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.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted February 5, 6, 7, & 8, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On February 5, 6, 7, & 8, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		3/16/18

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

Electronically Signed | 03/09/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review, the facility failed to ensure 1 of 1 resident (R145) reviewed for dignity was treated in a respectable manner during a therapy session.	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 Findings include: R145 admitted to facility on 2/1/18, from hospital with diagnosis of pulmonary embolism (a sudden blockage in lung artery) for short-term rehabilitation therapy according to the admission form. During initial interview on 2/6/18, at 12:52 p.m., R145 stated in regards to registered nurse (RN)-B, "Well, first of all she [RN-B] hates her job." I think she [RN-B] was called in or something, it was Friday, morning. The therapy girls were in here at the time. She [RN-B] came in and plopped down on the bed and said, 'If this happens again I'm just going to have to leave.' [RN-B] then continue with other stupid statements that did not pertain to me. "I felt like she did not want to be here and that I was a burden." While talking R145 stopped talking and looked at door, door had opened about 2 inches and then quickly closed. No knock on the door or identification of self opening door was heard. During interview on 2/7/18, at 1:06 p.m. with Family Member (FM)-A who had confirmed R145 was upset with a nurse who come into room not to long ago. FM-A said she had not been at facility when this incident occurred. During follow-up interview on 2/7/18, with R145 at 2:09 p.m., R145 stated that he had not told anyone about the incident with RN-B. When R145 was asked if comfortable with RN-B providing services in the future. R145 stated, "No, I don't want her near me." During phone interview with occupational therapist, register (OTR)-A, on 2/7/18, at 3:03	F 550	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. R145 and family were interviewed on 2/8/2018 by social worker regarding the incident. Resident reports no emotional or mental distress related to the incident. Social worker encouraged resident to report concerns to staff in the future. RN-B was provided with immediate education by the DON upon being notified by surveyors regarding facility policy on dignity. R145 is now deceased. 2. All interview able residents have been interviewed to ensure that they are treated in a respectful manner. 3. All staff will be provided with education by the Social Worker or designee on 3/13/2018 regarding Good Samaritan Society policy and procedure for ensuring resident dignity and reporting. Education was given to therapy staff on 2/12/2018 regarding ensuring resident dignity and reporting. 4. Audits will be conducted by Social Worker or designee on 5 random interview able residents to ensure their resident dignity is being upheld, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 p.m., OTR-A confirmed that during her initial evaluation of R145 on 2/2/18 around 9:00 a.m. a nurse came into the room and was a little disgruntled. RN-B made the comments that "I'm not supposed to be working now, and wanting to go home." OTR also stated that it was the nurse, R145, and herself in the room during this incident. OTR said it was inappropriate for the nurse to say the things she said to R145. During interview on 2/8/18, at 1:06 p.m., with director of nursing, (DON) who said, "My exception is to provide care that is respectful and in a dignified mannered, according to the resident performances. This should not have been a conservation in front of resident." Review of policy and procedure, "Resident Dignity" revision date 2/2017 included: The location will promote resident care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Procedure: Respecting the resident's social status by speaking respectfully, listening carefully and treating residents with respect. Focusing on resident as individuals when employees talk to them and addressing them as individuals when providing cares and services.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 4 §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. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify the preference for Health Care Directives for 1 of 1 resident (R4) reviewed	F 578	1. R4□s code status was identified and entered into the electronic medical record on 2/5/2018. R4 expired on 2/18/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5 for advanced directives. Findings include: 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. During an interview on 2/7/18, at 2:36 p.m. the director of nursing (DON) stated she had actually printed the POLST R4 had on file prior to R4's hospitalization, and printed a blank POLST and discussed this with the nurse prior to R4 coming back to the facility Friday afternoon. The DON stated she explained to the nurse this was a part of the admission process. The DON stated she was concerned it would be difficult based to obtain a POLST based on the history of R4, so I was trying to provide her with the information and education prior to R4's return from the hospital. The DON stated she followed up with the nurse who re-admitted R4 and stated the nurse that completed the readmission did talk to R4 about	F 578	2. All resident□s electronic medical records were reviewed on 2/5/2018 to ensure a code status was documented per the resident□s choice. 3. All nurses will be provided with education on GSS policy and procedure for advanced care planning and code status documentation by DON or designee on 3/16/2018. 4. Audits will conducted by HIM or designee to ensure all resident□s code status are documented in the electronic medical record, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 her code status and R4 did not want to provide a clear indication of full code or do not resuscitate. The DON stated the nurse did educate R4 that if she did not provide a code status that meant she would have to resuscitate her and perform CPR [cardiopulmonary resuscitation] if she had a cardiac arrest. The DON stated the nurse did attempt to call the R4's daughter to discuss code status and stated she left the daughter a message. The DON stated the nurse did not document the education and discussion held with R4 or the attempt to contact the daughter. The DON stated the nurse should have indicated R4 was full code in the EMR. The DON stated because of this I did put out a memo to all staff and provided education on advanced directive procedures. Policy regarding advanced directives was requested and none provided.	F 578		
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the risk for elopement for 2 of 2 resident (R14 and R12) who had a history of leaving the facility without authorization.	F 689	1. The Social Worker has assessed and care planned appropriate interventions for R12 and R14 for elopement risk. 2. All residents at risk of elopement have been reviewed by the Social Worker and	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 7 Findings include: According to face sheet R14 admitted to the facility 6/3/14. Diagnoses include: chronic obstructive pulmonary disease; chronic kidney disease; major depressive disorder; disorder of bone; unspecified osteoarthritis; unspecified hypertension; heart failure; insomnia; unspecific dementia with behavioral disturbance. R14 had been observed on 2/6/18, at 6:29 p.m. in dining room on unit eating supper. On 2/7/18, at 10:00 a.m. R14 attending a devotions activity in the chapel. In addition, at 2:40 p.m. attending BINGO in the lodge unit dining room. On 2/8/18, at 10:25 a.m. R14 in room in wheelchair still in pajamas, looking though her belongings. At 10:38 a.m. R14 in room visiting family members (FM)-A & B, who were leaving, R14 stating not feeling well. R14's care plan included a has history of wandering behavior. In addition, that she is independent with transfers. monitored for mood/behavior per nursing assist care sheet (Kardex). Care plan also included: Behavior of Agitation/talking about wanting to leave: Attempt to redirect thought process, offer activities and snacks resident prefers such as root beer float or decaf coffee. Continue to monitor and ensure resident is in a safe place. Behavior of agitation and starting to wander intervention: Approach R14 right when starting to wheeling around the hallway and offer things such as a root beer float, glass of root beer, decaf	F 689	DON to ensure their elopement risk has been assessed and care plans updated appropriately with interventions to prevent elopement. 3. All staff will be provided with education on GSS policy and procedure for elopement risk including assessing upon admission, re-admission, and with any onset of exit seeking behavior, as well as care planning appropriate interventions. 4. Audits of all residents at risk of elopement will be conducted by Quality Coordinator or designee to ensure assessments have been completed and care plans reflect appropriate interventions, weekly x4, monthly x3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 8	F 689		

coffee, turn on old time music on DVD player on unit, to help reduce any escalation of behavior. If unable to keep on unit, one staff to follow R14 in hallways. Attempt to divert her to chapel where she appears to deescalate. Behavior of yelling and being combatative intervention: Leave resident in safe position and re-approach at a later time. Also, ask resident to show her "bike" that she has in her room.

Review of incident reports for R14 revealed that R14 had eloped from the facility on 5/27/17, 6/9/17, and again on 7/12/17.

R14's electronic medical record (EMR) was reviewed and revealed a comprehensive elopement risk assessment had not been completed for R14 since her admission to the facility on 6/3/14, even though she had exhibited elopement behavior in the past year.

R14's incident report for elopement on 5/27/17, at 5:45 p.m. certified nursing assistant (CNA) received a report from another CNA that resident was out the front door in the parking lot.

R14's investigation summary vulnerable adult report dated 6/2/17, to the Office of Health facility Complaints included the following: resident had exited her neighborhood with a wander bracelet on her ankle. Alarms did sound on her neighborhood. Floor staff were in another resident's room with an emergency. A visitor came and notified a CNA from another neighborhood that a resident was at the front door in between the double doors. CNA went to get resident to return her to her neighborhood and when he got to the front door, R14 had got out into the parking lot by the parked cars looking

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 9	F 689		

for vehicle to go home. CNA stated front door was alarming and locked. Action taken to prevent reoccurrence: Immediate action taken was R14 was brought back for safety. 15 min checks minute checks were care planned for the next 48 hours. Double doors to resident's neighborhood were closed until maintenance could assess to determine if in good working condition.
Long-term action plan is in place to audit exit doors to determine they are working appropriately and wander bracelets daily for function. A memo was sent to all nursing staff to re-educate that they need to assess the area when a door alarm is going off and not being turned off by staff immediately.

R14's incident report for elopement on 6/9/17, at 9:21 a.m., unable to locate resident, CNA found R14 outside in enclosed patio.

R14's investigation summary vulnerable adult report dated 6/15/17, to the Office of Health facility Complaints included the following: upon investigation it was determined that some of the exterior doors alarm boxes were not working appropriately. Maintenance and director of nursing (DON) tested all doors with wander-guard alarm systems immediately and determined some were not alarming when they should be. All residents who have a wander guard in place were put on 15-minute checks, as the company for the system could not come to the facility until 612/17. On 6/12/17, a technician from IFC (the alarm company) had come to facility to assess and fix wander-guard door alarms. The technician checked each door and all were working well with only a few minor adjustments needing to be done. He made all annunciator panels alarm louder and adjusted a few magnetic holds on the doors that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

needed it. There are few adjustments that need fixing on the doors that will not cause an elopement but should get done per the technician, these are a key box needs to be place on the another wall on the Garden to accurately detect the wander-guard. This is door is locked until that unit can be moved. The door to the patio door in the Garden needs a new magnetic piece replaced. This is the same door resident had eloped from and why it happened so easily. The technician will be back to facility on 6/20/17, make these repairs and that patio door will remain locked until then. Action taken to prevent reoccurrence: Wander-guard alarm system assessed and being fixed and updated per recommendations from technician from IFC.

R14's incident report for elopement on 7/12/17, at 10:00 p.m., CNA reported the when she went on break around 8:30 p.m. resident was outside the building, in front, under canopy. CNA reports resident said, "I want those kids out of my house."

R14's investigation summary vulnerable adult report dated 7/20/17, to the Office of Health facility Complaints included the following: R14 was found sitting out front of the facility wanting the kids off her porch. After interviewing staff working that evening it has been discovered that resident does like to wheel around the facility in her wheelchair. Staff had shut off alarm to the neighborhood doorway as R14 was wheeling around facility. Staff then did not go check on R14 every 5-10 minutes and had not tried to redirect resident to come back to R14's neighborhood. R14 possibly followed a visitor out of the door or had pushed the door for 15 seconds or more to get it open. R14 found by another staff member of another neighborhood and that staff person

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

brought resident back to her unit. R14 not injured nor is there a change in her functional status. Action taken to prevent reoccurrence: Education was done with staff on her unit stating that when a door alarm goes off they cannot shut of the alarm and let resident with a wander guard in the place continue to wander the building alone.

Review of progress notes from 11/8/17-2/8/17, showed R14 continues to have behaviors of wandering on R14's neighborhood by wandering up and down hallways; in and out of other resident rooms, and attempting to exit the front doors, by following visitors. With the last progress note dated 1/30/18, were R14 had attempted to follow family member (FM)-A out the front doors of facility.

During interview on 2/8/18, at 10:28 a.m., nursing assistant (NA)-B stated that R14 is independent with most of care though R14 is declining and I will go assist R14 when allows due to refusal. R14 has not allowed me to help yet today.

During interview on 2/8/18, 11:10 a.m., register nurse (RN)-A states, R14 will not call for assistance and will refuse care. Staff will reproached and help R14 as allows. Some days R14 is perfectly fine with help, the next time will refuse and if attempts to encourage continue R14, can become combative, by kicking, or hitting, or yelling at staff to get out of here.

During interview on 2/8/18, at 11:15 a.m., maintenance-A stated the he checks the wander guard alarm on the all neighborhood doors (healing grace, the lodge, the garden), along with front door, and all patio doors weekly, every Friday. In addition, will check each resident's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

wanderguard bracelet by bringing them to the doors and ensuring that alarm sounds. Review of logs showed no concerns.

During interview on 2/8/18 at 2:42 p.m., with director of nursing who stated there is no specific document for elopement risk assessment. However, everyone with a elopement risk is evaluatated, with the quarterly assessments, after each elopement we do a checklist, that we do not scan into the resident medical chart. As it is a checklist it is not part of the resident chart. R12 was observed on 2/05/18, at 9:58 a.m. wheeling around the unit in her wheelchair and was looking for her mother.

R12's admission record identified R12 had diagnoses of dementia. R12's annual Minimum Data Set (MDS) dated 11/28/18, indicated severely impaired decision-making skills for daily living.

Review of incident reports revealed R12 had eloped from the facility on 9/17/17.

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.

R12's Incident Report dated 9/17/17, indicated: Elopement. Activity Director brought resident back to the Gardens. Stated resident was found in the parking lot. Resident stated she was going to a wedding.

R12's investigation summary vulnerable adult

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

report dated 9/22/17, to the Office of Health facility Complaints included the following: R12 had wheeled herself to the front door of the facility and went out onto the sidewalk. A family member saw R12 out there and reported to a staff member that they believed a resident was outside that should not be and that R12 would not come back inside with them. The staff member then went and saw R12 out front between two building pillars in a wheelchair. The staff member approached R12 and asked what R12 was doing and the R12 stated, "I'm going to a wedding." R12 did come back into the facility without any incident with the staff member. Action taken to prevent reoccurrence: R12 did not exhibit elopement behavior in the past. R12 would wheel around the long-term side of the facility but would rarely come to the front door. R12's dementia has declined and so a wander guard was placed on R12's ankle for prevention of elopement.

R12's Elopement Checklist Worksheet that was to be completed after R12 eloped on 9/17/17 per 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 on 2/8/18, at 11:24 a.m. the director of nursing (DON) stated elopement risk assessments were completed upon admission and readmission to the facility and were addressed at care conferences. The DON stated she expected an elopement risk assessment to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

be completed upon an elopement. The DON stated an elopement risk assessment should be completed if a resident started to display behaviors that would indicate they would be at risk for eloping or if a resident had an elopement from the facility. The DON stated she planned to create a form that would be kept with the nurses' checklist binder to be completed when there was an elopement or when behaviors were noted that increase their flight risk. The DON stated the facility would also continue to review residents' elopement risk, the continued need for a wander guard and if the interventions were effective. The DON stated she felt like they (facility staff) assessed R12's risk for elopement and placed measures to minimize the risk of the elopement after R12 eloped. The DON stated she felt like the facility did follow their policy for elopement.

During an interview on 2/8/18, at 2:05 p.m. the director of nursing (DON) said the policy for elopement did not provide a clear indication of how to document an elopement risk assessment in one comprehensive assessment. The DON stated in the progress notes there was not a specific comprehensive summary analysis of R12's elopement risk assessment. The DON stated I personally would like to know the whole story (regarding R12's elopement) and am unable to tell by the documentation. The DON stated residents' elopement risk was reviewed quarterly at care conferences, but R12's care conference documentation did not reflect this.

The Elopement policy and procedure revised 4/2016 included, "The location will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring and managing residents at risk for elopement. These

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15 include identifying environmental hazards and resident risk; evaluating/analyzing hazard and risks; implementing interventions; and monitoring/modifying interventions as needed. All residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed ...After an elopement has occurred, use the Elopement Checklist Worksheet that follows as a reference to ensure all required steps were followed. This is a worksheet and therefore not a part of the medical record"	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed ensure a physician's order was in place for oxygen for 1 of 2 residents (R2) reviewed for respiratory care. Findings include: R4 was observed on 2/5/18, at 10:13 a.m. in the chapel participating in a coloring activity. R4 had oxygen in place. R4 was re-admitted to the facility on 2/2/18	F 695	1. An oxygen order was obtained from the physician for R4 and added to the electronic medical record on 2/6/2018. 2. All residents□ records who utilize oxygen were reviewed to ensure an oxygen order was in place on 2/6/2018. 3. Re-education will be provided to nurses on 3/16/2018 regarding the process of ensuring a physician□s order is in place for resident□s requiring respiratory care. 4. Audits will be conducted by DON or	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued 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. 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. R4's physician orders in the electronic medical record (EMR) were reviewed and revealed R4 had no current orders for oxygen therapy. R4's care plan dated 10/2/17, included R4 altered respiratory status/difficulty breathing related to chronic obstructive culinary disease. Interventions included oxygen therapy per medical doctor order. During an interview on 2/6/18, at 6:46 p.m. 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 order for oxygen. LPN-B stated R4 was on three liters of oxygen prior to being hospitalized and stated she just assumed R4 was on 3 liters of oxygen as that had been her previous order prior to being in the hospital. LPN-B stated this was her first night working on this unit since R4's hospital return. LPN-B stated when she came in on her shift the concentrator had been set to 3 liters and she has not made any changes. LPN-B looked through the hospital discharge summary and was not able to locate an order for oxygen. LPN-B stated she would need to call and get an order for R4's oxygen right	F 695	designee on residents requiring respiratory care to ensure orders are present, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 17 away. LPN-B stated when a resident returned from the hospital on oxygen and there was not an oxygen order upon readmission she would have gotten an order for oxygen, especially for her as one of her main issues is being short of breath. During an interview on 2/6/18, at 7:10 p.m., the director of nursing (DON) stated absolutely when R4 was readmitted from the hospital the admitting nurse should have obtained an oxygen order from the doctor if R4 returned from the hospital on oxygen and there was not an order for oxygen in the hospital dismissal summary. During an interview on 2/7/18, at 2:25 p.m. the director of nursing (DON) stated the hospital dismissal summary did not include orders for oxygen. The DON verified there were no oxygen orders in place for R4 from 2/2/18 until 2/6/18, after it was brought to the facilities attention through the survey process.	F 695		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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 review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph	F 756		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 18 (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document reviews, the facility failed to ensure that pharmacist drug regimen recommendations were evaluated and addressed by physician and that a sleep 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	F 756	1. A sleep study and assessment was completed on 2/20/2018 for R14. 2. All pharmacy recommendations for the past 2 months will be reviewed to ensure they have been addressed appropriately. 3. All nurses will be provided with education on the center process that has been developed and put in place to ensure pharmacy recommendations are addressed appropriately and timely. The pharmacist will communicate and route the recommendations to the DON who will now delegate completion to nursing staff	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 19 hypertension; heart failure; insomnia; unspecific dementia with behavioral disturbance. R14's Care plan indicates sleep disturbance related to interrupted sleep during the night. Intervention include allow resident time to respond due to slower processing of cognition skills. Adjust environment to promote sleep, follow R14's usual bedtime routine, likes to be in bed between 7-9 pm. Resident prefers room lights off, keeping nightlight or bathroom light on with door slightly closed. Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. Sleep study as needed. Pharmacy consultant recommendation dated 12/30/17, indicated that R14 was due for a six month drug reevaluation for the following medications: Zoloft 50 milligrams (MG) in a.m. for depression /dementia: Benadryl 50 mg for sleep. With the following recommendations: dose hold of Benadryl must be attempted since this was ordered for sleep. And sleep assessment. Per electronic record last sleep assessment was completed on 12/3/16. Physician ordered medications are: Benadryl Tablet 25 MG Give 25 mg by mouth one time a day related to unspecified dementia with behavioral disturbance, and Give 50 mg by mouth one time a day related to insomnia. Zoloft Tablet 50 MG Give 50 mg by mouth one time a day related to depression Primary physician visit note dated 1/18/18 had been reviewed and no response to the	F 756	and will track responses to ensure appropriate and timely completion. All nurses will be provided education on the process related to pharmacy consultant recommendations on 3/16/2018. 4. Audits will be conducted by Quality Coordinator or designee on the completion of pharmacy consultant recommendations monthly X3, quarterly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 20 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. 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 areas. DON stated, "That is all I can find for sleep after 12/30/17." When asked, DON if she would consider the documentation given a complete sleep assessment. DON stated, "No."	F 756		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. 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)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or	F 757		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 21 §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate parameters and attempt nonpharmacological pain interventions for 3 of 5 residents (R14, R40, R15) reviewed for unnecessary medications. Findings include: According to the face sheet R14 was admitted to the facility 6/3/14. Diagnoses included chronic obstructive pulmonary disease; chronic kidney disease; major depressive disorder; disorder of bone; unspecified osteoarthritis; unspecified hypertension; heart failure; insomnia; unspecific dementia with behavioral disturbance. R14's care plan included the potential for alteration in comfort related to osteoarthritis, non-pharmacological interventions included, encourage R14 to wear left wrist brace when she has pain. R14 is able to on /off brace independently. Observe skin for redness or irritation when using brace. According to R14's current physician orders, the following as needed pain medication were ordered; Ultram 50 mg for Pain-Moderate pain rate of 1-5 out of a 1 to 10 scale with 10 being worst pain ever. R40 received as needed Ultram 10 times in December 2017, 8 times in January 2018, and 2 times February 1 to 6, 2018. No non-pharmacological attempts had been	F 757	1. R14, 15, and 40□s pain medications were reviewed to ensure non-pharmacological interventions and parameters were in place for administration. 2. All residents on pain medications electronic medical records will be reviewed to ensure appropriate parameters are in place. 3. Education will be provided to nurses on 3/16/2018 regarding GSS policy and procedure for managing pain, including parameters for administration and non-pharmacological interventions and appropriate documentation. 4. Audits will be conducted by DON or designee on 5 random resident□s non-pharmacological interventions utilized and to ensure appropriate parameters are in place, weekly x4, monthly x3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 22 documented prior to administration of as needed pain medication. According to the face sheet, R40 admitted to facility on 1/15/18, with diagnosis of fracture to spine, after a fall at home. R40's care plan indicated R40 has pain/discomfort related to wedge compression fracture of thoracic (T) T11 -T12 and lumbar (L) L4 back pain, wears a TLSO (Thoracolumbosacral Orthosis) back brace. and left knee swelling secondary to advanced osteoarthritis. Approaches to try for pain: attempt non-pharmacological inventions: R40 prefers to lay down and use pillows on her sides. According to the medication administration record (MAR) R40 had an orders for the following pain medications: Oxycodone 5 mg tablet every 8 hours for moderated pain; to severe pain started on 1/16/18, for 7 days one table as needed for moderate pain score of 4-6 out of 10 or severe pain of score of 7-10 out 10 for 7 days. R40 received oxycodone 11 times since ordered on 1/16/18. No documentation of any non-pharmacological attempted prior to administrating as needed oxycodone were noted. Percocet 5-325 mg tablet give 1 tablet 8 hours as needed for moderate to severe pain was started on 1/26/18, for 10 days. R40 received Percocet 8 times in the 10 days ordered. No documentation of any non-pharmacological intervention attempts prior to administrating as needed Percocet were noted. Tylenol (Acetaminophen) 325 mg, Give 650 mg by mouth every four hours as needed for pain. R40 received Tylenol 650 mg 20 times since admission without any indication non-pharmacological interventions were attempted prior to medication. No documentation	F 757		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 23	F 757		

of any non-pharmacological intervention attempts prior administrating as needed Tylenol were noted.
R15's admission face sheet included admitted to the facility on 9/22/15, including diagnosis of a hip fracture, back pain and dementia with behaviors.

The quarterly Minimum Data Set dated 12/12/17 an assessment, indicated R15 had occasional pain.

According to the medication administration record (MAR) dated 2/2018, R15 had an order for Tramadol 50 mg every 6 hours for pain and Tylenol 1000 mg by mouth every 8 hours as needed for pain. No parameters were noted on the MAR as to when each medication should be given.

During an interview with licensed practical nurse (LPN)-A on 2/7/18, at 1:31 p.m.stated if there were nonpharmacological interventions done they would be documented in the medical record, although she stated they do not always document them even when they are done.

In an interview with the director of nurses on 2/7/18 at 2:04 p.m., she acknowledged that documentation has been an issue and she had addressed this with the nurses at the last meeting which was held 1/23/18. She verified that the facility has been hit and miss with parameters, and documenting nonpharmacological interventions.

A facility policy revised on 5/2017, indicated that nonpharmacological interventions should be tried prior to or in conjunction with pain medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 24 Review of Policy and Procedure for "Pain Management, Data Collection and Assessment and Non-Pharmacological Pain Interventions" with revision date of 5/17. Procedure: Non-pharmacological interventions should be attempt first, however, in the event they are not successful, they maybe combined with a pharmacological regimen.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive	F 758		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 25 psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reassess antipsychotic medication that had been ordered as needed for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1's admission form included an admitting date of 4/11/17. Also a diagnosis of dementia, Alzheimer's kidney disease, and hypertension. The physician's orders dated 12/21/17, include an order for haloperidol 0.5 milligrams (a first generation antipsychotic medication) by mouth every six hours as needed (prn) for agitation. R1 received this medication on 12/16/17,	F 758	1. R1□s PRN antipsychotic medication was discontinued on 2/8/2018. 2. All residents utilizing PRN antipsychotic medications were reviewed by Social Worker to ensure they are evaluated by a physician for appropriateness or discontinued within 14 days. 3. Re-education on Good Samaritan Society policy and procedure regarding PRN antipsychotic medications will be provided to the Social Worker and nurses by 3/16/2018. 4. Audits will be conducted by Social Worker or designee on resident□s with PRN antipsychotic orders, weekly X4, monthly X3, with results being reported to Quality Committee for further	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	C 02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 26 12/17/17, 12/29/17, 1/5/18, 1/10/18, 1/13/18, 1/27/18, 1/28/18, 1/31/18, 2/1/18, and 2/3/18. As needed antipsychotic medications are to be limited to fourteen days. In order to continue the order a provider must first evaluate the resident. In an interview with the director of nursing (DON) on 2/7/18 at 2:35 p.m., she verified that R1 had been ordered the medication in anticipation of being admitted to hospice and the medication was intended for end of life agitation. R1 did not meet the criteria for hospice and the medication remained. The DON verified that R1 should have had face to face contact with the physician after fourteen days and stated she will work on discontinuing the medication after speaking with family. In a facility policy revised 6/2017, prn antipsychotic drugs are limited to fourteen days and cannot be renewed without the prescribing practitioner evaluates the resident for appropriateness of the medication.	F 758	recommendations.	

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9GS8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**

2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **04/04/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)
13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

* Code: **A** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Danette Bakken, HFE NE II — 4/11/2018
(L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Kamala Fiske-Downing, Enforcement Specialist — 4/11/2018
(L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03401
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

CMS Certification Number (CCN): 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,

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

cc: Licensing and Certification File

DEPARTMENT OF HEALTH

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,

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

cc: Licensing and Certification File

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: 9GS8

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00967

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245317**

2.STATE VENDOR OR MEDICAID NO.
(L2) **692515400**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - COMFORCARE**
(L4) **1201 17TH STREET NE**
(L5) **AUSTIN, MN** (L6) **55912**

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

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

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **02/08/2018** (L34)

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

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

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **45** (L18)

13.Total Certified Beds **45** (L17)

10.THE FACILITY IS CERTIFIED AS:

A. In Compliance With Program Requirements Compliance Based On:
__1. Acceptable POC

X B. Not in Compliance with Program Requirements and/or Applied Waivers:

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

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	45			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE — Date :
Jodie Fox, HFE NE II — 03/15/2018 (L19)

18. STATE SURVEY AGENCY APPROVAL — Date:
Amy Johnson, Enforcement Specialist — 03/23/2018 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
06/01/1986
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

26. TERMINATION ACTION: (L30)

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

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

OTHER
07-Provider Status Change
00-Active

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
03401
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

DEPARTMENT OF HEALTH

Protecting, Maintaining and Improving the Health of All Minnesotans

Electronically delivered
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:

> Opportunity to Correct - the facility is allowed an opportunity to correct identified deficiencies before remedies are imposed;
>
> Electronic Plan of Correction - when a plan of correction will be due and the information to be contained in that document;
>
> Remedies - the type of remedies that will be imposed with the authorization of the Centers for Medicare and Medicaid Services (CMS) if substantial compliance is not attained at the time of a revisit;

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

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

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

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: http://www.health.state.mn.us/divs/fpc/profinfo/ltc/ltc_idr.cfm

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

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

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

Mr. Tom Linhoff, Fire Safety Supervisor
Health Care Fire Inspections
Minnesota Department of Public Safety
State Fire Marshal Division
445 Minnesota Street, Suite 145

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

Feel free to contact me if you have questions.

Sincerely,

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments A survey for compliance with CMS Appendix Z Emergency Preparedness Requirements, was conducted February 5, 6, 7, & 8, 2018, during a recertification survey. The facility is in compliance with the Appendix Z Emergency Preparedness Requirements.	E 000		
F 000	INITIAL COMMENTS On February 5, 6, 7, & 8, 2018, a standard survey was completed at your facility by the Minnesota Department of Health to determine if your facility was in compliance with requirements of 42 CFR Part 483, Subpart B, and Requirements for Long Term Care Facilities. The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility may be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000 3/9/18 gpn		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident	F 550		3/16/18

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

Electronically Signed | 03/09/2018

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 1 with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interviews, and document review, the facility failed to ensure 1 of 1 resident (R145) reviewed for dignity was treated in a respectable manner during a therapy session.	F 550	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 2 Findings include: R145 admitted to facility on 2/1/18, from hospital with diagnosis of pulmonary embolism (a sudden blockage in lung artery) for short-term rehabilitation therapy according to the admission form. During initial interview on 2/6/18, at 12:52 p.m., R145 stated in regards to registered nurse (RN)-B, "Well, first of all she [RN-B] hates her job." I think she [RN-B] was called in or something, it was Friday, morning. The therapy girls were in here at the time. She [RN-B] came in and plopped down on the bed and said, 'If this happens again I'm just going to have to leave.' [RN-B] then continue with other stupid statements that did not pertain to me. "I felt like she did not want to be here and that I was a burden." While talking R145 stopped talking and looked at door, door had opened about 2 inches and then quickly closed. No knock on the door or identification of self opening door was heard. During interview on 2/7/18, at 1:06 p.m. with Family Member (FM)-A who had confirmed R145 was upset with a nurse who come into room not to long ago. FM-A said she had not been at facility when this incident occurred. During follow-up interview on 2/7/18, with R145 at 2:09 p.m., R145 stated that he had not told anyone about the incident with RN-B. When R145 was asked if comfortable with RN-B providing services in the future. R145 stated, "No, I don't want her near me." During phone interview with occupational therapist, register (OTR)-A, on 2/7/18, at 3:03	F 550	correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. 1. R145 and family were interviewed on 2/8/2018 by social worker regarding the incident. Resident reports no emotional or mental distress related to the incident. Social worker encouraged resident to report concerns to staff in the future. RN-B was provided with immediate education by the DON upon being notified by surveyors regarding facility policy on dignity. R145 is now deceased. 2. All interview able residents have been interviewed to ensure that they are treated in a respectful manner. 3. All staff will be provided with education by the Social Worker or designee on 3/13/2018 regarding Good Samaritan Society policy and procedure for ensuring resident dignity and reporting. Education was given to therapy staff on 2/12/2018 regarding ensuring resident dignity and reporting. 4. Audits will be conducted by Social Worker or designee on 5 random interview able residents to ensure their resident dignity is being upheld, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 550	Continued From page 3 p.m., OTR-A confirmed that during her initial evaluation of R145 on 2/2/18 around 9:00 a.m. a nurse came into the room and was a little disgruntled. RN-B made the comments that "I'm not supposed to be working now, and wanting to go home." OTR also stated that it was the nurse, R145, and herself in the room during this incident. OTR said it was inappropriate for the nurse to say the things she said to R145. During interview on 2/8/18, at 1:06 p.m., with director of nursing, (DON) who said, "My exception is to provide care that is respectful and in a dignified mannered, according to the resident performances. This should not have been a conservation in front of resident." Review of policy and procedure "Resident Dignity" revision date 2/2017 included: The location will promote resident care in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Procedure: Respecting the resident's social status by speaking respectfully, listening carefully and treating residents with respect. Focusing on resident as individuals when employees talk to them and addressing them as individuals when providing cares and services.	F 550		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.	F 578		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 4 §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. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State Law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify the preference for Health Care Directives for 1 of 1 resident (R4) reviewed	F 578	1. R4□s code status was identified and entered into the electronic medical record on 2/5/2018. R4 expired on 2/18/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 5 for advanced directives. Findings include: 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. During an interview on 2/7/18, at 2:36 p.m. the director of nursing (DON) stated she had actually printed the POLST R4 had on file prior to R4's hospitalization, and printed a blank POLST and discussed this with the nurse prior to R4 coming back to the facility Friday afternoon. The DON stated she explained to the nurse this was a part of the admission process. The DON stated she was concerned it would be difficult based to obtain a POLST based on the history of R4, so I was trying to provide her with the information and education prior to R4's return from the hospital. The DON stated she followed up with the nurse who re-admitted R4 and stated the nurse that completed the readmission did talk to R4 about	F 578	2. All resident□s electronic medical records were reviewed on 2/5/2018 to ensure a code status was documented per the resident□s choice. 3. All nurses will be provided with education on GSS policy and procedure for advanced care planning and code status documentation by DON or designee on 3/16/2018. 4. Audits will conducted by HIM or designee to ensure all resident□s code status are documented in the electronic medical record, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 578	Continued From page 6 her code status and R4 did not want to provide a clear indication of full code or do not resuscitate. The DON stated the nurse did educate R4 that if she did not provide a code status that meant she would have to resuscitate her and perform CPR [cardiopulmonary resuscitation] if she had a cardiac arrest. The DON stated the nurse did attempt to call the R4's daughter to discuss code status and stated she left the daughter a message. The DON stated the nurse did not document the education and discussion held with R4 or the attempt to contact the daughter. The DON stated the nurse should have indicated R4 was full code in the EMR. The DON stated because of this I did put out a memo to all staff and provided education on advanced directive procedures. Policy regarding advanced directives was requested and none provided.	F 578		
F 684 SS=D	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on interview and record review the facility failed to ensure accurate and complete documentation was maintained in health records regarding interventions/services provided for 2 of	F 684	1. R42 and R192 are expired. 2. The center will review the medical records of all residents deceased at the center in the last 30 days to ensure there	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 7 2 residents (R42, R192) reviewed for death. Findings include: R42 admission form included they had been admitted on 3/17/17, with admitting diagnosis of heart failure. R42 died on 11/10/17. Progress note dated 11/9/17, included that R42 had a scratch on lower back, stating it had happened while scratching. The next progress notes regarding resident health status was on 11/10/17, at 2:00 p.m. family present when vitals ceased. At 2:49 p.m. regarding call from funeral home. At 5:01 p.m. medical doctor to release body to mortician. There was a lack of documentation of when R42 began to decline in health and what interventions including any assessments, interventions, comfort cares, in pain, if physician was contacted prior to passing, was roommate present and what counseling/support given, who took personal items, disposition of medications, etc. During interview on 2/7/18, at 9:20 a.m., regarding circumstances leading up to and ongoing assessments done prior to death with licensed practical nurse (LPN)-A "I was not working, but they told me, she was fine at lunch, they went to check on her and she had passed." During interview on 2/7/18, at 2:25 p.m. with Administrator, state from want I know, R42 had be doing fine at lunch, R42 normal was to nap in wheelchair in room and family would come visit in the afternoon. When R42's daughter came, she went into room with a nursing assistant and notice R42 was unresponsive at that time. They then got a nurse.	F 684	is adequate documentation leading up to the resident death. 3. Education will be provided to nurses on 3/16/2018 regarding GSS policy and procedure for documentation requirements. 4. Audits will be conducted by DON or designee for any resident death at the center to ensure adequate documentation, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 684	Continued From page 8 During interview on 2/8/18, at 12:30 p.m., with director of nursing (DON) stated, "I would expect them to chart what they had done." For them to tell the story of exactly what happened so that someone reading it would be able to follow and know what happened and what was done." DON also stated that she had a nursing meeting on 1/23/18, regarding documentation when a resident died including a checklists tool that include death. R192 had admitted to the facility on 1/26/18 according to admission form with admitting diagnosis of malignant neoplasm of colon and liver, chronic obstructive pulmonary disease. Also received hospice services on admission. Progress notes dated 2/6/18 at 4:29 a.m., indicating that resident slept most of shift, was given pain medication and stated pain was at a 5 out of a pain scale of 0 to 10 with 10 being worst pain ever. At 5:40 p.m. indicating that vitals ceased at 5:30 p.m., and that family was called to notify of R192 passing, confirmed funeral home, that daughter-in-law was on way to facility. However, there was lack of assessment regarding pain control, other health status changes, any interventions such as oxygen, from 4:29 a.m. until death at 5:30 p.m. During follow-up interview on 2/8/18 at 1:25 p.m., with DON, confirmed documentation for R192 showed no notes prior to R192 passing comfortable. When asked if the documentation met the death checklist education presented on 1/23/18, at nurse's meeting. DON stated "No, the documentation did not tell the story of him having a peaceful passing."	F 684		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689 SS=D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review, the facility failed to comprehensively assess the risk for elopement for 2 of 2 resident (R14 and R12) who had a history of leaving the facility without authorization. Findings include: According to face sheet R14 admitted to the facility 6/3/14. Diagnoses include: chronic obstructive pulmonary disease; chronic kidney disease; major depressive disorder; disorder of bone; unspecified osteoarthritis; unspecified hypertension; heart failure; insomnia; unspecific dementia with behavioral disturbance. R14 had been observed on 2/6/18, at 6:29 p.m. in dining room on unit eating supper. On 2/7/18, at 10:00 a.m. R14 attending a devotions activity in the chapel. In addition, at 2:40 p.m. attending BINGO in the lodge unit dining room. On 2/8/18, at 10:25 a.m. R14 in room in wheelchair still in pajamas, looking though her belongings. At 10:38 a.m. R14 in room visiting	F 689	1. The Social Worker has assessed and care planned appropriate interventions for R12 and R14 for elopement risk. 2. All residents at risk of elopement have been reviewed by the Social Worker and DON to ensure their elopement risk has been assessed and care plans updated appropriately with interventions to prevent elopement. 3. All staff will be provided with education on GSS policy and procedure for elopement risk including assessing upon admission, re-admission, and with any onset of exit seeking behavior, as well as care planning appropriate interventions. 4. Audits of all residents at risk of elopement will be conducted by Quality Coordinator or designee to ensure assessments have been completed and care plans reflect appropriate interventions, weekly x4, monthly x3, with results being reported to Quality Committee for further recommendations.	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 10	F 689		

family members (FM)-A & B, who were leaving, R14 stating not feeling well.

R14's care plan included a has history of wandering behavior. In addition, that she is independent with transfers.
monitored for mood/behavior per nursing assist care sheet (Kardex). Care plan also included: Behavior of Agitation/talking about wanting to leave: Attempt to redirect thought process, offer activities and snacks resident prefers such as root beer float or decaf coffee. Continue to monitor and ensure resident is in a safe place. Behavior of agitation and starting to wander intervention: Approach R14 right when starting to wheeling around the hallway and offer things such as a root beer float, glass of root beer, decaf coffee, turn on old time music on DVD player on unit, to help reduce any escalation of behavior. If unable to keep on unit, one staff to follow R14 in hallways. Attempt to divert her to chapel where she appears to deescalate. Behavior of yelling and being combatative intervention: Leave resident in safe position and re-approach at a later time. Also, ask resident to show her "bike" that she has in her room.

Review of incident reports for R14 revealed that R14 had eloped from the facility on 5/27/17, 6/9/17, and again on 7/12/17.

R14's electronic medical record (EMR) was reviewed and revealed a comprehensive elopement risk assessment had not been completed for R14 since her admission to the facility on 6/3/14, even though she had exhibited elopement behavior in the past year.

R14's incident report for elopement on 5/27/17, at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 11	F 689		

5:45 p.m. certified nursing assistant (CNA) received a report from another CNA that resident was out the front door in the parking lot.

R14's investigation summary vulnerable adult report dated 6/2/17, to the Office of Health facility Complaints included the following: resident had exited her neighborhood with a wander bracelet on her ankle. Alarms did sound on her neighborhood. Floor staff were in another resident's room with an emergency. A visitor came and notified a CNA from another neighborhood that a resident was at the front door in between the double doors. CNA went to get resident to return her to her neighborhood and when he got to the front door, R14 had got out into the parking lot by the parked cars looking for vehicle to go home. CNA stated front door was alarming and locked. Action taken to prevent reoccurrence: Immediate action taken was R14 was brought back for safety. 15 min checks minute checks were care planned for the next 48 hours. Double doors to resident's neighborhood were closed until maintenance could assess to determine if in good working condition.
Long-term action plan is in place to audit exit doors to determine they are working appropriately and wander bracelets daily for function. A memo was sent to all nursing staff to re-educate that they need to assess the area when a door alarm is going off and not being turned off by staff immediately.

R14's incident report for elopement on 6/9/17, at 9:21 a.m., unable to locate resident, CNA found R14 outside in enclosed patio.

R14's investigation summary vulnerable adult report dated 6/15/17, to the Office of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 12	F 689		

facility Complaints included the following: upon investigation it was determined that some of the exterior doors alarm boxes were not working appropriately. Maintenance and director of nursing (DON) tested all doors with wander-guard alarm systems immediately and determined some were not alarming when they should be. All residents who have a wander guard in place were put on 15-minute checks, as the company for the system could not come to the facility until 612/17. On 6/12/17, a technician from IFC (the alarm company) had come to facility to assess and fix wander-guard door alarms. The technician checked each door and all were working well with only a few minor adjustments needing to be done. He made all annunciator panels alarm louder and adjusted a few magnetic holds on the doors that needed it. There are few adjustments that need fixing on the doors that will not cause an elopement but should get done per the technician, these are a key box needs to be place on the another wall on the Garden to accurately detect the wander-guard. This is door is locked until that unit can be moved. The door to the patio door in the Garden needs a new magnetic piece replaced. This is the same door resident had eloped from and why it happened so easily. The technician will be back to facility on 6/20/17, make these repairs and that patio door will remain locked until then. Action taken to prevent reoccurrence: Wander-guard alarm system assessed and being fixed and updated per recommendations from technician from IFC.

R14's incident report for elopement on 7/12/17, at 10:00 p.m., CNA reported the when she went on break around 8:30 p.m. resident was outside the building, in front, under canopy. CNA reports resident said, "I want those kids out of my house."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 13	F 689		

R14's investigation summary vulnerable adult report dated 7/20/17, to the Office of Health facility Complaints included the following: R14 was found sitting out front of the facility wanting the kids off her porch. After interviewing staff working that evening it has been discovered that resident does like to wheel around the facility in her wheelchair. Staff had shut off alarm to the neighborhood doorway as R14 was wheeling around facility. Staff then did not go check on R14 every 5-10 minutes and had not tried to redirect resident to come back to R14's neighborhood. R14 possibly followed a visitor out of the door or had pushed the door for 15 seconds or more to get it open. R14 found by another staff member of another neighborhood and that staff person brought resident back to her unit. R14 not injured nor is there a change in her functional status. Action taken to prevent reoccurrence: Education was done with staff on her unit stating that when a door alarm goes off they cannot shut of the alarm and let resident with a wander guard in the place continue to wander the building alone.

Review of progress notes from 11/8/17-2/8/17, showed R14 continues to have behaviors of wandering on R14's neighborhood by wandering up and down hallways; in and out of other resident rooms, and attempting to exit the front doors, by following visitors. With the last progress note dated 1/30/18, were R14 had attempted to follow family member (FM)-A out the front doors of facility.

During interview on 2/8/18, at 10:28 a.m., nursing assistant (NA)-B stated that R14 is independent with most of care though R14 is declining and I will go assist R14 when allows due to refusal.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 14	F 689		

R14 has not allowed me to help yet today.

During interview on 2/8/18, 11:10 a.m., register nurse (RN)-A states, R14 will not call for assistance and will refuse care. Staff will reproached and help R14 as allows. Some days R14 is perfectly fine with help, the next time will refuse and if attempts to encourage continue R14, can become combative, by kicking, or hitting, or yelling at staff to get out of here.

During interview on 2/8/18, at 11:15 a.m., maintenance-A stated the he checks the wander guard alarm on the all neighborhood doors (healing grace, the lodge, the garden), along with front door, and all patio doors weekly, every Friday. In addition, will check each resident's wanderguard bracelet by bringing them to the doors and ensuring that alarm sounds. Review of logs showed no concerns.

During interview on 2/8/18 at 2:42 p.m., with director of nursing who stated there is no specific document for elopement risk assessment. However, everyone with a elopement risk is evaluatated, with the quarterly assessments, after each elopement we do a checklist, that we do not scan into the resident medical chart. As it is a checklist it is not part of the resident chart.
R12 was observed on 2/05/18, at 9:58 a.m. wheeling around the unit in her wheelchair and was looking for her mother.

R12's admission record identified R12 had diagnoses of dementia. R12's annual Minimum Data Set (MDS) dated 11/28/18, indicated severely impaired decision-making skills for daily living.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 15	F 689		

Review of incident reports revealed R12 had eloped from the facility on 9/17/17.

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.

R12's Incident Report dated 9/17/17, indicated: Elopement. Activity Director brought resident back to the Gardens. Stated resident was found in the parking lot. Resident stated she was going to a wedding.

R12's investigation summary vulnerable adult report dated 9/22/17, to the Office of Health facility Complaints included the following: R12 had wheeled herself to the front door of the facility and went out onto the sidewalk. A family member saw R12 out there and reported to a staff member that they believed a resident was outside that should not be and that R12 would not come back inside with them. The staff member then went and saw R12 out front between two building pillars in a wheelchair. The staff member approached R12 and asked what R12 was doing and the R12 stated, "I'm going to a wedding." R12 did come back into the facility without any incident with the staff member. Action taken to prevent reoccurrence: R12 did not exhibit elopement behavior in the past. R12 would wheel around the long-term side of the facility but would rarely come to the front door. R12's dementia has declined and so a wander guard was placed on R12's ankle for prevention of elopement.

R12's Elopement Checklist Worksheet that was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 16	F 689		

to be completed after R12 eloped on 9/17/17 per 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 on 2/8/18, at 11:24 a.m. the director of nursing (DON) stated elopement risk assessments were completed upon admission and readmission to the facility and were addressed at care conferences. The DON stated she expected an elopement risk assessment to be completed upon an elopement. The DON stated an elopement risk assessment should be completed if a resident started to display behaviors that would indicate they would be at risk for eloping or if a resident had an elopement from the facility. The DON stated she planned to create a form that would be kept with the nurses' checklist binder to be completed when there was an elopement or when behaviors were noted that increase their flight risk. The DON stated the facility would also continue to review residents' elopement risk, the continued need for a wander guard and if the interventions were effective. The DON stated she felt like they (facility staff) assessed R12's risk for elopement and placed measures to minimize the risk of the elopement after R12 eloped. The DON stated she felt like the facility did follow their policy for elopement.

During an interview on 2/8/18, at 2:05 p.m. the director of nursing (DON) said the policy for elopement did not provide a clear indication of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 689	Continued From page 17 how to document an elopement risk assessment in one comprehensive assessment. The DON stated in the progress notes there was not a specific comprehensive summary analysis of R12's elopement risk assessment. The DON stated I personally would like to know the whole story (regarding R12's elopement) and am unable to tell by the documentation. The DON stated residents' elopement risk was reviewed quarterly at care conferences, but R12's care conference documentation did not reflect this. The Elopement policy and procedure revised 4/2016 included, "The location will be responsible for maintaining a system that clearly defines the mechanisms and procedures for monitoring and managing residents at risk for elopement. These include identifying environmental hazards and resident risk; evaluating/analyzing hazard and risks; implementing interventions; and monitoring/modifying interventions as needed. All residents will be assessed for risk of elopement through the pre-admission and/or admission process and as needed ...After an elopement has occurred, use the Elopement Checklist Worksheet that follows as a reference to ensure all required steps were followed. This is a worksheet and therefore not a part of the medical record"	F 689		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of	F 695		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 18 practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, the facility failed ensure a physician's order was in place for oxygen for 1 of 2 residents (R2) reviewed for respiratory care. Findings include: R4 was observed on 2/5/18, at 10:13 a.m. in the chapel participating in a coloring activity. R4 had oxygen in place. 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 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. R4's physician orders in the electronic medical record (EMR) were reviewed and revealed R4 had no current orders for oxygen therapy. R4's care plan dated 10/2/17, included R4 altered respiratory status/difficulty breathing related to chronic obstructive culinary disease. Interventions included oxygen therapy per medical doctor order.	F 695	1. An oxygen order was obtained from the physician for R4 and added to the electronic medical record on 2/6/2018. 2. All residents□ records who utilize oxygen were reviewed to ensure an oxygen order was in place on 2/6/2018. 3. Re-education will be provided to nurses on 3/16/2018 regarding the process of ensuring a physician□s order is in place for resident□s requiring respiratory care. 4. Audits will be conducted by DON or designee on residents requiring respiratory care to ensure orders are present, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 19 During an interview on 2/6/18, at 6:46 p.m. 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 order for oxygen. LPN-B stated R4 was on three liters of oxygen prior to being hospitalized and stated she just assumed R4 was on 3 liters of oxygen as that had been her previous order prior to being in the hospital. LPN-B stated this was her first night working on this unit since R4's hospital return. LPN-B stated when she came in on her shift the concentrator had been set to 3 liters and she has not made any changes. LPN-B looked through the hospital discharge summary and was not able to locate an order for oxygen. LPN-B stated she would need to call and get an order for R4's oxygen right away. LPN-B stated when a resident returned from the hospital on oxygen and there was not an oxygen order upon readmission she would have gotten an order for oxygen, especially for her as one of her main issues is being short of breath. During an interview on 2/6/18, at 7:10 p.m., the director of nursing (DON) stated absolutely when R4 was readmitted from the hospital the admitting nurse should have obtained an oxygen order from the doctor if R4 returned from the hospital on oxygen and there was not an order for oxygen in the hospital dismissal summary. During an interview on 2/7/18, at 2:25 p.m. the director of nursing (DON) stated the hospital dismissal summary did not include orders for oxygen. The DON verified there were no oxygen orders in place for R4 from 2/2/18 until 2/6/18, after it was brought to the facilities attention through the survey process.	F 695		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 20	F 756		
F 756 SS=D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §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 review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take	F 756		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 21 when he or she identifies an irregularity that requires urgent action to protect the resident. This REQUIREMENT is not met as evidenced by: Based on interview and document reviews, the facility failed to ensure that pharmacist drug regimen recommendations were evaluated and addressed by physician and that a sleep 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 hypertension; heart failure; insomnia; unspecific dementia with behavioral disturbance. R14's Care plan indicates sleep disturbance related to interrupted sleep during the night. Intervention include allow resident time to respond due to slower processing of cognition skills. Adjust environment to promote sleep, follow R14's usual bedtime routine, likes to be in bed between 7-9 pm. Resident prefers room lights off, keeping nightlight or bathroom light on with door slightly closed. Consult with pharmacy, health care provider, etc. to consider dosage reduction when clinically appropriate. Sleep study as needed. Pharmacy consultant recommendation dated 12/30/17, indicated that R14 was due for a six month drug reevaluation for the following medications: Zoloft 50 milligrams (MG) in a.m. for	F 756	1. A sleep study and assessment was completed on 2/20/2018 for R14. 2. All pharmacy recommendations for the past 2 months will be reviewed to ensure they have been addressed appropriately. 3. All nurses will be provided with education on the center process that has been developed and put in place to ensure pharmacy recommendations are addressed appropriately and timely. The pharmacist will communicate and route the recommendations to the DON who will now delegate completion to nursing staff and will track responses to ensure appropriate and timely completion. All nurses will be provided education on the process related to pharmacy consultant recommendations on 3/16/2018. 4. Audits will be conducted by Quality Coordinator or designee on the completion of pharmacy consultant recommendations monthly X3, quarterly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 756	Continued From page 22	F 756		

depression /dementia: Benadryl 50 mg for sleep. With the following recommendations: dose hold of Benadryl must be attempted since this was ordered for sleep. And sleep assessment.

Per electronic record last sleep assessment was completed on 12/3/16.

Physician ordered medications are:
Benadryl Tablet 25 MG Give 25 mg by mouth one time a day related to unspecified dementia with behavioral disturbance, and Give 50 mg by mouth one time a day related to insomnia.
Zoloft Tablet 50 MG Give 50 mg by mouth one time a day related to depression

Primary physician visit note dated 1/18/18 had been reviewed and no response to the 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. 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 areas. DON stated, "That is all I can find for sleep after 12/30/17." When asked, DON if she would consider the documentation given a complete sleep assessment. DON stated, "No."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. 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)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to provide adequate parameters and attempt nonpharmacological pain interventions for 3 of 5 residents (R14, R40, R15) reviewed for unnecessary medications. Findings include: According to the face sheet R14 was admitted to the facility 6/3/14. Diagnoses included chronic obstructive pulmonary disease; chronic kidney disease; major depressive disorder; disorder of bone; unspecified osteoarthritis; unspecified hypertension; heart failure; insomnia; unspecific	F 757	1. R14, 15, and 40□s pain medications were reviewed to ensure non-pharmacological interventions and parameters were in place for administration. 2. All residents on pain medications electronic medical records will be reviewed to ensure appropriate parameters are in place. 3. Education will be provided to nurses on 3/16/2018 regarding GSS policy and procedure for managing pain, including parameters for administration and	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 24 dementia with behavioral disturbance. R14's care plan included the potential for alteration in comfort related to osteoarthritis, non-pharmacological interventions included, encourage R14 to wear left wrist brace when she has pain. R14 is able to on /off brace independently. Observe skin for redness or irritation when using brace. According to R14's current physician orders, the following as needed pain medication were ordered; Ultram 50 mg for Pain-Moderate pain rate of 1-5 out of a 1 to 10 scale with 10 being worst pain ever. R40 received as needed Ultram 10 times in December 2017, 8 times in January 2018, and 2 times February 1 to 6, 2018. No non-pharmacological attempts had been documented prior to administration of as needed pain medication. According to the face sheet, R40 admitted to facility on 1/15/18, with diagnosis of fracture to spine, after a fall at home. R40's care plan indicated R40 has pain/discomfort related to wedge compression fracture of thoracic (T) T11 -T12 and lumbar (L) L4 back pain, wears a TLSO (Thoracolumbosacral Orthosis) back brace. and left knee swelling secondary to advanced osteoarthritis. Approaches to try for pain: attempt non-pharmacological inventions: R40 prefers to lay down and use pillows on her sides. According to the medication administration record (MAR) R40 had an orders for the following pain medications: Oxycodone 5 mg tablet every 8 hours for moderated pain; to severe pain started on 1/16/18, for 7 days one table as needed for moderate pain score of 4-6 out of 10 or severe pain of score of 7-10 out 10 for 7 days. R40 received oxycodone 11 times since ordered on	F 757	non-pharmacological interventions and appropriate documentation. 4. Audits will be conducted by DON or designee on 5 random resident□s non-pharmacological interventions utilized and to ensure appropriate parameters are in place, weekly x4, monthly x3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 25	F 757		

1/16/18. No documentation of any non-pharmacological attempted prior to administrating as needed oxycodone were noted.
Percocet 5-325 mg tablet give 1 tablet 8 hours as needed for moderate to severe pain was started on 1/26/18, for 10 days. R40 received Percocet 8 times in the 10 days ordered. No documentation of any non-pharmacological intervention attempts prior to administrating as needed Percocet were noted.
Tylenol (Acetaminophen) 325 mg, Give 650 mg by mouth every four hours as needed for pain. R40 received Tylenol 650 mg 20 times since admission without any indication non-pharmacological interventions were attempted prior to medication. No documentation of any non-pharmacological intervention attempts prior administrating as needed Tylenol were noted.
R15's admission face sheet included admitted to the facility on 9/22/15, including diagnosis of a hip fracture, back pain and dementia with behaviors.

The quarterly Minimum Data Set dated 12/12/17 an assessment, indicated R15 had occasional pain.

According to the medication administration record (MAR) dated 2/2018, R15 had an order for Tramadol 50 mg every 6 hours for pain and Tylenol 1000 mg by mouth every 8 hours as needed for pain. No parameters were noted on the MAR as to when each medication should be given.

During an interview with licensed practical nurse (LPN)-A on 2/7/18, at 1:31 p.m.stated if there were nonpharmacological interventions done they would be documented in the medical record,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 757	Continued From page 26 although she stated they do not always document them even when they are done. In an interview with the director of nurses on 2/7/18 at 2:04 p.m., she acknowledged that documentation has been an issue and she had addressed this with the nurses at the last meeting which was held 1/23/18. She verified that the facility has been hit and miss with parameters, and documenting nonpharmacological interventions. A facility policy revised on 5/2017, indicated that nonpharmacological interventions should be tried prior to or in conjunction with pain medication. Review of Policy and Procedure for "Pain Management, Data Collection and Assessment and Non-Pharmacological Pain Interventions" with revision date of 5/17. Procedure: Non-pharmacological interventions should be attempt first, however, in the event they are not successful, they maybe combined with a pharmacological regimen.	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic	F 758		3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 27 Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to reassess antipsychotic medication	F 758	1. R1□s PRN antipsychotic medication was discontinued on 2/8/2018.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 28 that had been ordered as needed for 1 of 5 residents (R1) reviewed for unnecessary medications. Findings include: R1's admission form included an admitting date of 4/11/17. Also a diagnosis of dementia, Alzheimer's kidney disease, and hypertension. The physician's orders dated 12/21/17, include an order for haloperidol 0.5 milligrams (a first generation antipsychotic medication) by mouth every six hours as needed (prn) for agitation. R1 received this medication on 12/16/17, 12/17/17, 12/29/17, 1/5/18, 1/10/18, 1/13/18, 1/27/18, 1/28/18, 1/31/18, 2/1/18, and 2/3/18. As needed antipsychotic medications are to be limited to fourteen days. In order to continue the order a provider must first evaluate the resident. In an interview with the director of nursing (DON) on 2/7/18 at 2:35 p.m., she verified that R1 had been ordered the medication in anticipation of being admitted to hospice and the medication was intended for end of life agitation. R1 did not meet the criteria for hospice and the medication remained. The DON verified that R1 should have had face to face contact with the physician after fourteen days and stated she will work on discontinuing the medication after speaking with family. In a facility policy revised 6/2017, prn antipsychotic drugs are limited to fourteen days and cannot be renewed without the prescribing practitioner evaluates the resident for	F 758	2. All residents utilizing PRN antipsychotic medications were reviewed by Social Worker to ensure they are evaluated by a physician for appropriateness or discontinued within 14 days. 3. Re-education on Good Samaritan Society policy and procedure regarding PRN antipsychotic medications will be provided to the Social Worker and nurses by 3/16/2018. 4. Audits will be conducted by Social Worker or designee on resident□s with PRN antipsychotic orders, weekly X4, monthly X3, with results being reported to Quality Committee for further recommendations.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 758	Continued From page 29 appropriateness of the medication.	F 758		
F 867 SS=F	QAPI/QAA Improvement Activities CFR(s): 483.75(g)(2)(ii) §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on interview and document review, the facility failed to identify ongoing quality concerns related to incomplete medical records documentation as previously cited on last recertification survey exited 12/15/16. and did not provide oversite of facility systems that had been previously cited in a survey (F514) with an exit date of 12/15/16. This could affect 37 of 37 residents currently living in the facility Findings include: Please refer to citation F684 regarding lack of documenting concerns with health status changes. This same citation was issued on the survey exited 12/15/16 at F514. In an interview on 2/8/18, at 2:18 p.m., with the quality director, she stated that the usual process for a plan of correction is to require audits for three months after the problem was identified. In this particular instance the audits were reported as positive (meaning the problem at that time had been resolved) and the audits were discontinued. The quality director went on to say that the	F 867	1. The Quality Coordinator was instructed to include annual survey results in the monthly quality meeting minutes. Survey deficiencies and remedies will be reviewed and audited by the quality committee on a quarterly basis. The Administrator or designee will audit the quality minutes for compliance monthly for one year.	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING _____ B. WING _____	02/08/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 30 corporation has a new sustainability tool that will ensure after the three month audit there will be a follow up after six months enabling recognition of any continuing noncompliance.	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**02/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ON-SITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey dated 02/07/2018, Good Samaritan Society Comforcare was found not in compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2012 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. PLEASE RETURN THE PLAN OF CORRECTION FOR THE FIRE SAFETY DEFICIENCIES (K-TAGS) TO: Health Care Fire Inspections State Fire Marshal Division 445 Minnesota St., Suite 145	K 000	EPOC	

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**02/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 1 St Paul, MN 55101-5145, or By email to: Marian.Whitney@state.mn.us <mailto:Marian.Whitney@state.mn.us> and Angela.Kappenman@state.mn.us <mailto:Angela.Kappenman@state.mn.us> THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society Comforcare, is a 1-story building with no basement. The building was constructed in 2007 and was determined to be of Type II(111) construction. The building is fully sprinklered. The facility has a fire alarm system with full corridor smoke detection, spaces open to the corridors that is monitored for automatic fire department notification. There is smoke alarms in all resident rooms that are monitored by the nurse call system and light outside each resident room. The facility has a capacity of 45 beds and had a	K 000		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**02/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	Continued From page 2 census of 38 at the time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 293 SS=E	Exit Signage CFR(s): NFPA 101 Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 (Indicate N/A in one-story existing occupancies with less than 30 occupants where the line of exit travel is obvious.) This REQUIREMENT is not met as evidenced by: Based on observation and interview, the Facility failed to ensure that exit and directional signs are displayed in accordance with 7.10 .This deficient practice could affect 30 of the 38 residents. Exit Signage 2012 EXISTING Exit and directional signs are displayed in accordance with 7.10 with continuous illumination also served by the emergency lighting system. 19.2.10.1 FINDINGS INCLUDE: On facility tour between 10:00 AM and 1:00 PM on 02/07/2018, observation revealed that the exterior door from the physical therapy department is not designated as an exit. This door was not marked as a "No Exit". This deficient practice was verified by the Facility	K 293	Preparation and execution of this response and plan of correction does not constitute an admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law. For the purposes of any allegation that the center is not in substantial compliance with federal requirements of participation, this response and plan of correction constitutes the center□s allegation of compliance in accordance with section 7305 of the State Operations Manual. A "No Exit" sign was placed on the exterior therapy door on 3/6/2018.	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**02/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 293	Continued From page 3 Maintenance Director.	K 293		
K 372 SS=D	Subdivision of Building Spaces - Smoke Barrie CFR(s): NFPA 101 Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke barrier. 19.3.7.3, 8.6.7.1(1) Describe any mechanical smoke control system in REMARKS. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, the facility failed to maintain smoke barrier walls construction that meet the requirements of NFPA 101 - 2012 edition, Sections 19-3.7.3 and 8.6.7.1. (1). This deficient practice could affect 15 of 45 residents by allowing smoke to propagate from one smoke compartment to another. Subdivision of Building Spaces - Smoke Barrier Construction 2012 EXISTING Smoke barriers shall be constructed to a 1/2-hour fire resistance rating per 8.5. Smoke barriers shall be permitted to terminate at an atrium wall. Smoke dampers are not required in duct penetrations in fully ducted HVAC systems where an approved sprinkler system is installed for smoke compartments adjacent to the smoke	K 372	The smoke barrier penetration was filled appropriately by maintenance on 2/9/2018.	3/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245317	A. BUILDING **02 - BUILT IN 2007** B. WING _____	**02/07/2018**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN 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)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 372	Continued From page 4 barrier. 19.3.7.3, 8.6.7.1(1). FINDINGS INCLUDE: 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 in the smoke barriers. This deficient practice was verified by the Facility Maintenance Director.	K 372		