ATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIV CROSS-REFERENCE	N OF CORRECTION E ACTION SHOULD BE O TO THE APPROPRIATE CIENCY)	(X5) COMPLETIO DATE	
F 689	Continued From pa	age 15	F 68	39			
		reports revealed R12 had					
ree el co w fa R E ba in to R Fa ha fa m st o co th ba al al di w ree fa ba fa fa fa fa ba in to co th ba fa fa fa fa fa fa fa fa fa fa fa fa fa	R12's electronic medical record (EMR) was reviewed and revealed a comprehensive elopement risk assessment had not been completed for R12 even though she had wandering behavior and had eloped from the facility on 9/17/17.						
	Elopement. Activity back to the Garder	oort dated 9/17/17, indicated: v Director brought resident ns. Stated resident was found Resident stated she was going					
	report dated 9/22/1 facility Complaints had wheeled herse facility and went out member saw R12 of staff member that to outside that should come back inside w then went and saw building pillars in a approached R12 at and the R12 stated did come back into with the staff member reoccurrence: R12 behavior in the pas	summary vulnerable adult 7, to the Office of Health included the following: R12 If to the front door of the it onto the sidewalk. A family but there and reported to a they believed a resident was not be and that R12 would not with them. The staff member R12 out front between two wheelchair. The staff member nd asked what R12 was doing I, "I'm going to a wedding." R12 the facility without any incident ber. Action taken to prevent did not exhibit elopement it. R12 would wheel around the					
	come to the front d	ne facility but would rarely oor. R12's dementia has wander guard was placed on wention of elonement					

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		& MEDICAID SERVICES	-				. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY IPLETED
		245317	B. WING			02/	08/2018
NAME OF F	PROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		12 Al			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIO DATE
F 689	to be completed af	ter R12 eloped on 9/17/17 per	F 6	89			
	the elopement policy was requested and not provided. During an interview on 2/8/18, at 9:10 a.m. the quality director (QD) stated there was not an elopement risk assessment completed for this resident, and verified there was no elopement risk assessment completed after resident eloped on 9/17/17.						
	During an interview director of nursing assessments were and readmission to addressed at care	on 2/8/18, at 11:24 a.m. the (DON) stated elopement risk completed upon admission the facility and were conferences. The DON stated					
	be completed upon stated an elopemen completed if a resid behaviors that wou	opement risk assessment to an elopement. The DON nt risk assessment should be dent started to display Id indicate they would be at					
	from the facility. The create a form that we checklist binder to an elopement or we	a resident had an elopement e DON stated she planned to would be kept with the nurses' be completed when there was hen behaviors were noted that					
	facility would also of elopement risk, the guard and if the inte DON stated she fel	risk. The DON stated the continue to review residents' continued need for a wander erventions were effective. The t like they (facility staff) k for elegement and placed					
	measures to minim after R12 eloped. T	k for elopement and placed ize the risk of the elopement The DON stated she felt like w their policy for elopement.					
	director of nursing	on 2/8/18, at 2:05 p.m. the (DON) said the policy for provide a clear indication of					

		& MEDICAID SERVICES). 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		FIPLE CONSTRUCTION		TE SURVEY MPLETED
		245317	B. WING		02	2/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETIO DATE
F 689	Continued From pa	ige 17	F 6	89		
		n elopement risk assessment				
	in one comprehensive assessment. The DON stated in the progress notes there was not a					
		ss notes there was not a not a sive summary analysis of				
	R12's elopement ris	sk assessment. The DON				
		would like to know the whole				
		2's elopement) and am unable nentation. The DON stated				
	residents' elopeme	nt risk was reviewed quarterly				
		s, but R12's care conference				
	documentation did	not reflect this.				
		icy and procedure revised				
		he location will be responsible				
		stem that clearly defines the rocedures for monitoring and				
		s at risk for elopement. These				
		environmental hazards and				
	resident risk; evaluarisks; implementing	ating/analyzing hazard and				
		interventions as needed. All				
		sessed for risk of elopement				
		mission and/or admission ededAfter an elopement has				
		Elopement Checklist				
		ows as a reference to ensure				
		vere followed. This is a refore not a part of the medical				
F 695		ostomy Care and Suctioning	F 6	95		3/16/18
SS=D		,				
	§ 483.25(i) Respira	tory care, including				
	tracheostomy care	and tracheal suctioning.				
		sure that a resident who				
		are, including tracheostomy uctioning, is provided such				
		h professional standards of				

Facility ID: 00967

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STATEMEN	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		PLE CONSTRUCTION	(X3) DAT	<u>. 0938-039</u> E SURVEY IPLETED
			A. BUILDING	3		
		245317	B. WING		02	/08/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 695	practice, the compr care plan, the resid and 483.65 of this s This REQUIREMEN by: Based on observat review, the facility f order was in place (R2) reviewed for re Findings include: R4 was observed of chapel participating oxygen in place. R4 was re-admitted according to the ad obtained from the ed (EMR) which includ pulmonary disease congestive heart fa and gastrointestina R4's quarterly Minir assessment dated brief interview for m 15, which indicated R4's physician order record (EMR) were had no current order R4's care plan dater respiratory status/d chronic obstructive	The hensive person-centered lents' goals and preferences, subpart. NT is not met as evidenced tion, interview and record ailed ensure a physician's for oxygen for 1 of 2 residents espiratory care. On 2/5/18, at 10:13 a.m. in the g in a coloring activity. R4 had d to the facility on 2/2/18 mission form, with diagnoses electronic medical record led chronic obstructive with acute exacerbation, ilure, pulmonary hypertension	F 69	 An oxygen order was obtained the physician for R4 and added to electronic medical record on 2/6/2. All residents records who u oxygen were reviewed to ensure oxygen order was in place on 2/63. Re-education will be provided nurses on 3/16/2018 regarding th process of ensuring a physician is in place for resident requiring respiratory care. Audits will be conducted by D designee on residents requiring respiratory care to ensure orders present, weekly X4, monthly X3, results being reported to Quality Committee for further recommen 	o the 2018. tilize an /2018. d to le s order g DON or are with	

Facility ID: 00967

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	IPLE CONSTRUCTION		TE SURVEY MPLETED	
		245317	B. WING _		02	2/08/2018	
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	•		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIC DATE	
F 695	- 1	age 19 / on 2/6/18, at 6:46 p.m.	F 69	95			
	licensed practical nurse (LPN)-B stated R4's orders for oxygen should be in the orders in the computer. LPN-B verified the orders in the EMR						
	did not include an o R4 was on three lite	order for oxygen. LPN-B stated ers of oxygen prior to being ated she just assumed R4 was					
	previous order prio LPN-B stated this v	n as that had been her r to being in the hospital. vas her first night working on					
	when she came in had been set to 3 li	hospital return. LPN-B stated on her shift the concentrator ters and she has not made					
	discharge summar order for oxygen. L	B looked through the hospital y and was not able to locate an PN-B stated she would need					
	away. LPN-B stated from the hospital of	rder for R4's oxygen right d when a resident returned n oxygen and there was not an readmission she would have					
	gotten an order for	oxygen, especially for her as ues is being short of breath.					
	director of nursing R4 was readmitted nurse should have the doctor if R4 retu	on 2/6/18, at 7:10 p.m., the (DON) stated absolutely when from the hospital the admitting obtained an oxygen order from urned from the hospital on vas not an order for oxygen in sal summary.					
	director of nursing dismissal summary oxygen. The DON	on 2/7/18, at 2:25 p.m. the (DON) stated the hospital did not include orders for verified there were no oxygen R4 from 2/2/18 until 2/6/18,					

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE CONSTRUCTION	(X3) DA	<u>). 0938-039</u> TE SURVEY
ND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	NG	co	MPLETED
		245317	B. WING _		02	2/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	E	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETIO DATE
F 756	Continued From pa	ge 20	F 75	56		
SS=D	· ·	iew, Report Irregular, Act On	F 75			3/16/18
	§483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist.					
	§483.45(c)(2) This of the resident's me	review must include a review edical chart.				
	irregularities to the facility's medical dir and these reports n (i) Irregularities inc drug that meets the (d) of this section fo (ii) Any irregularities during this review n separate, written re attending physician director and directo minimum, the resid and the irregularity (iii) The attending p resident's medical r irregularity has bee action has been tak be no change in the	bharmacist must report any attending physician and the rector and director of nursing, nust be acted upon. Iude, but are not limited to, any criteria set forth in paragraph or an unnecessary drug. Is noted by the pharmacist nust be documented on a port that is sent to the and the facility's medical r of nursing and lists, at a ent's name, the relevant drug, the pharmacist identified. hysician must document in the record that the identified in reviewed and what, if any, then to address it. If there is to a medication, the attending pocument his or her rationale in cal record.				
	maintain policies ar drug regimen review limited to, time fram	acility must develop and nd procedures for the monthly w that include, but are not nes for the different steps in eps the pharmacist must take				

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		AND HUMAN SERVICES				FORM	03/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DAT	E SURVEY PLETED
		245317	B. WING	;		02/	08/2018
	PROVIDER OR SUPPLIER	- COMFORCARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1201 17TH STREET NE AUSTIN, MN 55912				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 756	when he or she ide requires urgent acti This REQUIREMEN by: Based on interview facility failed to ens regimen recommer addressed by physi assessment was co (R14) reviewed for Findings include: R14 admitted to the the admission form obstructive pulmon disease; major dep bone; unspecified of hypertension; heard dementia with beha R14's Care plan ind related to interrupte Intervention include respond due to slow skills. Adjust enviro follow R14's usual I bed between 7-9 pr lights off, keeping n with door slightly ch health care provide reduction when clin as needed. Pharmacy consulta 12/30/17, indicated month drug reevalu	ntifies an irregularity that ion to protect the resident. NT is not met as evidenced and document reviews, the ure that pharmacist drug indations were evaluated and ician and that a sleep completed for 1 of 5 residents unnecessary medications.	F	756	 A sleep study and assess completed on 2/20/2018 for R All pharmacy recommend the past 2 months will be revise ensure they have been address appropriately. All nurses will be provided education on the center proce been developed and put in platensure pharmacy recommend addressed appropriately and the pharmacist will communicates the recommendations to the E now delegate completion to not and will track responses to en appropriate and timely complet nurses will be provided educa process related to pharmacy of recommendations on 3/16/2014. Audits will be conducted to Coordinator or designee on the completion of pharmacy constructions monthly X3 X3, with results being reported Committee for further recommendations 	14. ations for ewed to ssed I with ss that has ace to lations are imely. The and route DON who will ursing staff sure etion. All tion on the consultant 18. by Quality e ultant 5, quarterly d to Quality	

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	OF DEFICIENCIES	& MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MI II TI	IPLE CONSTRUCTION		<u>). 0938-039</u> TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:				MPLETED
		245317	B. WING _		02	2/08/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETIO DATE
F 756	depression /demen With the following r of Benadryl must b ordered for sleep. Per electronic reco completed on 12/3/ Physician ordered f Benadryl Tablet 25 time a day related t behavioral disturba mouth one time a c Zoloft Tablet 50 MC time a day related f Primary physician v been reviewed and pharmacists recom pharmacists recom pharmacists recom pharmacists recom pharmacists recom pharmacists on 12/3 When asked if sleet completed after 12 recommendations. documentation, dat behavioral symptor areas: c. trouble fi sleeping too much, the above, checked comprehensive ass pattern. During interview on Director of Nursing nursing documenta	tia: Benadryl 50 mg for sleep. recommendations: dose hold e attempted since this was And sleep assessment. rd last sleep assessment was (16. medications are: MG Give 25 mg by mouth one to unspecified dementia with nce, and Give 50 mg by day related to insomnia. G Give 50 mg by mouth one to depression visit note dated 1/18/18 had no response to the imendations as written by the	F 75	56		

		AND HUMAN SERVICES			FORM	D: 03/09/201 MAPPROVE D. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` <i>´</i>	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245317	B. WING		02	2/08/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF C X (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETIO DATE
F 757 SS=D	Drug Regimen is F CFR(s): 483.45(d)(ree from Unnecessary Drugs 1)-(6)	F 7	57		3/16/18
	Each resident's dru	essary Drugs-General. g regimen must be free from . An unnecessary drug is any				
	§483.45(d)(1) In ex duplicate drug thera	cessive dose (including apy); or				
	§483.45(d)(2) For e	excessive duration; or				
	§483.45(d)(3) With	out adequate monitoring; or				
	§483.45(d)(4) With use; or	out adequate indications for its				
		e presence of adverse ch indicate the dose should be nued; or				
	stated in paragraph section.	combinations of the reasons is (d)(1) through (5) of this				
	by: Based on interview facility failed to prov attempt nonpharma for 3 of 5 residents	NT is not met as evidenced v and document review, the vide adequate parameters and acological pain interventions (R14, R40, R15) reviewed for		1. R14, 15, and 40 □s pa were reviewed to ensure non-pharmacological inter parameters were in place	ventions and	
	the facility 6/3/14. I obstructive pulmon disease; major dep bone; unspecified of	ce sheet R14 was admitted to Diagnoses included chronic ary disease; chronic kidney ressive disorder; disorder of osteoarthritis; unspecified : failure; insomnia; unspecific		 administration. 2. All residents on pain n electronic medical records reviewed to ensure approp parameters are in place. 3. Education will be prov on 3/16/2018 regarding G procedure for managing p parameters for administra 	s will be priate ided to nurses SS policy and ain, including	

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	OF DEFICIENCIES	<u>& MEDICAID SERVICES</u> (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION	OMB NO. (X3) DAT	E SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	. ,	G		PLETED
		245317	B. WING		02/	08/2018
NAME OF I	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	ODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 757	• • • • • • • • • • • • • • • • • • •	-	F 75	7 non-pharmacological interve	entions and	
	dementia with behavioral disturbance. R14's care plan included the potential for alteration in comfort related to osteoarthritis, non-pharmacological interventions included,			appropriate documentation.4. Audits will be conducted designee on 5 random resid	by DON or	
	encourage R14 to v has pain. R14 is ab independently. Obs	wear left wrist brace when she ble to on /off brace serve skin for redness or		non-pharmacological interve and to ensure appropriate p in place, weekly x4, monthly	entions utilized arameters are v x3, with	
	following as needed	current physician orders, the data data data data data data data dat		results being reported to Qu Committee for further recom		
	rate of 1-5 out of a worst pain ever. R4	mg for Pain-Moderate pain 1 to 10 scale with 10 being 0 received as needed Ultram				
	2018, and 2 times I non-pharmacologic	ber 2017, 8 times in January February 1 to 6, 2018. No al attempts had been				
	pain medication.	o administration of as needed ce sheet, R40 admitted to				
	facility on 1/15/18, spine, after a fall at	with diagnosis of fracture to home.				
	fracture of thoracio	ated to wedge compression c (T) T11 -T12 and lumbar (L)				
	left knee swelling s	ral Orthosis) back brace. and econdary to advanced				
	non-pharmacologic	oaches to try for pain: attempt cal inventions: R40 prefers to pillows on her sides.				
		edication administration record orders for the following pain				
	Oxycodone 5 mg ta moderated pain; to	ablet every 8 hours for severe pain started on one table as needed for				
	moderate pain scor pain of score of 7-1	re of 4-6 out of 10 or severe 0 out 10 for 7 days. R40 e 11 times since ordered on				

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			()(0)			D. 0938-039
	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·	TIPLE CONSTRUCTION		TE SURVEY MPLETED
		245317	B. WING_		02	2/08/2018
NAME OF	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIF	P CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 757	 1/16/18. No docum non-pharmacologic administrating as n Percocet 5-325 mg needed for modera on 1/26/18, for 10 of times in the 10 day of any non-pharma prior to administration noted. Tylenol (Acetamino by mouth every four R40 received Tylen admission without a non-pharmacologic attempted prior to r of any non-pharma prior administrating noted. R15's admission fat the facility on 9/22/ fracture, back pain The quarterly Minim an assessment, inco pain. According to the m (MAR) dated 2/201 Tramadol 50 mg ev Tylenol 1000 mg by needed for pain. N the MAR as to whe given. During an interview (LPN)-A on 2/7/18, were nonpharmaco 	entation of any cal attempted prior to eeded oxycodone were noted. tablet give 1 tablet 8 hours as te to severe pain was started days. R40 received Percocet 8 s ordered. No documentation cological intervention attempts ing as needed Percocet were ophen) 325 mg, Give 650 mg ir hours as needed for pain. tool 650 mg 20 times since	F 7	57		

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		AND HUMAN SERVICES			FORM	: 03/09/2018 APPROVED . 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´	IPLE CONSTRUCTION		E SURVEY IPLETED
		245317	B. WING _		02	/08/2018
NAME OF F	PROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP COD		
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 757 F 758 SS=D	them even when the In an interview with 2/7/18 at 2:04 p.m. documentation has addressed this with which was held 1/2 facility has been hit and documenting m interventions. A facility policy revision nonpharmacological prior to or in conjum Review of Policy ar Management, Data and Non-Pharmacological attempt first, however successful, they ma pharmacological re Free from Unnec P CFR(s): 483.45(c)(§483.45(c)(3) A psy affects brain activiti processes and beh	d they do not always document ey are done. the director of nurses on , she acknowledged that been an issue and she had the nurses at the last meeting 3/18. She verified that the and miss with parameters, ionpharmacological sed on 5/2017, indicated that al interventions should be tried oction with pain medication. A Procedure for "Pain Collection and Assessment ological Pain Interventions" of 5/17. Procedure: cal interventions should be ver, in the event they are not aybe combined with a gimen. sychotropic Meds/PRN Use 3)(e)(1)-(5) tropic Drugs. vchotropic drug is any drug that ies associated with mental avior. These drugs include, to, drugs in the following	F 75	57		3/16/18

Facility ID: 00967

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	-	I AND HUMAN SERVICES			O		APPROVED 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION		E SURVEY PLETED
		245317	B. WING			02/	08/2018
NAME OF I	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			201 17TH STREET NE USTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 758	Continued From pa	age 27	F 7	58			
		ehensive assessment of a / must ensure that					
	psychotropic drugs unless the medicat	dents who have not used are not given these drugs ion is necessary to treat a is diagnosed and documented d;					
	drugs receive grad behavioral interven	dents who use psychotropic ual dose reductions, and tions, unless clinically an effort to discontinue these					
	psychotropic drugs unless that medica	dents do not receive pursuant to a PRN order tion is necessary to treat a condition that is documented d; and					
	are limited to 14 da §483.45(e)(5), if the prescribing practition appropriate for the beyond 14 days, he rationale in the resi	l orders for psychotropic drugs ays. Except as provided in e attending physician or oner believes that it is PRN order to be extended e or she should document their ident's medical record and on for the PRN order.					
	drugs are limited to renewed unless the prescribing practition the appropriateness	l orders for anti-psychotic o 14 days and cannot be e attending physician or oner evaluates the resident for s of that medication. NT is not met as evidenced					
	Based on interview	v and document review, the ssess antipsychotic medication			1. R1□s PRN antipsychotic medic was discontinued on 2/8/2018.	cation	

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		AND HUMAN SERVICES			FORM	03/09/2018 APPROVED 0938-0391
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		E SURVEY IPLETED
		245317	B. WING		- 02/	08/2018
	PROVIDER OR SUPPLIER	- COMFORCARE		STREET ADDRESS, CITY, STAT 1201 17TH STREET NE AUSTIN, MN 55912	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION ACTION SHOULD BE TO THE APPROPRIATE IENCY)	(X5) COMPLETION DATE
F 758	that had been orderesidents (R1) reviewedications. Findings include: R1's admission formof 4/11/17. Also a content of 4/11/17. Also a content of 4/11/17. Also a content of a haloperide generation antipsycewery six hours as a second s	m included an admitting date diagnosis of dementia, disease, and hypertension. ders dated 12/21/17, include an of 0.5 milligrams (a first chotic medication) by mouth needed (prn) for agitation. edication on 12/16/17, , 1/5/18, 1/10/18, 1/13/18, /31/18, 2/1/18, and 2/3/18. chotic medications are to be days. In order to continue the ust first evaluate the resident. the director of nursing (DON) .m., she verified that R1 had nedication in anticipation of nospice and the medication nd of life agitation. R1 did not r hospice and the medication oN verified that R1 should have ontact with the physician after stated she will work on nedication after speaking with evised 6/2017, prn s are limited to fourteen days ewed without the prescribing	F 7	 All residents utiliz antipsychotic medica by Social Worker to e evaluated by a physic appropriateness or di days. Re-education on Society policy and pro PRN antipsychotic m provided to the Socia by 3/16/2018. Audits will be cor Worker or designee of PRN antipsychotic or monthly X3, with resu Quality Committee for recommendations. 	tions were reviewed ensure they are cian for iscontinued within 14 Good Samaritan ocedure regarding edications will be al Worker and nurses nducted by Social on resident □s with ders, weekly X4, ults being reported to	

		AND HUMAN SERVICES			FORM	: 03/09/2018 APPROVED . 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED
		245317	B. WING _		02/	08/2018
NAME OF F	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD SA	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 758	Continued From pa	ge 29	F 75	8		
	appropriateness of QAPI/QAA Improve CFR(s): 483.75(g)(ement Activities	F 86	7		3/16/18
	§483.75(g) Quality	assessment and assurance.				
	assurance committ (ii) Develop and imp action to correct ide This REQUIREMEN by: Based on interview facility failed to iden related to incomple documentation as p recertification surve provide oversite of previously cited in a date of 12/15/16. T residents currently Findings include:	olement appropriate plans of entified quality deficiencies; NT is not met as evidenced and document review, the ntify ongoing quality concerns te medical records previously cited on last ey exited 12/15/16. and did not facility systems that had been a survey (F514) with an exit his could affect 37 of 37 living in the facility		1. The Quality Coordinator was instructed to include annual surve in the monthly quality meeting mi Survey deficiencies and remedies reviewed and audited by the qual committee on a quarterly basis. T Administrator or designee will aud quality minutes for compliance m one year.	nutes. s will be ity he dit the	
	documenting conce changes. This same citation we exited 12/15/16 at F In an interview on 2 quality director, she for a plan of correct three months after this particular instant as positive (meaning been resolved) and	tion F684 regarding lack of erns with health status was issued on the survey F514. 2/8/18, at 2:18 p.m., with the e stated that the usual process tion is to require audits for the problem was identified. In nace the audits were reported by the problem at that time had the audits were discontinued. went on to say that the				

		AND HUMAN SERVICES				FORM	03/09/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATI	E SURVEY PLETED
		245317	B. WING	i		02/	08/2018
NAME OF F	PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- COMFORCARE			1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 867	ensure after the thr	ew sustainability tool that will ee month audit there will be a nonths enabling recognition of	F	367			

Facility ID: 00967

		AND HUMAN SERVICES & MEDICAID SERVICES	Ŧ	5317026	PRINTED: 03/15/2018 FORM APPROVED MB NO: 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	IPLE CONSTRUCTION NG 02 - BUILT IN 2007	(X3) DATE SURVEY COMPLETED
		245317	B. WING		02/07/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETION
K 000	INITIAL COMMENT	ſS	K 00	00	
	FIRE SAFETY				
	ALLEGATION OF O DEPARTMENT'S A SIGNATURE AT TH	OC WILL SERVE AS YOUR COMPLIANCE UPON THE CCEPTANCE. YOUR TE BOTTOM OF THE FIRST S-2567 WILL BE USED AS COMPLIANCE.			
	ON-SITE REVISIT CONDUCTED TO SUBSTANTIAL CO REGULATIONS HA	F AN ACCEPTABLE POC, AN OF YOUR FACILITY MAY BE VALIDATE THAT MPLIANCE WITH THE AS BEEN ATTAINED IN ITH YOUR VERIFICATION.			
	Minnesota Departm Fire Marshal Divisio dated 02/07/2018, C Comforcare was fo requirements for pa Medicare/Medicaid 483.70(a), Life Safe edition of National I	at 42 CFR, Subpart ety from Fire, and the 2012 Fire Protection Association 01, Life Safety Code (LSC),		EPOC	
	PLEASE RETURN CORRECTION FO DEFICIENCIES (K-TAGS) TO:	THE PLAN OF R THE FIRE SAFETY			
	Health Care Fire In State Fire Marshal 445 Minnesota St.,	Division			
	DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIG	NATURE	TITLE	(X6) DATE 03/09/201

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.

		AND HUMAN SERVICES				FORM /	03/15/2018 APPROVED 0938-0391
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION 02 - BUILT IN 2007	(X3) DATE COMF	
		245317	B, WING			02/0	7/2018
	PROVIDER OR SUPPLIER	- COMFORCARE		1	TREET ADDRESS, CITY, STATE, ZIP CODE 201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
K 000	Angela.Kappenmar <mailto:angela.kap THE PLAN OF CO DEFICIENCY MUS FOLLOWING INFO 1. A description of v to correct the defici 2. The actual, or pr 3. The name and/o responsible for corr</mailto:angela.kap 	-5145, or tate.mn.us itney@state.mn.us> and n@state.mn.us openman@state.mn.us> RRECTION FOR EACH IT INCLUDE ALL OF THE DRMATION: what has been, or will be, done iency. oposed, completion date.	κo	000			
	building with no bas constructed in 2007 Type II(111) constru- The building is fully fire alarm system w detection, spaces of monitored for autor notification. There rooms that are more	ociety Comforcare, is a 1-story sement. The building was 7 and was determined to be of action. • sprinklered. The facility has a with full corridor smoke open to the corridors that is matic fire department is smoke alarms in all resident hitored by the nurse call atside each resident room.					
	The facility has a c	apacity of 45 beds and had a					

Event ID: 9GS821

Facility ID: 00967

If continuation sheet Page 2 of 5

	OF DEFICIENCIES	& MEDICAID SERVICES		LE CONSTRUCTION (X3) DA	TE SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	1 . /		MPLETED
		245317	B, WING		2/07/2018
NAME OF I	PROVIDER OR SUPPLIER		5	STREET ADDRESS, CITY, STATE, ZIP CODE	
GOOD S	AMARITAN SOCIETY	- COMFORCARE		201 17TH STREET NE AUSTIN, MN 55912	
(X4) ID PREFIX T A G	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETIOI DATE
K 000	Continued From pa census of 38 at the	age 2 e time of the survey,	K 000		
K 293	The requirement a NOT MET as evide	t 42 CFR, Subpart 483.70(a) is enced by:	K 293		3/16/18
	CFR(s): NFPA 101				
	accordance with 7. also served by the 19.2.10.1 (Indicate N/A in on with less than 30 o travel is obvious.) This REQUIREME by: Based on observa failed to ensure tha displayed in accord practice could affe Exit Signage 2012			Preparation and execution of this response and plan of correction does no 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	
	accordance with 7 also served by the 19.2.10.1 FINDINGS INCLU			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	I,
	on 02/07/2018, ob exterior door from	ween 10:00 AM and 1:00 PM servation revealed that the the physical therapy designated as an exit. This ed as a "No Exit".		constitutes the center □s allegation of compliance in accordance with section 7305 of the State Operations Manual. A "No Exit" sign was placed on the exterior therapy door on 3/6/2018.	

Facility ID: 00967

If continuation sheet Page 3 of 5

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION (X	3) DATE SURV COMPLETE	
ID PLAN O	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	02 - BUILT IN 2007	COMPLETE	U
		245317	B. WING		02/07/20	18
AME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
SOOD S	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	E COMF	X5) PLETIO ATE
K 293	Continued From pa	-	K 293			
	Maintenance Direc Subdivision of Build CFR(s): NFPA 101	tor. ding Spaces - Smoke Barrie	K 372		3/16/	/18
	Construction 2012 EXISTING Smoke barriers sha fire resistance ratir be permitted to tern Smoke dampers at penetrations in fully an approved sprint smoke compartme barrier. 19.3.7.3, 8.6.7.1(1) Describe any mech in REMARKS. This REQUIREME by: Based on observa facility failed to ma construction that m 101 - 2012 edition, (1). This deficient residents by allowin one smoke compa	NT is not met as evidenced tion and staff interview, the intain smoke barrier walls neet the requirements of NFPA Sections 19-3.7.3 and 8.6.7.1. practice could affect 15 of 45 ng smoke to propagate from rtment to another.		The smoke barrier penetration was appropriately by maintenance on 2/9/2018.	filled	
	Construction 2012 EXISTING Smoke barriers shi fire resistance ratir shall be permitted Smoke dampers a penetrations in fully	ding Spaces - Smoke Barrier all be constructed to a 1/2-hour ng per 8.5. Smoke barriers to terminate at an atrium wall. re not required in duct y ducted HVAC systems where kler system is installed for	ų.			

Facility ID: 00967

If continuation sheet Page 4 of 5

		AND HUMAN SERVICES			FORM	: 03/15/20 APPROVE 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION NG 02 - BUILT IN 2007	(X3) DAT COM	TE SURVEY MPLETED
		245317	B. WING		02	/07/2018
NAME OF F	PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE,		
GOOD SA	AMARITAN SOCIETY	- COMFORCARE		1201 17TH STREET NE AUSTIN, MN 55912		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETIO DATE
K 372	Continued From pa barrier. 19.3.7.3, 8.6.7.1(1)	-	К 3	72		
	FINDINGS INCLUE	DE:				
	On facility tour between 10:00 AM and 1:00 PM on 02/7/2018, a penetration was observed above the lay-in ceiling tile at the smoke barrier for the Garden Wing.					
	NOTE: All smoke barriers in the Facility need to be checked to ensure there are no penetrations i the smoke barriers.	ı				
	This deficient pract Maintenance Direc	ice was verified by the Facility tor.				