DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: E0TV

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

1	PART I - TO BE COMPLETED BY TH						E STATE SURVEY AGENCY Facility ID: 00			
1. MEDICARE/MEDICAID PROVIDER NO. (L1) 245441 2.STATE VENDOR OR MEDICAID NO. (L2) 418840300		3. NAME AND AD (L3) GOOD SAM (L4) 75507 240TH (L5) ALBERT LE	IARITAN SOC H STREET			56007	 Initia Term Valid 	ination ation	2. Recertification 4. CHOW 6. Complaint	
5. EFFECTIVE DATE CHANGE OF OWNER (L9)		7. PROVIDER/SU 01 Hospital	IPPLIER CATEG	ORY 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-Si 8. Full S	ite Visit Survey After (9. Other Complaint	
6. DATE OF SURVEY 03/12/201: 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	5 (L34) _ (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF D 15 ASC 16 HOSPICE			EAR ENDING 2/31	G DATE: (L35)	
11. LTC PERIOD OF CERTIFICATION From (a): To (b): 12. Total Facility Beds 13. Total Certified Beds 114		Compliance1. Ac B. Not in Com		gram	2. Tech 3. 24 H 4. 7-Da 5. Life	ved Waivers Of ' nical Personnel four RN ty RN (Rural SN Safety Code	6. S 7. M F) 8. F	Requirement cope of Serv Medical Direct Patient Room Beds/Room	rices Limit	
14. LTC CERTIFIED BED BREAKDOWN	Į.				15. FACILITY M	IEETS				
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):	(L15)		
114 (L37) (L38)	(L39)	(L42)	(L43)							
16. STATE SURVEY AGENCY REMARKS (I	IF APPLICA	BLE SHOW LTC CA	ANCELLATION I	DATE):						
17. SURVEYOR SIGNATURE		Date :			18. STATE SUR	RVEY AGENCY	APPROVAL		Date:	
Kathryn Serie, Unit Supervisor		0.	3/16/2015	(L19)	K <u>amala Fiske</u>	-Downing, I	Enforceme	nt Specia	dist 04/10/2015 (L20)	
PART II -	TO BE (COMPLETED E	BY HCFA RE	EGIONAI	L OFFICE OF	R SINGLE S	TATE AGE	ENCY		
19. DETERMINATION OF ELIGIBILITY _X 1. Facility is Eligible to Participate	e		IPLIANCE WITH HTS ACT:	H CIVIL	2. C	tatement of Finan Ownership/Contro both of the Above	l Interest Discl			
2. Facility is not Eligible	(L21)									
22. ORIGINAL DATE 23. LT	TC AGREEM	MENT 24	4. LTC AGREEM	MENT	26. TERMINA	TION ACTION:		(L	.30)	
OF PARTICIPATION B 02/01/1987	BEGINNING	DATE	ENDING DAT	ГЕ	VOLUNTARY 01-Merger, Clos		_	INVOLUNT 05-Fail to M	TARY eet Health/Safety	
(L24)	L41)		(L25)		02-Dissatisfactio			06-Fail to M	eet Agreement	
		/E SANCTIONS of Admissions:	(L44)		03-Risk of Involu 04-Other Reason	=		OTHER 07-Provider 00-Active	Status Change	
(L27) B	. Rescind Su	spension Date:	(L44)					001101110		
			(L45)							
28. TERMINATION DATE:	29.	INTERMEDIARY/	CARRIER NO.		30. REMARKS					
		00140								
(L2	8)			(L31)						
31. RO RECEIPT OF CMS-1539	32.	DETERMINATION	OF APPROVAL	DATE						
(L3:	2)	03/12/2015		(L33)	DETERMIN	ATION APPF	ROVAL			



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered

CMS Certification Number (CCN): 245441

April 10, 2015

Ms. Katie Davis, Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, Minnesota 56007

Dear Ms. Davis:

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 2, 2015 the above facility is certified for:

114 Skilled Nursing Facility/Nursing Facility Beds

Your facility's Medicare approved area consists of all 114 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, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered March 16, 2015

Ms. Katie Davis, Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, MN 56007

RE: Project Number S5441024

Dear Ms. Davis:

On February 12, 2015, we informed you that we would recommend enforcement remedies based on the deficiencies cited by this Department for a standard survey, completed on January 29, 2015. This survey found the most serious deficiencies to be isolated deficiencies that constituted no actual harm with potential for more than minimal harm that was not immediate jeopardy (Level D) whereby corrections were required.

On March 12, 2015, the Minnesota Department of Health completed a Post Certification Revisit (PCR) by review of your plan of correction and on March 1, 2015 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 January 29, 2015. We presumed, based on your plan of correction, that your facility had corrected these deficiencies as of March 2, 2015. Based on our PCR, we have determined that your facility has corrected the deficiencies issued pursuant to our standard survey, completed on January 29, 2015, effective March 2, 2015 and therefore remedies outlined in our letter to you dated February 12, 2015, 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, Program Specialist

Licensing and Certification Program

Kumala Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1)	Provider / Supplier / CLIA / Identification Number 245441	(Y2) Multiple Construction A. Building B. Wing		(Y3) Date of Revisit 3/12/2015
Name	e of Facility		Street Address, City, State, Zip Code	
G	OOD SAMARITAN SOCIETY - ALBEF	RT LEA	75507 240TH STREET ALBERT LEA, MN 56007	

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

(Y4) Item		(Y5)	Date	(Y4) Item		(Y5)	Date	(Y4)	Item		(Y5)	Date
		(Correction				Correction					Correction
ID Prefix	F0155		Completed 03/02/2015	ID Prefix	F0282		Completed 03/02/2015		ID Prefix	F0314		Completed 03/02/2015
	483.10(b)(4)		. G, G = , E G		483.20(k)(3)(ii)		-			483.25(c)		
LSC	400.10(5)(4)			LSC	400.20(R)(O)(II)		-		LSC	100.20(0)		_
			Correction				Correction					Correction
ID Prefix			Completed	ID Prefix			Completed		ID Prefix			Completed
Reg. #				Reg. #			-		Reg. #			
LSC				LSC			-					 _
		(Correction				Correction					Correction
			Completed				Completed					Completed
ID Prefix				ID Prefix					ID Prefix			
Reg. #				Reg. #					Reg. #			
LSC				LSC					LSC			
		(Correction				Correction					Correction
		(Completed				Completed					Completed
ID Prefix	-			ID Prefix			-		ID Prefix			_
Reg. #				Reg. #			=		Reg. #			
				130								_
		(Correction				Correction					Correction
ID Dueffix			Completed	ID Duefis			Completed		ID Dueffy			Completed
Reg. # LSC				Reg. # LSC			-		Reg. # LSC			_
Reviewed E	Rv Rev	viewed I	Rv	Date:	Signoture	of S	WONOR:				Date:	
State Agen		S/kfd	-,	03/16/20	Signature		-	048				12/2015
		viewed l	Bv	Date:	Signature			U40			Date:	14/4013
CMS RO	,		-,		2.9.14.410	J. Ju	,					
Followup t	o Survey Comple	eted on:			Check for any						1	
	1/29/201	15								the Facility?	YES	NO

Form Approved OMB NO. 0938-0390

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 245441	(Y2) Multiple Con A. Building B. Wing		BERT LEA GOOD SAMARITAN CEN	(Y3) Date of Revisit 3/1/2015		
Name of Facility		Street Address, City, State, Zip Code				
GOOD SAMARITAN SOCIETY - ALBER	RT LEA		75507 240TH STREET ALBERT LEA, MN 56007			

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

(Y4) Item		(Y5) D	ate	(Y4) Item	(Y5)	Date	(Y4)	Item	(Y5)	Date
ID Prefix		Com	ection pleted 7/2015	ID Prefix		Correction Completed		ID Profix		Correction Completed
		OZ/Z	7/2013			=				
•	NFPA 101 K0050			Reg. #				Reg. # LSC		
			_							
			ection			Correction				Correction
ID Prefix			pleted	ID Prefix		Completed		ID Prefix		Completed
Reg. #				D "						
LSC				LSC _	_	•		LSC		
		Corr	ection			Correction				Correction
		Com	pleted			Completed				Completed
ID Prefix				ID Prefix				ID Prefix		<u> </u>
Reg. #				Reg. #				Reg. #		
LSC				LSC				LSC		<u> </u>
		Corr	ection			Correction				Correction
ID Drofiv			pleted	ID Profix		Completed		ID Brofiv		Completed
ID Prefix						=				
Reg. # LSC				Reg. #				Reg. # LSC		
							-	-		
		Corr	ection			Correction				Correction
ID Prefix			pleted	ID Prefix		Completed		ID Prefix		Completed
Reg. #				Daa: #		-		Reg. #		
								LSC		
Reviewed I	By Re	viewed By		Date:	Signature of Sur	veyor:			Date	:
State Agen	cy PS	/kfd		03/16/2015		2	2582	2	03/	01/2015
Reviewed I	Ву Re	viewed By		Date:	Signature of Sur		_		Date	:
CMS RO										
Followup t	o Survey Compl				Check for any Unco	rrected Defi	cienci	es. Was a	the Feetling	
	1/28/20	15			Uncorrected Defic	ciencies (CN	15-25	or) Sent to	tne Facility? YES	NO

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS FOR MEDICARE & MEDICAID SERVICES

ID: E0TV

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL
PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

	PART I - TO BE COMPLETED BY TH					HE STATE SURVEY AGENCY Facility ID: 0			
MEDICARE/MEDICAID PROVIDE (L1) 245441 2.STATE VENDOR OR MEDICAID N (L2) 418840300		3. NAME AND AL (L3) GOOD SAM (L4) 75507 240TH (L5) ALBERT LI	IARITAN SOO H STREET			56007	 Initia Term Valid 	ination ation	2. Recertification 4. CHOW 6. Complaint
5. EFFECTIVE DATE CHANGE OF (L9)	OWNERSHIP	7. PROVIDER/SU 01 Hospital	PPLIER CATEG	GORY 09 ESRD	02 (L7) 13 PTIP	22 CLIA	7. On-S 8. Full S	Survey After (9. Other Complaint
6. DATE OF SURVEY 01/2 8. ACCREDITATION STATUS: 0 Unaccredited 1 TJC 2 AOA 3 Other	9/2015 (L34) (L10)	02 SNF/NF/Dual 03 SNF/NF/Distinct 04 SNF	06 PRTF 07 X-Ray 08 OPT/SP	10 NF 11 ICF/III 12 RHC	14 CORF 15 ASC 16 HOSPICE			EAR ENDIN 2/31	IG DATE: (L35)
11LTC PERIOD OF CERTIFICATION From (a): To (b): 12.Total Facility Beds 13.Total Certified Beds	114 (L18) 114 (L17)	Complianc1. A: X B. Not in Com	nce With equirements e Based On: cceptable POC	gram	2. Tech 3. 24 F 4. 7-Da 5. Life	oved Waivers Of ' nnical Personnel Hour RN ay RN (Rural SN Safety Code	6. S 7. M F) 8. I	g Requirement Scope of Serv Medical Dire Patient Room Beds/Room	vices Limit
14. LTC CERTIFIED BED BREAKDO	WN				15. FACILITY M	MEETS			
18 SNF 18/19 SNF	19 SNF	ICF	IID		1861 (e) (1) or	1861 (j) (1):		(L15)	
(L37) (L38)	(L39)	(L42)	(L43)						
16. STATE SURVEY AGENCY REMA	ARKS (IF APPLICA	ABLE SHOW LTC CA	NCELLATION	DATE):					
17. SURVEYOR SIGNATURE		Date :			18. STATE SUF	RVEY AGENCY	APPROVAL		Date:
Mary Whitlock NE 11			2/23/2015	(L19)	K <u>amala Fiske</u>	-Downing, I	Enforceme	nt Specia	alist 03/12/2015
PAI	RT II - TO BE	COMPLETED I	BY HCFA RE	EGIONAI	COFFICE OF	R SINGLE S'	TATE AGI	ENCY	
DETERMINATION OF ELIGIBIL			IPLIANCE WITE ITS ACT:	H CIVIL	2. (Statement of Finan Ownership/Contro Both of the Above	l Interest Disc		
22. ORIGINAL DATE	23. LTC AGREEN	MENT 24	I. LTC AGREEN	MENT	26. TERMINA	TION ACTION:		(I)	L30)
OF PARTICIPATION 02/01/1987	BEGINNING	G DATE	ENDING DA	ГЕ	VOLUNTARY 01-Merger, Clos	00	_	INVOLUNT 05-Fail to M	TARY Meet Health/Safety
(L24)	(L41)		(L25)			on W/ Reimburse		06-Fail to M	Ieet Agreement
25. LTC EXTENSION DATE:	27. ALTERNATI A. Suspension	VE SANCTIONS n of Admissions:	(L44)		03-Risk of Involution 04-Other Reason	antary Termination for Withdrawal	n	OTHER 07-Provider 00-Active	r Status Change
(L27)	B. Rescind Su	uspension Date:							
20 TED MUATION DATE	20	D. D. TELLON	(L45)		20 DEMARKS				_
28. TERMINATION DATE:	29). INTERMEDIARY/	CARRIER NO.		30. REMARKS				
	(L28)	00140		(L31)					
31. RO RECEIPT OF CMS-1539		. DETERMINATION	OF APPROVAL						
	(L32)			(L33)	DETERMIN	ATION APPF	ROVAL		



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically delivered February 12, 2015

Ms. Katie Davis, Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, Minnesota 56007

RE: Project Number S5441024

Dear Ms. Davis:

On January 29, 2015, a standard survey was completed at your facility by the Minnesota Departments of Health and Public Safety to determine if your facility was in compliance with Federal participation requirements for skilled nursing facilities and/or nursing facilities participating in the Medicare and/or Medicaid programs. This survey found the most serious deficiencies in your facility to be isolated deficiencies that constitute no actual harm with potential for more than minimal harm that is not immediate jeopardy (Level D), as evidenced by the attached CMS-2567 whereby corrections are required. A copy of the Statement of Deficiencies (CMS-2567) is enclosed.

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

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

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

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

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

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

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

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

DEPARTMENT CONTACT

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

Kathryn Serie, Unit Supervisor Minnesota Department of Health 1400 E. Lyon Street Marshall, Minnesota 56258 Kathryn.serie@state.mn.us

Office: (507) 476-4233 Fax: (507) 537-7194

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 10, 2015, the Department of Health will impose the following remedy:

• State Monitoring. (42 CFR 488.422)

ELECTRONIC PLAN OF CORRECTION (ePoC)

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

- Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice;
- Address how the facility will identify other residents having the potential to be affected by the same deficient practice;
- Address what measures will be put into place or systemic changes made to ensure that

the deficient practice will not recur;

- Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. The facility must develop a plan for ensuring that correction is achieved and sustained. This plan must be implemented, and the corrective action evaluated for its effectiveness. The plan of correction is integrated into the quality assurance system;
- Include dates when corrective action will be completed. The corrective action completion dates must be acceptable to the State. If the plan of correction is unacceptable for any reason, the State will notify the facility. If the plan of correction is acceptable, the State will notify the facility. Facilities should be cautioned that they are ultimately accountable for their own compliance, and that responsibility is not alleviated in cases where notification about the acceptability of their plan of correction is not made timely. The plan of correction will serve as the facility's allegation of compliance; and,
- Submit electronically to acknowledge your receipt of the electronic 2567, your review and your ePoC submission.

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

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

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

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

PRESUMPTION OF COMPLIANCE - CREDIBLE ALLEGATION OF COMPLIANCE

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

VERIFICATION OF SUBSTANTIAL COMPLIANCE

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

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

Original deficiencies not corrected

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

Original deficiencies not corrected and new deficiencies found during the revisit

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

Original deficiencies corrected but new deficiencies found during the revisit

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

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

If substantial compliance with the regulations is not verified by April 29, 2015 (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 July 29, 2015 (six months after the identification of noncompliance) if your facility does not achieve substantial compliance. This action is mandated by the Social Security Act at Sections 1819(h)(2)(C) and 1919(h)(3)(D) and Federal regulations at 42 CFR Sections 488.412 and 488.456.

INFORMAL DISPUTE RESOLUTION

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

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

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

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

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

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

Mr. Patrick Sheehan, Supervisor Health Care Fire Inspections State Fire Marshal Division pat.sheehan@state.mn.us Telephone: (651) 201-7205

Fax: (651) 215-0525

Feel free to contact me if you have questions.

Sincerely,

Kamala Fiske Downing

Kamala Fiske-Downing, Program Specialist Licensing and Certification Program Division of Compliance Monitoring Minnesota Department of Health Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112

Fax: (651) 215-9697

Enclosure

cc: Licensing and Certification File

PRINTED: 02/23/2015 FORM APPROVED OMB NO. 0938-0391

	EMENT OF DEFICIENCIES PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MUL A. BUILD		(X3) DATE SURVEY COMPLETED		
		245441	B. WING			01/	29/2015
	NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA			75	REET ADDRESS, CITY, STATE, ZIP CODE 507 240TH STREET BERT LEA, MN 56007	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMEN	тѕ	F(000			
	as your allegation of Department's acce	of correction (POC) will serve of compliance upon the ptance. Your signature at the page of the CMS-2567 form will tion of compliance.					
	revisit of your facilit that substantial cor has been attained i verification.	acceptable POC an on-site ty will be conducted to validate in accordance with your					
F 155 SS=D	483.10(b)(4) RIGH ADVANCE DIREC	T TO REFUSE; FORMULATE TIVES	F 1	55			3/2/15
	refuse to participate and to formulate ar	ne right to refuse treatment, to e in experimental research, n advance directive as aph (8) of this section.					
	specified in subpar related to maintain procedures regardi requirements include provide written info concerning the right or surgical treatme option, formulate a includes a written opticies to impleme applicable State law						
		NT is not met as evidenced					
I ABORATOR'	Y DIRECTOR'S OR PROVID	DER/SUPPLIER REPRESENTATIVE'S SIGN	VATURE		TITLE		(X6) DATE

Electronically Signed 02/20/2015

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.

	TEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245441	B. WING _		01	/29/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 155	by: Based on observareview the facility factors (vs) benefits of refunderessed and doc (R6) reviewed with refused care. Findings include: R6 had been a resistation and that been a resistation are services on 9/24/14 breast cancer, poosenile dementia wire chronic kidney disease record review, included the participate with act and that her nutrition. The progress notes the progress notes that her nutrition. The progress notes that her coccyx, likely a many that her was no docuber informed of rise with interventions for pressure ulcers. A wound assessment 1/26/15, identified the transportation of the coccy of the composition of the	tion, interview and document ailed to ensure the risks verses using repositioning were cumented for 1 of 1 resident a stage 3 pressure ulcer and dident at the facility since been admitted to hospice 4, with diagnoses including: r appetite with weight loss, the delusional features, and ease with mixed incontinence. Inding nursing notes, hospice in and nurse practitioner notes, ecently declined in her ability to invities of daily living (ADLs), and intake had declined. Is dated 1/19/15, and timed at that R6 had an open area on a stage 3 pressure ulcer (PU). Immented evidence that R6 had sks related to failing to comply or prevention/treatment of the coccyx ulcer as a measurements were imeter (cm) long x 3 cm wide x certified nurse practitioner ed R6's coccyx wound on ed, "Previously, there was alcer noted on buttocks that erged with the wound located	F 15	F155: Plan of correction: The care plans of all resider reviewed and updated with interventions for educating and benefits of treatment reapplicable. Nursing staff education was 2/19/15 regarding the facilit documentation of resident reatment and the care plant Education was also provide process of documentation of the risks of not complying was recommended. Random audits to ensure of be conducted by nursing maresidents that either current treatment or have a history treatments. Audits will be oweekly x 4, then monthly x 3 results will be referred to the Assurance Performance Im Team. Resident R6 was receiving and passed away on 2/9/15	appropriate on the risks of usals when a provided on ies process for efusals of uning process. It do not the of teaching on with treatments ompliance will an agement for refusing completed and a Audit e Quality provement.	:	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			TE SURVEY MPLETED
		245441	B. WING		01	/29/2015
_	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007		, = 0, = 0
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		OULD BE	(X5) COMPLETION DATE
F 155	was assisted to the by nursing assistant on her back in bed preferred to lie on her back in bed preferred to lie on her back in bed preferred to lie on her back in the preferred to lie on her back in the preferred to lie on her back in the preferring and to been more indeper prior to R6 experien NA-B also added, flately". NA-B state using pillows, but Fand lay on her back repositioning. During a subseque 9:31 a.m. NA-B reto hourly checks conthese checks were assistance with trait to a repositioning sassistants care plated and/or attempts to schedule/program breakdown. During an interview RN-E verified the attential documentarea located on the areas. The skin assibuttock and coccypt 1.5 centimeter (cmdeep and contained a scratch on her rigcm. long x 0.2 cm. The most recent questions as the preferring to the pref	1/27/15, at 3:00 p.m. that R6 to toilet and then back into bed at (NA)-B. R6 was positioned (supine). NA-B indicated R6 her back and commented that he pillows staff used when sition R6 onto either side. 1/28/15, at 9:22 a.m. NA-B and staff assistance with leting, and previously had hadent. She indicated this was noting an increase in pain. R6 "not been eating much distaff attempt to reposition R6 would remove the pillows or would refuse to allow and interview on 1/28/15, at viewed documentation related ompleted for R6 and verified related to safety and staff insfers/toileting and not related chedule. The nursing in did not include reminders maintain R6 on a repositioning to reduce further skin on 1/29/15, at 11:00 a.m. assessment dated 1/17/15, was tation of a stage 3 pressure a right buttock and coccyx sessment identified R6's right a pressure areas measured) long x 3 cm wide x 1 cm did a yellow center. R6 also had another buttock that measured 1	F 1	155		

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245441	B. WING			01/2	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		75	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE
F 155	score of 4/15, which impairment. A progress noted of stated: "The patie observation of coord worsened in the last repositioning and a patient is on hospid She has been losin dementia, she will historically and prelying position. Last in diameter. It was erythematous base has changed to a benlarged significant sero sanguineous wound. The patient However, with just the wound, she con In addition, the CN "pain with reposition the Roxanol (narcon every 4 hours while night, as well as exprior to movement." The care plan was which included doos stage 3 PU located interventions identification, and mace lacking on the care notes indicating the been educated on the care of the state of the sta	al Status (BIMS) assessment h indicated severe cognitive lated 1/29/15 by the CNP nt was seen today with staff for cyx ulcer. This is significantly at week despite frequent appropriate treatment. The ce for suspected breast cancer. In weight. Due to her not stay repositioned. She sently prefers back supine to week the ulcer was a few cm a stage 2 to 3 with e. However, until last week it blackened discoloration and tly. There is a small amount of drainage on the front of the lat denies pain with asking. Slight repositioning to inspect implains of quite a bit of pain. P documented that R6 has ning, therefore was increasing the rery 30 minutes as needed	F 1	55			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMF	SURVEY
		245441	B. WING		01/2	9/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA	7	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET ALBERT LEA, MN 56007	.	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 282 F 282 SS=D	483.20(k)(3)(ii) SEI PERSONS/PER Control The services provided to	RVICES BY QUALIFIED	F 282 F 282			3/2/15
	by: Based on observareview the facility farelated to intervent breakdown for 1 of with an identified provided in the facility of the facility	tion, interview, and document ailed to follow the plan of care ions to prevent further skin 3 residents (R194) reviewed ressure ulcer. ecord was reviewed and was 14. The nurses' note dated :14 p.m.) indicated: "Note Text: ned area on right heel, likely to ep tissue injury. resident area. Will recommend the if loading boots. Resident was on the importance of mote wound healing and a damage." The wound data ed 1/20/15 indicated R194 had a on the right heel measuring in length (L) by (x) 0.6 cm in of the physician order dated Blue Boots to B/L (bilateral) stage 1 pressure ulcer on reses note dated 1/23/15 at ing a telephone order from the practice registered nurse) DX of right heel to suspected		F282: Plan of Correction: The care plans of all residents with concerns will be reviewed to ensure the appropriate interventions are into in the plan of care. Updates will be as appropriate. Nursing staff education was provide 2/19/15 regarding the facilities procrelated to following care planned interventions to ensure appropriate interventions are in place to maximize residents functioning and well-being Random audits to ensure that care are being followed will be conducted nursing management for residents are at risk for skin breakdown or whave current skin issues. Audits with completed weekly x 4, then monthly Audit results will be referred to the Cassurance Performance Improvem Team. Resident R194 was receiving hospicare and passed away on 2/13/15.	e that cluded e made e made e don edures ize the g. plans d by that no ll be y x 3. Quality ent	

AND BLANCE CORRECTION IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION A. BUILDING	(X3) DATE SURVEY COMPLETED		
245441 B	3. WING	01/29/2015		
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA	STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007	:		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOUTH ACTI	OULD BE COMPLÉTION		
F 282 Continued From page 5 deep tissue trauma." Review of the care plan dated 1/14/15 included: "Blue Boots on B/L [bilateral] feet while in bed." The following observations were noted: (1) On 1/27/2015, at 3:42 p.m. R194 was observed lying on his back in bed with stockings only on his feet and both heels resting on the bed. (2) On 1/28/2015, at 10:09 a.m. R194 was observed lying on his back in bed with stockings only on his feet and both heels resting on the bed. (3) On 1/28/2015, at 11:24 a.m. R194 was observed lying on his back in bed with stockings only on his feet and both heels resting on the bed. (4) On 1/28/2015 at 1:25 p.m. R194 was observed lying on his back in bed with stockings only on his feet and both heels resting on the bed. When interviewed on 1/28/2015, at 10:12 a.m. nursing assistant (NA)-A stated R194 was to be repositioned every 2 hours. NA-A stated there were no special positioning interventions when R194 was in bed other than repositioning from side to side and on his back. NA-A further stated the resident prefers to lie on his back when in bed. When interviewed on 1/28/2015, at 2:39 p.m. registered nurse (RN)-C stated she would expect R194 to be wearing the blue boots anytime he was in bed as this was the only intervention in place to relieve pressure to the pressure ulcer located on the right heel. RN-C talked with a staff member who was just arrived to work the afternoon/evening shift. RN-C stated she had been informed that R194 would often times	F 282			

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		245441	B. WING _		01/	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007	•	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 314 SS=D	what occurred prior observations. On 1/28/2015, at 2: observed R194 lyin socks on his feet. If underneath his low floating. RN-D remote the right foot. The prosent. RN-D means which measured 1 was interviewed at the wore the heel boremove them as the When asked wheth the day while in been shoulders and state sometimes they for had not offered the nor had they been provided by the care play and the care p	to the surveyor's 56 p.m. surveyor and RN-D g on his back in bed with only 194 had a pillow positioned rer legs with both heels red the resident's sock from ressure area was observed d in color with no discharge asured the pressure area cm (L) x 0.7 cm (W). R194 that time and confirmed that rots in bed at night but would rev become uncomfortable. re he wore the boots during d, R194 shrugged his red, "Sometimes, but red". R194 confirmed that staff rheel boots to be worn that day red to follow-up with staff. The DON confirmed that R194 rearing the blue boots when in an.	F 3			3/2/15

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		l ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		245441	B. WING		01/2	9/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETION DATE
F 314	This REQUIREMENT by: Based on observative review the facility factors assess, plan for, are prevent pressure undevelopment/reocc & R194) reviewed with the r	from developing. NT is not met as evidenced tion, interview, and document alled to comprehensively and implement interventions to	F 314	F314: Plan of Correction: The care plans of all residents with or current pressure ulcers will be represented to ensure that appropriate prevention/treatment interventions place. Updates will be made as appropriate. Nursing staff education was provide 2/19/15 regarding the facilities pronotifying the appropriate personne	are in ded on cess of	
	813/2001. R6 had services on 9/24/14 breast cancer, poor senile dementia wit chronic kidney dise Record review, incl notes, the care plar indicated R6 had reparticipate with acti and that her nutritic During an evening 6:00 p.m. R6 was reposition (on her bac observation the follop.m. R6 was assist into bed by nursing positioned onto her time, NA-B indicate back and comment pillows staff utilized either side. During interview on	been admitted to hospice I, with diagnoses including: rappetite with weight loss, h delusional features, and ase with mixed incontinence. Uding nursing notes, hospice in and nurse practitioner notes, ecently declined in her ability to vities of daily living (ADLs), and intake had declined. Observation on 1/26/15, at noted to be lying in a supine owing day on 1/27/15, at 3:00 ed to the toilet and then back assistant (NA)-B. R6 was back in bed (supine). At that d R6 preferred to lie on her ed that R6 would remove the for repositioning R6 onto		regarding changes in resident so and/or ability to participate in ADL Education was also provided to the nursing staff on initiating appropriate assessments at the time changes noted and to make updates to the plan in a timely manner. Random audits to ensure compliate these processes will be conducted nursing management for residents are at risk for skin breakdown or whave current pressure ulcers. Audite be completed weekly x 4, then moderated and the surface of the plan in a timely manner.	condition s. e ate are care nce in I by s that tho dits will nthly x	

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245441	B. WING			01/:	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP 75507 240TH STREET ALBERT LEA, MN 56007	CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		N SHOULD E APPROPE	BE	(X5) COMPLETION DATE
F 314	more independent. more independent increase in pain. No been eating much attempted to repose would remove the property would refuse to allow During a subseque 9:31 a.m. NA-B reston hourly checks coverified the checks related to safety and transfers/toileting, a repositioning scheod assistants' care pla and/or attempts to schedule/program. During an observation between the pressure ulcer local soaked incontinent LPN-A performed a donned gloves. LF adhesive pad cover located on the coccolight brown drainaged dressing and the gainches in length) us stated the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the days prior (1/24/15 been no tunneling the states of the pressure tunneling the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin) which efform the wound edwound size had incontinent the pressure tunneling (the ulcer intact skin)	leting, but previously had been She indicated R6 had been prior to experiencing an IA-B also stated R6 had "not ately," and stated staff ition R6 using pillows, but R6 billows and lay on her back or ow repositioning. In interview on 1/28/15, at viewed documentation related ompleted for R6 however, being documented were ind staff assistance with	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		245441	B. WING			01/:	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		75	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET LBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	extending the full sight skin surrounding the color. No additional the skin. LPN-A cleated the ulcer with a gaut foam dressing using technique. Upon conchange, a clean incomposite the facility's resider mattress on her behad a pressure reliated wheelchair. RN-E signification in the past month a staff assistance with During an interview RN-E verified initial of the stage 3 pressions was dated 1/17/15. At that time was 90 granulation with a maserosanguinous draws a serosanguinous draws and the stage of the st	dark gray/black discoloration, urface of the wound bed. R6's e wound was dark pink in I open areas were noted on eansed the wound, repacked ize strip and reapplied the groper infection control empletion of the dressing continent brief was applied. Egistered nurse (RN)-E on m. verified R6, as did each of its, had a pressure relief d. In addition, RN-E stated R6 eving gel cushion placed in her tated R6's status had declined and that R6 required increased the her ADL's. on 1/29/15, at 11:00 a.m. assessment documentation sure ulcer (PU) on R6's coccyx Description of the wound bed 26 yellow slough, 10%	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245441	B. WING		01	/29/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	updated. Under the documented, "resici independently; she frequent repositioni and prevent further review of the residerevisions had been the initial identificat stage 3 PU. During an interview 1/29/15, at 11:15 a. losing approximate been slowly declinin hospice RN added pain until the development of a pdue to R6's ability to Documentation on (Prediction of Press 12/22/14, identified which indicated miliaddition this Brader documentation which indicated miliaddition this Brader documentation which indicated miliaddition the Brader documentation on the Brader docum	Ge 10 Comment section the RN had lent is able to move was educated on the need for ng to promote wound healing skin breakdown". However, ent's care plan revealed no made to R6's care plan after ion of the newly developed with the hospice RN on m. she stated R6 had been ly 1 lb. (pound)/week and had ng in health status. The that R6 had not experienced opment of the coccygeal hospice RN further stated the ressure ulcer was unexpected to reposition independently. The Braden Assessment sure Sore Risk) dated that R6 had a score of 15-18, drisk for skin breakdown. In assessment form included the identified additional risk for dietary protein intake, hemodynamic instability. aden, these additional factors 's total score to moderate risk. Interventions identified on the breakdown included: frequent led schedule; use of foam ree lateral (side lying) al remobilization; protect heels; manage nutrition; manage However, R6 had not been lifted as moderate risk for skin any of the interventions listed according to the care plan. assessment 1/17/15, the next	F3	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
		245441	B. WING			01/2	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP C 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		N SHOULD	BE	(X5) COMPLETION DATE
F 314	11:55 a.m. and ider area on her coccyx PU. The wound be slough with 10% graph of serosanguinous had an open area obed is 100% granul noted. A new physic been received: Hycchange every 5 day healed. Nursing notes incluulcer documentatio later) another wound completed by RN-Fulcer as unstageab recorded as 8 cm lowedges being black in experienced pain, reprogress note dated educated on the new ound healing and there was no docuprovided to the resi regarding risks versito allow repositionir buttocks/coccyx. The most recent que (MDS) dated 12/22. Interview for Mental score of 4/15, which impairment. A nursi included: demonstrater staff noted brut forehead after a fall 1/14/15, in which R	ge 11 PU was dated 1/19/15, at a tiffied R6 as having an open which was likely a stage 3 d description included: 90% anulation. A minimal amount drainage was noted. R6 also on the right buttock, the wound ation and no drainage was being order on 1/19/15 had drocolloid to coccyx ulcers, as and prn (as needed) until ded no additional pressure on 1/26/15 (one week d assessment had been of the wound ation and no drainage was being x 3 cm wide x 5 cm deep. So described as the wound on color and indicated R6 had delated to the stage 3 PU. The delated to the stage 3 PU. The delated to the stage 3 PU. The delated to reposition to promote prevent further breakdown, mentation of education dent and/or guardian sees benefits of resident refusal and to relieve pressure on the status (BIMS) assessment on indicated severe cognitive in indicated severe cognitive ing note dated 1/13/15 rates poor safety judgement as on left hip and left on 1/9/15; and a fall on 6 complained of pain on her as to ADL (activity of daily living)	F3	14			

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		245441	B. WING			01/:	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		7	STREET ADDRESS, CITY, STATE, ZIP CODE S5507 240TH STREET ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 314	physical assist from 1/24; 1/25; 1/27 and Documentation by to (CNP) who assess included the following was another pressubuttocks that appear wound located on Fidiagnosis of-"end of A progress note doincluded: "The patfor observation of concluded: "The patfor observation of concerning frequent reposition. The patient is on how cancer. She has be dementia, she will reposition. Last in diameter. It was erythematous base to a blackened disconsificantly. There is serosanguineous of wound. The patient However, with just so the wound, she contract the wound, she contract the wound is even coming off the approximately 1 cm is quite hard; include 8 cm long, 5 cm with addition, the CNP of the contract o	is had required intermittent in one staff on 1/19; 1/22; 1/23; id 1/28/15. The certified nurse practitioner ed the wound on 1/26/15, and notation: Previously, there are ulcer noted an area on the ars to have merged with the R6's coccyx. The CNP added a f life skin failure". Cumented by the CNP 1/29/15 ient was seen today with staff occyx ulcer. This is ared in the last week despite and appropriate treatment. Expice for suspected breast even losing weight. Due to her not stay repositioned. She sently prefers back supine week the ulcer was a few cm	F	314			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			ļ	(X3) DATE SURVEY COMPLETED				
		245441	B. WING				01/2	29/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		75507 240TH S ALBERT LEA	A, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	(EACH	OVIDER'S PLAN OF COF I CORRECTIVE ACTION REFERENCED TO THE DEFICIENCY)	SHOULD	BE	(X5) COMPLETION DATE
F 314	every 30 minutes as. The care plan dated care deficit related evidenced by requiredaily hygiene and didentified a toileting during waking hours rounding during the also indicated that foffered assistance of 1/13/15). The care plan updastage 3 PU on the cofollowing intervention treatment, and to reheal, signs and symmaceration. Prior towas lacking to indiciplan had been deveas, frequent turning of foam wedges for positioning; maxima manage moisture; refriction and shear upun the coccyx or Although R6's declipassessment, planni interventions to predevelopment and/oconsistently implemented dated 1/26/15, back supine lying poplan of care had be encourage R6 to tustage 3 PU was distacking to indicate to been implemented.	ace during the night, as well as a needed prior to movement". d 7/15/14 included: ADL self to dx of dementia as ring supervision and cueing for ressing. Interventions schedule of independence and visualization with each night shift. The care plan R6 was to be monitored and every hour for safety (initiated ted on 1/26/15, identified the coccyx and included the ons: monitor location, size and eport abnormalities, failure to aptoms (S/S) of infection, and to this date, documentation ate that an individualized care eloped and implemented; such with a planned schedule; use 30 degree lateral (side lying) at remobilization; protect heels; manage nutrition; manage pon discovery of a stage 3 in 1/17/15 (9 days prior). Ining status was known, and and implementation of	F3	14				

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	IPLE CONSTRUCTION NG		COMPLETED		
		245441	B. WING _		01/29/2	015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COM	(X5) IPLETION DATE	
F 314	Continued From pa updating of the care	e plan on 1/26/15.	F 3 ⁻	14			
		not consistently implemented for R194 who had an area of nt heel.					
	lying on his back in	42 p.m. R194 was observed bed with stockings only on his resting on the bed.					
	lying on his back in	0:09 a.m. R194 was observed bed with stockings only on his resting on the bed.					
	lying on his back in	1:24 a.m. R194 was observed bed with stockings only on his resting on the bed.					
		25 p.m. R194 was observed bed with stockings only on his resting on the bed.					
	was admitted on 12 1/20/15 at 14:14 (2 resident has redder be a suspected deed denies pain in the a continued use of of provided education	ecord was reviewed. R194 2/26/14. A nurse's note dated :14 p.m.) indicated: "Note Text: ned area on right heel, likely to ep tissue injury. Resident area. Will recommend the f loading boots. Resident was on the importance of					
	prevent further skin collection form date a red pressure area 1.1 centimeters (cn width (W). Review of 1/20/15 included: "E	mote wound healing and damage." The wound data ed 1/20/15 indicated R194 had a on the right heel measuring in length (L) by (x) 0.6 cm in of the physician order dated Blue Boots to B/L (bilateral) stage 1 pressure ulcer on					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES (X1) PROVIDER/SLIPPLIER/CLIA

AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		. ,	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
		245441	B. WING _		01	/29/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, ZIP CO 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE / DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 314	p.m., regarding a te (advanced practice "Change DX of right tissue trauma." Review of the care "Blue Boots on B/L When interviewed NA-A stated R194 hours. NA-A stated roositioning interver other than repositioning interver other than repositioning the blue both is back. NA-A fur to lie on his back w When interviewed RN-C stated she wwaring the blue both is was the only in pressure to the preheel. RN-C talked just arrived to work RN-C stated she hwould often times i boots while in bed. whether that is whas surveyor's observation on 1/28/2015, at 2 observed R194 lyir socks only on his funder his lower leg RN-D removed the	elephone order from the APRN eregistered nurse) included: at heel to suspected deep plan dated 1/14/15 included: feet while in bed." on 1/28/2015, at 10:12 a.m. was to be repositioned every 2 defined there were no special attions when R194 was in bed oning from side to side and on their stated the resident prefers when in bed. on 1/28/2015, at 2:39 p.m. rould expect R194 to be cots anytime he was in bed as attervention in place to relieve essure ulcer located on the right with a staff member who was at the afternoon/evening shift. and been informed that R194 andependently remove the blue RN-C stated being unsure at occurred prior to the	F 31	4			
	foot. The pressure intact, dark red in c RN-D measured th	•					

	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		245441	B. WING		01/	/29/2015	
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA		STREET ADDRESS, CITY, STATE, 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 314	he wore the heel be sometimes would re uncomfortable. Wh the boots during the shrugged his should but sometimes they staff had not offered that day nor had the RN-D stated she we staff. When interviewed of director of nursing (chis observation and confirmed bots in bed at night but be move them as they became hen asked whether he wore a day when lying in bed, R194 ders and stated, "Sometimes, of forget". R194 confirmed that do the heel boots to be worn be been placed on his feet. Could need to follow-up with con 1/28/2015, at 3:41 p.m. the DON) confirmed that R194 wearing the blue boots when in	F 3	314			

F5441023

PRINTED: 02/25/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED **IDENTIFICATION NUMBER:** AND PLAN OF CORRECTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN **CENTER** B. WING 01/28/2015 245441 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 75507 240TH STREET **GOOD SAMARITAN SOCIETY - ALBERT LEA** ALBERT LEA, MN 56007 (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION ID (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL **PREFIX PRÉFIX** CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) K 000 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 FORM WILL BE USED AS VERIFICATION OF COMPLIANCE. UPON RECEIPT OF AN ACCEPTABLE POC, AN ONSITE REVISIT OF YOUR FACILITY MAY BE CONDUCTED TO VALIDATE THAT SUBSTANTIAL COMPLIANCE WITH THE REGULATIONS HAS BEEN ATTAINED IN ACCORDANCE WITH YOUR VERIFICATION. A Life Safety Code Survey was conducted by the Minnesota Department of Public Safety - State Fire Marshal Division. At the time of this survey, Good Samaritan Society - Albert Lea was found not in substantial compliance with the requirements for participation in Medicare/Medicaid at 42 CFR, Subpart 483.70(a), Life Safety from Fire, and the 2000 edition of National Fire Protection Association (NFPA) Standard 101, Life Safety Code (LSC), Chapter 19 Existing Health Care. 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 St Paul, MN 55101-5145, or (X6) DATE LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

Electronically Signed

02/20/2015

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.

Facility ID: 00131

PRINTED: 02/25/2015 FORM APPROVED OMB NO. 0938-0391

(X3) DATE SURVEY

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		ING	E CONSTRUCTION 101 - ALBERT LEA GOOD SAMARITAN	(X3) DATE SURVEY COMPLETED	
		245441	B. WING			01/	28/2015
	PROVIDER OR SUPPLIER	- ALBERT LEA		7	TREET ADDRESS, CITY, STATE, ZIP CODE 5507 240TH STREET ALBERT LEA, MN 56007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDERICIENCY)) BE	(X5) COMPLETION DATE
K 000	Continued From pa	age 1	K	000			
	By email to: Marian.Whitney@s Angela.Kappenma						
		RRECTION FOR EACH ST INCLUDE ALL OF THE DRMATION:					
	A description of to correct the defication.	what has been, or will be, done iency.					
	2. The actual, or pr	oposed, completion date.					
	responsible for cor	r title of the person rection and monitoring to ence of the deficiency.					
	building. The buildi different times. The constructed in 1963 Type II(111) constructed ar Type II(111) constructed ar Type II (111) constructed ar Type II(111) constructed ar Type II(1111) constructed ar Type II(11111) constructed ar Type II(11111) constructed ar Type II(11111) constructed ar Type II(11111) constructed ar Type II(111111) constructed ar Type II(111111) constructed ar Type II(1111111) constructed ar Type II(111111111) c	omatic sprinkler protected. The					
	The building is autofacility has a fire al	omatic sprinkler protected. The arm system with full corridor					

PRINTED: 02/25/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER			(X3) DATE SURVEY COMPLETED		
		245441	B. WING			01/	28/2015	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA				7	STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETION DATE	
K 000	smoke detection at corridors that is modepartment notification. The facility has a consus of 104 at time.	and spaces open to the conitored for automatic fire ation. apacity of 108 beds and had a me of the survey.	K	000				
K 050 SS=D	The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by: NFPA 101 LIFE SAFETY CODE STANDARD Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift. The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2		K 050				2/27/15	
	Based on docume interview, the facili were conducted or staff under varying required by 2000 N	is not met as evidenced by: entation review and staff ty failed to assure fire drills nce per shift per quarter for all times and conditions as IFPA 101, Section 19.7.1.2. tice could affect all 104			Environmental Services/ Mainten- binder updated to include a chart of specific fire drill times for each qual Audits done weekly X4 monthly X3	for arter		
	01/28/2015, the re-	ween 9:30 AM and 1:30 PM on view of the fire drill the past 12 months (January						

Facility ID: 00131

OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILD	TIPLE CONSTRUCTION ING 01 - ALBERT LEA GOOD SAMARITAN		(X3) DATE SURVEY COMPLETED	
245441		B. WING			01/28/2015	
NAME OF PROVIDER OR SUPPLIER GOOD SAMARITAN SOCIETY - ALBERT LEA			75	5507 240TH STREET		
(EACH DEFICIENC)	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			(EACH CORRECTIVE ACTION SHOUL	D BE	(X5) COMPLETION DATE
2014 to December for the day shifts w sufficiently vary the conducted - 1404, This deficient pract Facility Maintenant discovery. *TEAM COMPOSI*	2014) revealed that the drills ere completed, but did not a times that the drills were 1417, 0900 and 1000 hours. tice was confirmed by the ce Director (MW) at the time of	K	050			
	Continued From participation of Deficiency on Supplier amangan participation of the day shifts where the day shift	CONTINUED FROM PROVIDER SUPPLIER (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441 ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 2014 to December 2014) revealed that the drills for the day shifts were completed, but did not sufficiently vary the times that the drills were conducted - 1404, 1417, 0900 and 1000 hours. This deficient practice was confirmed by the Facility Maintenance Director (MW) at the time of	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA A BUILD CENTE! 245441 B. WING ROVIDER OR SUPPLIER AMARITAN SOCIETY - ALBERT LEA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 2014 to December 2014) revealed that the drills for the day shifts were completed, but did not sufficiently vary the times that the drills were conducted - 1404, 1417, 0900 and 1000 hours. This deficient practice was confirmed by the Facility Maintenance Director (MW) at the time of discovery. *TEAM COMPOSITION*	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441 ROVIDER OR SUPPLIER 245441 SUMMARITAN SOCIETY - ALBERT LEA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 2014 to December 2014) revealed that the drills for the day shifts were completed, but did not sufficiently vary the times that the drills were conducted - 1404, 1417, 0900 and 1000 hours. This deficient practice was confirmed by the Facility Maintenance Director (MW) at the time of discovery. *TEAM COMPOSITION*	AMARITAN SOCIETY - ALBERT LEA SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 2014 to December 2014) revealed that the drills for the day shifts were completed, but did not sufficiently vary the times that the drills were conducted - 1404, 1417, 0900 and 1000 hours. (X1) PROVIDER SUMULTIPLE CONSTRUCTION A BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTER B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007 PROVIDER'S PLAN OF CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIATE ACTION SHOULD CROSS-REFEREN	OF DEFICIENCIES F CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 245441 (X2) MULTIPLE CONSTRUCTION A, BUILDING 01 - ALBERT LEA GOOD SAMARITAN CENTRE B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET ALBERT LEA, MN 56007 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 2014 to December 2014) revealed that the drills for the day shifts were completed, but did not sufficiently vary the times that the drills were conducted - 1404, 1417, 0900 and 1000 hours. This deficient practice was confirmed by the Facility Maintenance Director (MW) at the time of discovery. *TEAM COMPOSITION*



Protecting, Maintaining and Improving the Health of Minnesotans

Electronically submitted February 12, 2015

Ms. Katie Davis, Administrator Good Samaritan Society - Albert Lea 75507 240th Street Albert Lea, Minnesota 56007

Re: Enclosed State Nursing Home Licensing Orders - Project Number S5441024

Dear Ms. Davis:

The above facility was surveyed on January 26, 2015 through January 29, 2015 for the purpose of assessing compliance with Minnesota Department of Health Nursing Home Rules. At the time of the survey, the survey team from the Minnesota Department of Health, Compliance Monitoring Division, noted one or more violations of these rules that are issued in accordance with Minnesota Stat. section 144.653 and/or Minnesota Stat. Section 144A.10. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a civil fine for each deficiency not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health.

To assist in complying with the correction order(s), a "suggested method of correction" has been added. This provision is being suggested as one method that you can follow to correct the cited deficiency. Please remember that this provision is <u>only a suggestion</u> and you are not required to follow it. Failure to follow the suggested method will not result in the issuance of a penalty assessment. You are reminded, however, that regardless of the method used, correction of the deficiency within the established time frame is required. The "suggested method of correction" is for your information and assistance only.

You have agreed to participate in the electronic receipt of State licensure orders consistent with the Minnesota Department of Health Informational Bulletin 14-01, available at http://www.health.state.mn.us/divs/fpc/profinfo/infobul.htm. The State licensing orders are delineated on the attached Minnesota Department of Health orders being submitted to you electronically. The Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

The assigned tag number appears in the far left column entitled "ID Prefix Tag." The state statute/rule number and the corresponding text of the state statute/rule out of compliance is listed in the "Summary Statement of Deficiencies" column and replaces the "To Comply" portion of the correction order. This column also includes the findings that are in violation of the state statute after the statement, "This Rule

is not met as evidenced by." Following the surveyors findings are the Suggested Method of Correction and the Time Period For Correction.

PLEASE DISREGARD THE HEADING OF THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES TO FEDERAL DEFICIENCIES ONLY. THIS WILL APPEAR ON EACH PAGE.

THERE IS NO REQUIREMENT TO SUBMIT A PLAN OF CORRECTION FOR VIOLATIONS OF MINNESOTA STATE STATUTES/RULES.

Although no plan of correction is necessary for State Statutes/Rules, please enter the word "corrected" in the box available for text. You must then indicate in the electronic State licensure process, under the heading completion date, the date your orders will be corrected prior to electronically submitting to the Minnesota Department of Health. We urge you to review these orders carefully, item by item, and if you find that any of the orders are not in accordance with your understanding at the time of the exit conference following the survey, you should immediately contact me.

You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

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.

Please feel free to call me with any questions.

Sincerely,

Kamala Fiske-Downing, Program Specialist

Licensing and Certification Program

Kumalu Fiske Downing

Division of Compliance Monitoring

Minnesota Department of Health

Kamala.Fiske-Downing@state.mn.us

Telephone: (651) 201-4112 Fax: (651) 215-9697

Enclosure(s)

cc: Original - Facility

Licensing and Certification File

PRINTED: 02/23/2015 FORM APPROVED Minnesota Department of Health STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY AND PLAN OF CORRECTION **IDENTIFICATION NUMBER:** COMPLETED A. BUILDING: _____ B. WING 00131 01/29/2015 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 75507 240TH STREET **GOOD SAMARITAN SOCIETY - ALBERT LEA** ALBERT LEA, MN 56007 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X4) ID (X5) COMPLETE (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE PRÉFIX PREFIX DATE REGULATORY OR LSC IDENTIFYING INFORMATION) CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY) 2 000 Initial Comments 2 000 *****ATTENTION***** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance.

INITIAL COMMENTS:

Department's staff, visited the above provider and the following correction orders are issued. When corrections are completed, please sign and date, make a copy of these orders and return the original to the Minnesota Department of Health,

Division of Compliance Monitoring, Licensing and

On January 26th thru 29th 2015, surveyors of this

Minnesota Department of Health is documenting the State Licensing Correction Orders using federal software. Tag numbers have been assigned to Minnesota state statutes/rules for Nursing Homes.

Minnesota Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

Electronically Signed

02/20/15

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00131	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1 01/2	<u> </u>
GOOD S	AMARITAN SOCIETY	- ALRERTLEA	TH STREET			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 000	Continued From pa	ge 1	2 000			
	·	m, P.O. Box 64900 St. Paul,		The assigned tag number appears far left column entitled "ID Prefix The state statute/rule number and corresponding text of the state state out of compliance is listed in the "Summary Statement of Deficience column and replaces the "To Comportion of the correction order. The column also includes the findings are in violation of the state statute statement, "This Rule is not met at evidenced by." Following the surfindings are the Suggested Method Correction and the Time Period Following the STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE FOURTH COLUMN WHICH STATES, "PROVIDER'S PLAN OF CORRECTION." THIS APPLIES THE SUBMIT A PLAN OF CORRECTION SUBMIT A PLAN O	Tag." the tute/rule ies" ply" nis s which after the s veyors d of or DING OF THIS O DN FOR	
2 565	MN Rule 4658.0409 Plan of Care; Use	5 Subp. 3 Comprehensive	2 565			3/2/15
		omprehensive plan of care I personnel involved in the 				
	This MN Requirement	ent is not met as evidenced				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING: (X3) DATE COMF			SURVEY LETED	
		00131	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY,	STATE, ZIP CODE		
GOOD S	AMARITAN SOCIETY	- AIRFRTIFA	TH STREET LEA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
2 565	by: SUGGESTED MET The director of nurs develop, review, an procedures to ensu plans according to t needs. The director of nurs educate all appropr procedures.The director designee could dev ensure ongoing cor	HOD OF CORRECTION: sing (DON) or designee could d/or revise policies and re the facility develops care the residents individualized sing (DON) or designee could tate staff on the policies and tector of nursing (DON) or elop monitoring systems to	2 565	The care plans of all residents with concerns will be reviewed to ensure the appropriate interventions are in in the plan of care. Updates will be as appropriate. Nursing staff education was provide 2/19/15 regarding the facilities procrelated to following care planned interventions to ensure appropriate interventions are in place to maxim residents functioning and well-being Random audits to ensure that care are being followed will be conducted nursing management for residents at risk for skin breakdown or who hourrent skin issues. Audits will be completed weekly x 4, then monthly Audit results will be referred to the Assurance Performance Improvement.	e that cluded e made ed on cedures dize the g. plans ed by that are nave y x 3. Quality	
2 900	Subp. 3. Pressure comprehensive res of nursing services development of a nursing services development of an provides that: A. a resident who without pressure sores unlessure sores un sorten sort	sores. Based on the ident assessment, the director must coordinate the ursing care plan which o enters the nursing home pres does not develop ess the individual's clinical ates, and a physician they were unavoidable; and the has pressure sores or treatment and services to	2 900			3/2/15

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		00131	B. WING		01/2	9/2015
NAME OF PROVIDER OR SUP	JER			STATE, ZIP CODE		
GOOD SAMARITAN SOC	ETY -	ALBERTLEA	TH STREET LEA, MN 56			
PREFIX (EACH DEFI	ENCY	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900 Continued Fro	n pag	ge 3	2 900			
promote healinew sores from		event infection, and prevent eloping.				
by: Based on obserview the face assess, plan for prevent pressed development/reserview. R194) review. Findings included R6 had been a 813/2001. R6 services on 9/breast cancersenile dements chronic kidney. Record review notes, the carrindicated R6 hoparticipate with and that her notes and that her notes are indicated R6 hoparticipate with and that her notes. Record review notes, the carrindicated R6 hoparticipate with and that her notes are indicated R6 hoparticipate with and that her notes are indicated R6 hoparticipate with and that her notes are into bed by nurposition (on her observation the p.m. R6 was a into bed by nurpositioned ont time, NA-B incompillows staff ut either side.	rvation ty fail r, and record where the control of	on, interview, and document led to comprehensively dimplement interventions to cers from arence for 2 of 3 residents (R6 tho had pressure ulcers. Ident at the facility since been admitted to hospice with diagnoses including: appetite with weight loss, a delusional features, and ase with mixed incontinence. Iding nursing notes, hospice and nurse practitioner notes, been daily living (ADLs), and intake had declined. In the bed in her ability to witte of daily living (ADLs), and intake had declined. In the bed in her ability to witte of daily living in a supine k) on her bed. During an an awing day on 1/27/15, at 3:00 and to the toilet and then back assistant (NA)-B. R6 was back in bed (supine). At that if R6 preferred to lie on her and that R6 would remove the for repositioning R6 onto		The care plans of all residents with or current pressure ulcers will be to ensure that appropriate prevention/treatment interventions place. Updates will be made as appropriate. Nursing staff education was provided to the plan in a timely manner. Random audits to ensure compliate these processes will be conducted nursing management for resident at risk for skin breakdown or who current pressure ulcers. Audits we completed weekly x 4, then month Audit results will be referred to the Assurance Performance Improver Team.	reviewed s are in ded on ocess of el condition s. e ate are care nce in d by s that are have ill be aly x 3. e Quality	

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 4 of 17

Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′			LETED
			25/25/1140.			
		00131	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
			TH STREET			
GOOD SAMARITAN SOCIETY - ALBERT LEA		- ALBERT LEA	LEA, MN 560			
		1			0/5)	
(X4) ID PREFIX		TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
2 900	Continued From pa	ge 4	2 900			
	transferring and toil	eting, but previously had been				
		She indicated R6 had been				
	•	orior to experiencing an				
		A-B also stated R6 had "not				
		ately," and stated staff				
		tion R6 using pillows, but R6				
		oillows and lay on her back or				
	would refuse to allo					
		nt interview on 1/28/15, at				
		viewed documentation related				
		mpleted for R6 however,				
		being documented were				
		d staff assistance with				
	transfers/toileting, a					
		lule. NA-B verified the nursing n did not include reminders				
		maintain R6 on a repositioning				
		o reduce skin breakdown.				
		ion on 1/28/15, at 10:16 a.m.				
		urse (LPN)-A was observed				
		ng change to a stage 3				
		ted on R6's coccyx. A urine				
		brief was removed, and				
		ppropriate hand hygiene and				
	donned gloves. LP	N-A then removed an				
		ing the stage 3 pressure ulcer				
		yx. A moderate amount of				
		e was noted on both the soiled				
		auze strip (approximately 12				
		ed to pack the wound. LPN-A				
		ulcer had recently developed				
		continued to grow under xtended 1 centimeter (cm)				
		ges. LPN-A further verified the				
		reased in size daily and stated				
		R6's dressing change four				
		and at that time there had				
		evident. The wound edges				
		e dark gray/black in color and				
		dark gray/black discoloration,				

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 5 of 17

Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	` ,			LETED
		00131	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
0000	75507 24		TH STREET			
GOOD SAMARITAN SOCIETY - ALBERT LEA ALBERT		- ALBERT LEA ALBERT I	_EA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 5	2 900			
2 900	extending the full suskin surrounding the color. No additional the skin. LPN-A cleathe ulcer with a gauding foam dressing using technique. Upon conchange, a clean ince An interview with readility's resident mattress on her been had a pressure reliewheelchair. RN-E sin the past month a staff assistance with During an interview RN-E verified initial of the stage 3 pressions was dated 1/17/15. At that time was 90 granulation with a necessary serior surrounds and the stage of the stage	urface of the wound bed. R6's e wound was dark pink in I open areas were noted on eansed the wound, repacked ze strip and reapplied the g proper infection control ompletion of the dressing ontinent brief was applied. gistered nurse (RN)-E on m. verified R6, as did each of its, had a pressure relief d. In addition, RN-E stated R6 eving gel cushion placed in her tated R6's status had declined and that R6 required increased in her ADL's. on 1/29/15, at 11:00 a.m. assessment documentation sure ulcer (PU) on R6's coccyx Description of the wound bed by yellow slough, 10% ininimal amount of an amount of an amount of an acceptance on the dressing. The entitled measurements of the ne coccyx as: 1.5 centimeter ide x 1 cm deep with a yellow d a scratch on her right a scratch on her right red 1 cm. long x 0.2 cm wide. Initial assessment of the ection titled; Modifications to N had checked the areas that) repositioning/turning and (2) the section titled, Physician cumentation, was left blank, and choices: (1) continue with timent, (2) physician was yound status, (3) modifications to ceived and (4) care plan	2 900			
	had a pressure relie wheelchair. RN-E s in the past month a staff assistance with During an interview RN-E verified initial of the stage 3 press was dated 1/17/15. at that time was 90° granulation with a n serosanguinous dra The assessment idepressure ulcer on the (cm) long x 3 cm will center. R6 also had buttock that measu Also included in the wound, under the selection included the following current plan of treat notified regarding we to treatment plan re	eving gel cushion placed in her tated R6's status had declined and that R6 required increased in her ADL's. on 1/29/15, at 11:00 a.m. assessment documentation sure ulcer (PU) on R6's coccyx Description of the wound bed by yellow slough, 10% ainage noted on the dressing. The entified measurements of the ne coccyx as: 1.5 centimeter and ex 1 cm deep with a yellow do a scratch on her right a scratch on her right a scratch on her right assessment of the ection titled; Modifications to N had checked the areas that a repositioning/turning and (2) he section titled, Physician cumentation, was left blank, and choices: (1) continue with the ection titled, and (2) physician was round status, (3) modifications are cound status, (3) modifications are cound and (4) care plan Comment section the RN had				

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 6 of 17

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		A. BUILDING:			
	00131	B. WING		01/2	9/2015
NAME OF PROVIDER OR SUPPLIE	R STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COOD CAMADITAN COCIET	75507 240	TH STREET	•		
GOOD SAMARITAN SOCIET	Y - ALBERT LEA ALBERT I	LEA, MN 56	007		
PREFIX (EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
2 900 Continued From p	age 6	2 900			
independently; she frequent reposition and prevent furth review of the resister revisions had been the initial identification and interview of the resister revisions had been the initial identification and interview of the initial identification and shear assessed nor ide to Robits and the pain until the development of a due to Robits ability. Documentation of the land to the	e was educated on the need for ning to promote wound healing er skin breakdown". However, dent's care plan revealed no in made to R6's care plan after ation of the newly developed with which hospice RN on a.m. she stated R6 had been ely 1 lb. (pound)/week and had sing in health status. The did that R6 had not experienced belopment of the coccygeal he hospice RN further stated the pressure ulcer was unexpected to reposition independently. In the Braden Assessment soure Sore Risk) dated did that R6 had a score of 15-18, ild risk for skin breakdown. In the assessment form included hich identified additional risk poor dietary protein intake, did hemodynamic instability. Braden, these additional factors 6's total score to moderate risk in. Interventions identified on the breakdown included: frequent and schedule; use of foam gree lateral (side lying) and remobilization; protect heels; manage nutrition; manage However, R6 had not been nutified as moderate risk for skin did any of the interventions listed did according to the care plan. All assessment 1/17/15, the next are PU was dated 1/19/15, at entified R6 as having an open	2 900			

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 7 of 17

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
	00131	B. WING		01/2	29/2015	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	TATE, ZIP CODE			
COOR CAMARITAN COOLETY	75507 240	OTH STREET				
GOOD SAMARITAN SOCIETY -	ALBERT LEA ALBERT	LEA, MN 560	007			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
2 900 Continued From pag	e 7	2 900				
PU. The wound bed slough with 10% gran of serosanguinous di had an open area on bed is 100% granular noted. A new physicia been received: Hydrochange every 5 days healed. Nursing notes include ulcer documentation later) another wound completed by RN-F, ulcer as unstageable recorded as 8 cm long The stage 3 PU was edges being black in experienced pain, resprogress note dated educated on the nee wound healing and ponthere was no documprovided to the residing regarding risks verse to allow repositioning buttocks/coccyx. The most recent qual (MDS) dated 12/22/1 Interview for Mental Secore of 4/15, which impairment. A nursing included: demonstration after staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom". According the documentation, R6 in the staff noted in the staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom". According the documentation, R6 in the staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom". According the documentation, R6 in the staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom". According the documentation, R6 in the staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom". According the documentation, R6 in the staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom". According the staff noted bruis forehead after a fall of 1/14/15, in which R6 "bottom".	I description included: 90% nulation. A minimal amount rainage was noted. R6 also the right buttock, the wound ation and no drainage was an order on 1/19/15 had rocolloid to coccyx ulcers, and prn (as needed) until ded no additional pressure. On 1/26/15 (one week assessment had been who identified the coccyx at Ulcer measurements were many 3 cm wide x 5 cm deep. described as the wound a color and indicated R6 had alated to the stage 3 PU. The 1/26/15, indicated R6 was ad to reposition to promote prevent further breakdown.					

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 8 of 17

Minnesota Department of Health

	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	, ,			LETED
		00131	B. WING		01/2	9/2015
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		75507 240	TH STREET			
GOOD SAMARITAN SOCIETY - ALBERT LEA		LEA, MN 560				
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	.D BE	COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE
				DEL TOLENOTY		
2 900	Continued From pa	ge 8	2 900			
	(CNP) who assesse	ed the wound on 1/26/15,				
		ng notation: Previously, there				
		are ulcer noted an area on the				
		ars to have merged with the				
	wound located on F	R6's coccyx. The CNP added a				
	diagnosis of-"end o	f life skin failure".				
		cumented by the CNP 1/29/15				
		ient was seen today with staff				
	for observation of c					
		ed in the last week despite				
		ng and appropriate treatment.				
		ospice for suspected breast een losing weight. Due to her				
		not stay repositioned. She				
		sently prefers back supine				
		week the ulcer was a few cm				
	in diameter. It was					
		. However,it has changed				
		oloration and enlarged				
	significantly. There	is a small amount of				
		rainage on the front of the				
		t denies pain with asking.				
		slight repositioning to inspect				
		nplains of quite a bit of pain".				
		the wound as: "a black				
		eximately 3 cm deep; tunneling				
		region; what is striking, is that black including the edges and				
		e edges onto the epidermis				
		around the open region; base				
		ling the tunneling, the ulcer is				
		de and 3 cm deep." In				
		locumented R6 has "pain with				
		fore increasing the Roxanol				
		pain) to 5 mg every 4 hours				
	while awake and or	nce during the night, as well as				
		s needed prior to movement".				
		d 7/15/14 included: ADL self				
		to dx of dementia as				
	evidenced by require	ring supervision and cueing for				

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 9 of 17

STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		00131	B. WING		01/2	9/2015
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
GOOD S	GOOD SAMARITAN SOCIETY - ALBERT LEA					
	AMAINTAN OOOLTT	ALBERT I	_EA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 9	2 900			
	daily hygiene and didentified a toileting during waking hour rounding during the also indicated that offered assistance 1/13/15). The care plan updastage 3 PU on the ofollowing intervention treatment, and to reheal, signs and synmaceration. Prior twas lacking to indiciplan had been deveas, frequent turning of foam wedges for positioning; maxima manage moisture; if friction and shear up PUon the coccyx of Although R6's declipassessment, planninterventions to predevelopment and/oconsistently implemented dated 1/26/15, back supine lying per plan of care had be encourage R6 to tustage 3 PU was distang to indicate the time initial updating of the care Interventions were	ressing. Interventions schedule of independence is and visualization with each enight shift. The care plan R6 was to be monitored and every hour for safety (initiated atted on 1/26/15, identified the coccyx and included the coccy and included the coccy and included the coccy and implemented; such with a planned schedule; use 30 degree lateral (side lying) all remobilization; protect heels; manage nutrition; manage pon discovery of a stage 3 of 1/17/15 (9 days prior). In the coccy and implementation of coccy and implementation of coccy and implementation of coccy and implementation of coccy and included to the CNP and had historically preferred cosition when in bed, yet not en developed to cue and/or rn/reposition herself after the covered. Documentation was hat any interventions had to prevent further breakdown discovery on 1/17/15 and the coccy and included the coccy				
	On 1/27/2015, at 3:	42 p.m. R194 was observed				

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					OATE SURVEY OMPLETED	
		00131	B. WING		01/2	9/2015
	PROVIDER OR SUPPLIER AMARITAN SOCIETY	- ALBERT LEA 75507 240	DRESS, CITY, S DTH STREET LEA, MN 56			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
2 900	lying on his back in feet and both heels On 1/28/2015, at 10 lying on his back in feet and both heels On 1/28/2015, at 11 lying on his back in feet and both heels On 1/28/2015 at 11 lying on his back in feet and both heels On 1/28/2015 at 11 lying on his back in feet and both heels R194's electronic rewas admitted on 12 1/20/15 at 14:14 (2) resident has redder be a suspected deciency pain in the acontinued use of of provided education repositioning to proprevent further skin collection form date a red pressure area 1.1 centimeters (crowidth (W). Review of 1/20/15 included: "Efeet Dx (diagnosis) right foot." A nurse p.m., regarding a te (advanced practice "Change DX of right tissue trauma."	bed with stockings only on his resting on the bed. 2:09 a.m. R194 was observed bed with stockings only on his resting on the bed. 2:24 a.m. R194 was observed bed with stockings only on his resting on the bed. 2:5 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:5 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:6 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:6 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:6 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:7 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:8 p.m. R194 was observed bed with stockings only on his resting on the bed. 2:9 p.m. R194 was observed bed with stockings only on his resting only on his resting on the bed. 2:14 p.m.) indicated: "Note Text: ned area on right heel, likely to be pissue injury. Resident was on the importance of mote wound healing and damage." The wound data and 1/20/15 indicated R194 had a on the right heel measuring in length (L) by (x) 0.6 cm in of the physician order dated Blue Boots to B/L (bilateral) stage 1 pressure ulcer on so note dated 1/23/15 at 12:20 belephone order from the APRN registered nurse) included: theel to suspected deep	2 900			

6899

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					ATE SURVEY OMPLETED	
		00131	B. WING		01/	29/2015
NAME OF	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, S	TATE, ZIP CODE		
COODS	AMADITAN COCIETY	ALBERT LEA 75507 24	OTH STREET			
GOOD S	AMARITAN SOCIETY	- ALBERT LEA ALBERT	LEA, MN 560	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
2 900	Continued From pa	ge 11	2 900			
	NA-A stated R194 v hours. NA-A stated positioning interven other than repositio his back. NA-A furt to lie on his back will when interviewed on RN-C stated she will was the only interpressure to the presented. RN-C talked vijust arrived to work RN-C stated she has would often times in boots while in bed.	on 1/28/2015, at 2:39 p.m. puld expect R194 to be nots anytime he was in bed as tervention in place to relieve assure ulcer located on the righ with a staff member who was the afternoon/evening shift. In the deen informed that R194 and pendently remove the blue RN-C stated being unsure to occurred prior to the	t			
	observed R194 lying socks only on his fer under his lower legs RN-D removed the foot. The pressure intact, dark red in cornect RN-D measured the measured 1 cm (L) interviewed during the wore the heel be sometimes would refuncomfortable. When the boots during the shrugged his should but sometimes they staff had not offered that day nor had the	g on his back in bed with g on his back in bed with bet. The resident had a pillow is with heels floating. The resident's sock from the right area was observed to be color with no discharge present in pressure area which in x 0.7 cm (W). R194 was then this observation and confirmed this observation and confirmed the bed at hight but the move them as they became the day when lying in bed, R194 ders and stated, "Sometimes, of forget". R194 confirmed that it the heel boots to be worn bey been placed on his feet. Sould need to follow-up with	n d			

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3 A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00131	B. WING 01		01/2	9/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
GOOD S	AMARITAN SOCIETY	- ALBERT LEA	TH STREET LEA, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
2 900	Continued From pa	ge 12	2 900				
	staff.						
	director of nursing (on 1/28/2015, at 3:41 p.m. the (DON) confirmed that R194 wearing the blue boots when in the care plan.					
	SUGGESTED METHOD OF CORRECTION: The Director of Nursing (DON) or designee could review the facility's current policies and procedures related to pressure ulcers; and could provide education to staff regarding importance of assessment, planning and implementation of interventions for treatment of pressure ulcers. The DON or designee could conduct monitoring to ensure compliance of treatment for prevention of pressure ulcers.						
	TIME PERIOD FOR (21) days.	R CORRECTION: Twenty-one					
21840	MN St. Statute 144 Residents of HC Fa	.651 Subd. 12 Patients & ac.Bill of Rights	21840			3/2/15	
	residents shall have based on the inform 9. Residents who r or dietary restriction likely medical or mathe refusal, with domedical record. In cincapable of undershas not been adjud legal requirements treatment, the cond	o refuse care. Competent to the right to refuse treatment nation required in subdivision efuse treatment, medication, as shall be informed of the ajor psychological results of cumentation in the individual cases where a resident is standing the circumstances but icated incompetent, or when limit the right to refuse litions and circumstances shall d by the attending physician in cal record.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
			A. BUILDING.					
		00131	B. WING		01/29/2015			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE								
GOOD S	GOOD SAMARITAN SOCIETY - ALBERT LEA 75507 240TH STREET							
GOOD 3	AMANITAN SOCIETT	ALBERT I	LEA, MN 56	007				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE		
21840	Continued From pa	ae 13	21840					
	This MN Requirem	ent is not met as evidenced		The care plane of all recidents will	l b a			
Based on observation, i review the facility failed (vs) benefits of refusing addressed and docume		ion, interview and document ailed to ensure the risks verses using repositioning were umented for 1 of 1 resident a stage 3 pressure ulcer and		The care plans of all residents will be reviewed and updated with appropriate interventions for educating on the risks and benefits of treatment refusals when applicable. Nursing staff education was provided on 2/19/15 regarding the facilities process for documentation of resident refusals of treatment and the care planning process.				
	813/2001. R6 had services on 9/24/14 breast cancer, poor senile dementia wit chronic kidney dise Record review, includes, the care plan indicated R6 had reparticipate with acti	dent at the facility since been admitted to hospice I, with diagnoses including: r appetite with weight loss, h delusional features, and ase with mixed incontinence. uding nursing notes, hospice n and nurse practitioner notes, ecently declined in her ability to vities of daily living (ADLs), anal intake had declined.		Education was also provided on the process of documentation of teaching of the risks of not complying with treatment as recommended. Random audits to ensure compliance whose conducted by nursing management residents that either currently refuse treatment or have a history of refusing treatments. Audits will be completed weekly x 4, then monthly x 3. Audit reswill be referred to the Quality Assurance Performance Improvement Team.				
	11:55 a.m identified her coccyx, likely a There was no docubeen informed of ri with interventions for pressure ulcers. A wound assessment 1/26/15, identified the unstageable. Ulcer recorded as 8 centions of the composition	dated 1/19/15, and timed at that R6 had an open area on stage 3 pressure ulcer (PU). mented evidence that R6 had sks related to failing to comply or prevention/treatment of ent completed by RN-F on the coccyx ulcer as measurements were meter (cm) long x 3 cm wide x ertified nurse practitioner ed R6's coccyx wound on ed, "Previously, there was licer noted on buttocks that		Resident R6 was receiving hospic and passed away on 2/9/15.				

Minnesota Department of Health

STATE FORM 6899 E0TV11 If continuation sheet 14 of 17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		BENTI TOXT TON NOWBETT.	A. BUILDING:		CON	LLILD
		00131	B. WING		01/29/2015	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
COOD C	AMARITAN COCIETY	75507 240	TH STREET	•		
GOOD S	AMARITAN SOCIETY	- ALBERT LEA ALBERT I	LEA, MN 56	007		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
21840	Continued From pa	ge 14	21840			
21840	appears to have me on resident's (R6's) It was observed on was assisted to the by nursing assistant on her back in bed preferred to lie on her has would remove the attempting to repose During interview on stated R6 requeste transferring and toil been more independent of the end of the prior to R6 experier NA-B also added, Flately". NA-B stated using pillows, but Rand lay on her back repositioning. During a subseque 9:31 a.m. NA-B revito hourly checks conthese checks were assistance with trant to a repositioning seasistants care plant and/or attempts to schedule/program to breakdown. During an interview RN-E verified the atthe initial document area located on the areas. The skin assibuttock and coccyx 1.5 centimeter (cm) deep and contained	erged with the wound located	21840			
	a scratch on her rig cm. long x 0.2 cm	ht buttock that measured 1				

Minnesota Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				X3) DATE SURVEY COMPLETED	
THE PERIOD CONTINUES HON	BENTH IOMION HOMBEN.	A. BUILDING:		0011111		
	00131	B. WING		01/29/2015		
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
COOD CAMARITAN COCIETY	75507 240	TH STREET				
GOOD SAMARITAN SOCIETY -	ALBERT LEA ALBERT I	LEA, MN 560	007			
PREFIX (EACH DEFICIENCY N	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
21840 Continued From page	e 15	21840				
(MDS) dated 12/22/1 Interview for Mental S score of 4/15, which impairment. A progress noted dat stated: "The patient observation of coccy, worsened in the last repositioning and app patient is on hospice She has been losing dementia, she will not historically and prese lying position. Last w in diameter. It was s erythematous base, has changed to a bla enlarged significantly sero sanguineous dra wound. The patient of However, with just sli the wound, she comp In addition, the CNP "pain with repositioning the Roxanol (narcotic every 4 hours while a night, as well as ever prior to movement". The care plan was not which included docur stage 3 PU located of interventions identified size and treatment, a failure to heal, signs infection, and macera lacking on the care p notes indicating the r been educated on the	4, documented a Brief Status (BIMS) assessment indicated severe cognitive ted 1/29/15 by the CNP was seen today with staff for x ulcer. This is significantly week despite frequent propriate treatment. The for suspected breast cancer. weight. Due to her of stay repositioned. She ently prefers back supine week the ulcer was a few cm					

Minnesota Department of Health

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		00131	B. WING		01/2	9/2015	
NAME OF	PROVIDER OR SUPPLIER		STATE, ZIP CODE	1 01/2	.0/2010		
GOOD S	AMARITAN SOCIETY	- ALBERTTEA	OTH STREET LEA, MN 56				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE	
21840	A SUGGESTED ME The director of nurs develop and implen related to resident's after having been e The DON could dev ensure ongoing cor findings to the Qual	ge 16 ETHOD FOR CORRECTION: sing (DON) or designee could nent policies and procedures s rights to refuse treatment ducated to potential risks. velop monitoring systems to mpliance and report the lity Assurance Committee. R CORRECTION: Twenty one	21840				