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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E0TV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00131

1. MEDICARE/MEDICAID PROVIDER NO.
(L1) **245441**
2.STATE VENDOR OR MEDICAID NO.
(L2) **418840300**

3. NAME AND ADDRESS OF FACILITY
(L3) **GOOD SAMARITAN SOCIETY - ALBERT LEA**
(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

4. TYPE OF ACTION: **7** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **03/12/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **114** (L18)

13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:
X A. In Compliance With Program Requirements
Compliance Based On:
___1. Acceptable POC

B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **A** (L12)

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

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Kathryn Serie, Unit Supervisor 03/16/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 04/10/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
03/12/2015
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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

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

MINNESOTA MDH DEPARTMENT OF HEALTH

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

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

Department of Health and Human Services
Centers for Medicare & Medicaid Services

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	(Y2) Multiple Construction	(Y3) Date of Revisit
245441	A. Building B. Wing	3/12/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ALBERT 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 Correction Completed	(Y4) Item	(Y5) Date Correction Completed	(Y4) Item	(Y5) Date Correction Completed
ID Prefix **F0155** Reg. # **483.10(b)(4)** LSC	**03/02/2015**	ID Prefix **F0282** Reg. # **483.20(k)(3)(ii)** LSC	**03/02/2015**	ID Prefix **F0314** Reg. # **483.25(c)** LSC	**03/02/2015**
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	
ID Prefix Reg. # LSC		ID Prefix Reg. # LSC		ID Prefix Reg. # LSC	

Reviewed By	Reviewed By	Date:	Signature of Surveyor:	Date:
State Agency	KS/kfd	03/16/2015	03048	03/12/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/29/2015			

Department of Health and Human Services
Centers for Medicare & Medicaid Services

Form Approved
OMB NO. 0938-0390

Post-Certification Revisit Report

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(Y1) Provider / Supplier / CLIA / Identification Number	(Y2) Multiple Construction		(Y3) Date of Revisit
245441	A. Building B. Wing	01 - ALBERT LEA GOOD SAMARITAN CEN	3/1/2015

Name of Facility	Street Address, City, State, Zip Code
GOOD SAMARITAN SOCIETY - ALBERT 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
ID Prefix Reg. # NFPA 101 LSC K0050	Correction Completed 02/27/2015	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed
ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed	ID Prefix Reg. # LSC	Correction Completed

Reviewed By State Agency	Reviewed By	Date:	Signature of Surveyor:	Date:
	PS/kfd	03/16/2015	25822	03/01/2015
Reviewed By CMS RO	Reviewed By	Date:	Signature of Surveyor:	Date:

Followup to Survey Completed on:		Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility?	YES	NO
1/28/2015				

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

MEDICARE/MEDICAID CERTIFICATION AND TRANSMITTAL

ID: E0TV

PART I - TO BE COMPLETED BY THE STATE SURVEY AGENCY

Facility ID: 00131

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(L4) **75507 240TH STREET**
(L5) **ALBERT LEA, MN** (L6) **56007**

4. TYPE OF ACTION: **2** (L8)
1. Initial **2. Recertification**
3. Termination **4. CHOW**
5. Validation **6. Complaint**
7. On-Site Visit **9. Other**
8. Full Survey After Complaint

5. EFFECTIVE DATE CHANGE OF OWNERSHIP
(L9)

6. DATE OF SURVEY **01/29/2015** (L34)

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

7. PROVIDER/SUPPLIER CATEGORY 02 (L7)

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

FISCAL YEAR ENDING DATE: (L35)
12/31

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

12.Total Facility Beds **114** (L18)

13.Total Certified Beds **114** (L17)

10.THE FACILITY IS CERTIFIED AS:

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

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

X B. Not in Compliance with Program Requirements and/or Applied Waivers: * Code: **B*** (L12)

14. LTC CERTIFIED BED BREAKDOWN

18 SNF	18/19 SNF	19 SNF	ICF	IID
	114			
(L37)	(L38)	(L39)	(L42)	(L43)

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

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

17. SURVEYOR SIGNATURE Date :
Mary Whitlock NE 11 02/23/2015 (L19)

18. STATE SURVEY AGENCY APPROVAL Date:
Kamala Fiske-Downing, Enforcement Specialist 03/12/2015 (L20)

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

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

20. COMPLIANCE WITH CIVIL RIGHTS ACT:

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

22. ORIGINAL DATE OF PARTICIPATION
02/01/1987
(L24)

23. LTC AGREEMENT BEGINNING DATE
(L41)

24. LTC AGREEMENT ENDING DATE
(L25)

25. LTC EXTENSION DATE:
(L27)

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

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

28. TERMINATION DATE:
(L28)

29. INTERMEDIARY/CARRIER NO.
00140
(L31)

30. REMARKS

31. RO RECEIPT OF CMS-1539
(L32)

32. DETERMINATION OF APPROVAL DATE
(L33)

DETERMINATION APPROVAL

MINNESOTA
MDH
DEPARTMENT OF HEALTH

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;

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

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

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

DEPARTMENT CONTACT

Questions regarding this letter and all documents submitted as a response to the resident care deficiencies (those preceded by 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, 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245441	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The facility's plan of correction (POC) will serve as your allegation of compliance upon the Department's acceptance. Your signature at the bottom of the first page of the CMS-2567 form will be used as verification of compliance. Upon receipt of an acceptable POC an on-site revisit of your facility will be conducted to validate that substantial compliance with the regulations has been attained in accordance with your verification.	F 000		
F 155 SS=D	483.10(b)(4) RIGHT TO REFUSE; FORMULATE ADVANCE DIRECTIVES The resident has the right to refuse treatment, to refuse to participate in experimental research, and to formulate an advance directive as specified in paragraph (8) of this section. The facility must comply with the requirements specified in subpart I of part 489 of this chapter related to maintaining written policies and procedures regarding advance directives. These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the individual's option, formulate an advance directive. This includes a written description of the facility's policies to implement advance directives and applicable State law. This REQUIREMENT is not met as evidenced	F 155		3/2/15

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

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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F 155	Continued From page 1 by: Based on observation, interview and document review the facility failed to ensure the risks verses (vs) benefits of refusing repositioning were addressed and documented for 1 of 1 resident (R6) reviewed with a stage 3 pressure ulcer and refused care. Findings include: R6 had been a resident at the facility since 813/2001. R6 had been admitted to hospice services on 9/24/14, with diagnoses including: breast cancer, poor appetite with weight loss, senile dementia with delusional features, and chronic kidney disease with mixed incontinence. Record review, including nursing notes, hospice notes, the care plan and nurse practitioner notes, indicated R6 had recently declined in her ability to participate with activities of daily living (ADLs), and that her nutritional intake had declined. The progress notes dated 1/19/15, and timed at 11:55 a.m identified that R6 had an open area on her coccyx, likely a stage 3 pressure ulcer (PU). There was no documented evidence that R6 had been informed of risks related to failing to comply with interventions for prevention/treatment of pressure ulcers. A wound assessment completed by RN-F on 1/26/15, identified the coccyx ulcer as unstageable. Ulcer measurements were recorded as 8 centimeter (cm) long x 3 cm wide x 5 cm deep. The certified nurse practitioner (CNP) who assessed R6's coccyx wound on 1/26/15 documented, "Previously, there was another pressure ulcer noted on buttocks that appears to have merged with the wound located on resident's (R6's) coccyx".	F 155	F155: Plan of correction: 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. Education was also provided on the process of documentation of teaching on the risks of not complying with treatments as recommended. Random audits to ensure compliance will be conducted by nursing management for 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 results will be referred to the Quality Assurance Performance Improvement Team. Resident R6 was receiving hospice care and passed away on 2/9/15.	

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It was observed on 1/27/15, at 3:00 p.m. that R6 was assisted to the toilet and then back into bed by nursing assistant (NA)-B. R6 was positioned on her back in bed (supine). NA-B indicated R6 preferred to lie on her back and commented that R6 would remove the pillows staff used when attempting to reposition R6 onto either side.
During interview on 1/28/15, at 9:22 a.m. NA-B stated R6 requested staff assistance with transferring and toileting, and previously had been more independent. She indicated this was prior to R6 experiencing an increase in pain. NA-B also added, R6 "not been eating much lately". NA-B stated staff attempt to reposition R6 using pillows, but R6 would remove the pillows and lay on her back or would refuse to allow repositioning.
During a subsequent interview on 1/28/15, at 9:31 a.m. NA-B reviewed documentation related to hourly checks completed for R6 and verified these checks were related to safety and staff assistance with transfers/toileting and not related to a repositioning schedule. The nursing assistants care plan did not include reminders and/or attempts to maintain R6 on a repositioning schedule/program to reduce further skin breakdown.
During an interview on 1/29/15, at 11:00 a.m. RN-E verified the assessment dated 1/17/15, was the initial documentation of a stage 3 pressure area located on the right buttock and coccyx areas. The skin assessment identified R6's right buttock and coccyx pressure areas measured-1.5 centimeter (cm) long x 3 cm wide x 1 cm deep and contained a yellow center. R6 also had a scratch on her right buttock that measured 1 cm. long x 0.2 cm wide.
The most recent quarterly Minimum Data Set (MDS) dated 12/22/14, documented a Brief

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F 155	Continued From page 3 Interview for Mental Status (BIMS) assessment score of 4/15, which indicated severe cognitive impairment. A progress noted dated 1/29/15 by the CNP stated: "The patient was seen today with staff for observation of coccyx ulcer. This is significantly worsened in the last week despite frequent repositioning and appropriate treatment. The patient is on hospice for suspected breast cancer. She has been losing weight. Due to her dementia, she will not stay repositioned. She historically and presently prefers back supine lying position. Last week the ulcer was a few cm in diameter. It was stage 2 to 3 with erythematous base. However, until last week it has changed to a blackened discoloration and enlarged significantly. There is a small amount of sero sanguineous drainage on the front of the wound. The patient denies pain with asking. However, with just slight repositioning to inspect the wound, she complains of quite a bit of pain". In addition, the CNP documented that R6 has "pain with repositioning, therefore was increasing the Roxanol (narcotic to relieve pain) to 5 mg every 4 hours while awake and once during the night, as well as every 30 minutes as needed prior to movement". The care plan was not updated until 1/26/15, which included documentation that R6 had a stage 3 PU located on the coccyx and the interventions identified were: monitor location, size and treatment, and to report abnormalities, failure to heal, signs and symptoms (S/S) of infection, and maceration. Documentation was lacking on the care plan and in the progress notes indicating the resident and/or guardian had been educated on the risk vs. benefits of refusing repositioning to prevent further skin breakdown.	F 155		

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F 282	Continued From page 4	F 282		
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to follow the plan of care related to interventions to prevent further skin breakdown for 1 of 3 residents (R194) reviewed with an identified pressure ulcer. Findings include: R194's electronic record was reviewed and was admitted on 12/26/14. The nurses' note dated 1/20/15 at 14:14 (2:14 p.m.) indicated: "Note Text: resident has reddened area on right heel, likely to be a suspected deep tissue injury. resident denies pain in the area. Will recommend the continued use of off loading boots. Resident was provided education on the importance of repositioning to promote wound healing and prevent further skin damage." The wound data collection form dated 1/20/15 indicated R194 had a red pressure area on the right heel measuring 1.1 centimeters (cm) in length (L) by (x) 0.6 cm in width (W). Review of the physician order dated 1/20/15 included: "Blue Boots to B/L (bilateral) feet Dx (diagnosis) stage 1 pressure ulcer on right foot." The nurses note dated 1/23/15 at 12:20 p.m. regarding a telephone order from the APRN (advanced practice registered nurse) included: "Change DX of right heel to suspected	F 282	F282: Plan of Correction: The care plans of all residents with skin concerns will be reviewed to ensure that the appropriate interventions are included in the plan of care. Updates will be made as appropriate. Nursing staff education was provided on 2/19/15 regarding the facilities procedures related to following care planned interventions to ensure appropriate interventions are in place to maximize the residents functioning and well-being. Random audits to ensure that care plans are being followed will be conducted by nursing management for residents that are at risk for skin breakdown or who have current skin issues. Audits will be completed weekly x 4, then monthly x 3. Audit results will be referred to the Quality Assurance Performance Improvement Team. Resident R194 was receiving hospice care and passed away on 2/13/15.	3/2/15

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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 independently remove the blue boots while in bed. RN-C stated being unsure whether that is	F 282		

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F 282	Continued From page 6 what occurred prior to the surveyor's observations. On 1/28/2015, at 2:56 p.m. surveyor and RN-D observed R194 lying on his back in bed with only socks on his feet. F194 had a pillow positioned underneath his lower legs with both heels floating. RN-D removed the resident's sock from the right foot. The pressure area was observed to be intact, dark red in color with no discharge present. RN-D measured the pressure area which measured 1 cm (L) x 0.7 cm (W). R194 was interviewed at that time and confirmed that he wore the heel boots in bed at night but would remove them as they become uncomfortable. When asked whether he wore the boots during the day while in bed, R194 shrugged his shoulders and stated, "Sometimes, but sometimes they forget". R194 confirmed that staff had not offered the heel boots to be worn that day nor had they been placed on his feet. RN-D stated she would need to follow-up with staff. When interviewed on 1/28/2015, at 3:41 p.m. the director of nursing (DON) confirmed that R194 should have been wearing the blue boots when in bed per the care plan.	F 282		
F 314 SS=D	483.25(c) TREATMENT/SVCS TO PREVENT/HEAL PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and	F 314		3/2/15

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F 314	Continued From page 7 prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, plan for, and implement interventions to prevent pressure ulcers from development/reoccurence for 2 of 3 residents (R6 & R194) reviewed who had pressure ulcers. Findings include: R6 had been a resident at the facility since 813/2001. R6 had been admitted to hospice services on 9/24/14, with diagnoses including: breast cancer, poor appetite with weight loss, senile dementia with delusional features, and chronic kidney disease with mixed incontinence. Record review, including nursing notes, hospice notes, the care plan and nurse practitioner notes, indicated R6 had recently declined in her ability to participate with activities of daily living (ADLs), and that her nutritional intake had declined. During an evening observation on 1/26/15, at 6:00 p.m. R6 was noted to be lying in a supine position (on her back) on her bed. During an observation the following day on 1/27/15, at 3:00 p.m. R6 was assisted to the toilet and then back into bed by nursing assistant (NA)-B. R6 was positioned onto her back in bed (supine). At that time, NA-B indicated R6 preferred to lie on her back and commented that R6 would remove the pillows staff utilized for repositioning R6 onto either side. During interview on 1/28/15, at 9:22 a.m. NA-B stated R6 requested staff assistance with	F 314	F314: Plan of Correction: The care plans of all residents with risk for or current pressure ulcers will be reviewed to ensure that appropriate prevention/treatment interventions are in place. Updates will be made as appropriate. Nursing staff education was provided on 2/19/15 regarding the facilities process of notifying the appropriate personnel regarding changes in resident□s condition and/or ability to participate in ADL□s. Education was also provided to the nursing staff on initiating appropriate assessments at the time changes are noted and to make updates to the care plan in a timely manner. Random audits to ensure compliance in these processes will be conducted by nursing management for residents that are at risk for skin breakdown or who have current pressure ulcers. Audits will be completed weekly x 4, then monthly x 3. Audit results will be referred to the Quality Assurance Performance Improvement Team.	

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F 314	Continued From page 8	F 314		

transferring and toileting, but previously had been more independent. She indicated R6 had been more independent prior to experiencing an increase in pain. NA-B also stated R6 had "not been eating much lately," and stated staff attempted to reposition R6 using pillows, but R6 would remove the pillows and lay on her back or would refuse to allow repositioning.
During a subsequent interview on 1/28/15, at 9:31 a.m. NA-B reviewed documentation related to hourly checks completed for R6 however, verified the checks being documented were related to safety and staff assistance with transfers/toileting, and not related to a repositioning schedule. NA-B verified the nursing assistants' care plan did not include reminders and/or attempts to maintain R6 on a repositioning schedule/program to reduce skin breakdown.
During an observation on 1/28/15, at 10:16 a.m. licensed practical nurse (LPN)-A was observed to perform a dressing change to a stage 3 pressure ulcer located on R6's coccyx. A urine soaked incontinent brief was removed, and LPN-A performed appropriate hand hygiene and donned gloves. LPN-A then removed an adhesive pad covering the stage 3 pressure ulcer located on the coccyx. A moderate amount of light brown drainage was noted on both the soiled dressing and the gauze strip (approximately 12 inches in length) used to pack the wound. LPN-A stated the pressure ulcer had recently developed tunneling (the ulcer continued to grow under intact skin) which extended 1 centimeter (cm) from the wound edges. LPN-A further verified the wound size had increased in size daily and stated she had performed R6's dressing change four days prior (1/24/15) and at that time there had been no tunneling evident. The wound edges were observed to be dark gray/black in color and

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the wound bed had dark gray/black discoloration, extending the full surface of the wound bed. R6's skin surrounding the wound was dark pink in color. No additional open areas were noted on the skin. LPN-A cleansed the wound, repacked the ulcer with a gauze strip and reapplied the foam dressing using proper infection control technique. Upon completion of the dressing change, a clean incontinent brief was applied.
An interview with registered nurse (RN)-E on 1/28/15, at 12:20 p.m. verified R6, as did each of the facility's residents, had a pressure relief mattress on her bed. In addition, RN-E stated R6 had a pressure relieving gel cushion placed in her wheelchair. RN-E stated R6's status had declined in the past month and that R6 required increased staff assistance with her ADL's.
During an interview on 1/29/15, at 11:00 a.m. RN-E verified initial assessment documentation of the stage 3 pressure ulcer (PU) on R6's coccyx was dated 1/17/15. Description of the wound bed at that time was 90% yellow slough, 10% granulation with a minimal amount of serosanguinous drainage noted on the dressing. The assessment identified measurements of the pressure ulcer on the coccyx as: 1.5 centimeter (cm) long x 3 cm wide x 1 cm deep with a yellow center. R6 also had a scratch on her right buttock that measured 1 cm. long x 0.2 cm wide. Also included in the intial assessment of the wound, under the section titled; Modifications to Interventions, the RN had checked the areas that were applicable: (1) repositioning/turning and (2) wound treatment. The section titled, Physician Notification and Documentation,was left blank, included the following choices: (1) continue with current plan of treatment, (2) physician was notified regarding wound status, (3) modifications to treatment plan received and (4) care plan

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updated. Under the Comment section the RN had documented, "resident is able to move independently; she was educated on the need for frequent repositioning to promote wound healing and prevent further skin breakdown". However, review of the resident's care plan revealed no revisions had been made to R6's care plan after the initial identification of the newly developed stage 3 PU.

During an interview with the hospice RN on 1/29/15, at 11:15 a.m. she stated R6 had been losing approximately 1 lb. (pound)/week and had been slowly declining in health status. The hospice RN added that R6 had not experienced pain until the development of the coccygeal pressure ulcer. The hospice RN further stated the development of a pressure ulcer was unexpected due to R6's ability to reposition independently.

Documentation on the Braden Assessment (Prediction of Pressure Sore Risk) dated 12/22/14, identified that R6 had a score of 15-18, which indicated mild risk for skin breakdown. In addition this Braden assessment form included documentation which identified additional risk factors including: poor dietary protein intake, advanced age, and hemodynamic instability. According to the Braden, these additional factors would increase R6's total score to moderate risk for skin breakdown. Interventions identified on the form for Moderate breakdown included: frequent turning with a planned schedule; use of foam wedges for 30 degree lateral (side lying) positioning; maximal remobilization; protect heels; manage moisture; manage nutrition; manage friction and shear. However, R6 had not been assessed nor identified as moderate risk for skin breakdown nor had any of the interventions listed been implemented according to the care plan.

Following the initial assessment 1/17/15, the next

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entry describing the PU was dated 1/19/15, at 11:55 a.m. and identified R6 as having an open area on her coccyx which was likely a stage 3 PU. The wound bed description included: 90% slough with 10% granulation. A minimal amount of serosanguinous drainage was noted. R6 also had an open area on the right buttock, the wound bed is 100% granulation and no drainage was noted. A new physician order on 1/19/15 had been received: Hydrocolloid to coccyx ulcers, change every 5 days and prn (as needed) until healed.

Nursing notes included no additional pressure ulcer documentation. On 1/26/15 (one week later) another wound assessment had been completed by RN-F, who identified the coccyx ulcer as unstageable. Ulcer measurements were recorded as 8 cm long x 3 cm wide x 5 cm deep. The stage 3 PU was described as the wound edges being black in color and indicated R6 had experienced pain, related to the stage 3 PU. The progress note dated 1/26/15, indicated R6 was educated on the need to reposition to promote wound healing and prevent further breakdown. There was no documentation of education provided to the resident and/or guardian regarding risks verses benefits of resident refusal to allow repositioning to relieve pressure on buttocks/coccyx.

The most recent quarterly Minimum Data Set (MDS) dated 12/22/14, documented a Brief Interview for Mental Status (BIMS) assessment score of 4/15, which indicated severe cognitive impairment. A nursing note dated 1/13/15 included: demonstrates poor safety judgement after staff noted bruises on left hip and left forehead after a fall on 1/9/15; and a fall on 1/14/15, in which R6 complained of pain on her "bottom". According to ADL (activity of daily living)

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	245441	A. BUILDING _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 314	Continued From page 12	F 314		

documentation, R6 had required intermittent physical assist from one staff on 1/19; 1/22; 1/23; 1/24; 1/25; 1/27 and 1/28/15.
Documentation by the certified nurse practitioner (CNP) who assessed the wound on 1/26/15, included the following notation: Previously, there was another pressure ulcer noted an area on the buttocks that appears to have merged with the wound located on R6's coccyx. The CNP added a diagnosis of-"end of life skin failure".
A progress note documented by the CNP 1/29/15 included: "The patient was seen today with staff for observation of coccyx ulcer. This is significantly worsened in the last week despite frequent repositioning and appropriate treatment. The patient is on hospice for suspected breast cancer. She has been losing weight. Due to her dementia, she will not stay repositioned. She historically and presently prefers back supine lying position. Last week the ulcer was a few cm in diameter. It was stage 2 to 3 with erythematous base. However, ..it has changed to a blackened discoloration and enlarged significantly. There is a small amount of serosanguineous drainage on the front of the wound. The patient denies pain with asking. However, with just slight repositioning to inspect the wound, she complains of quite a bit of pain". The CNP described the wound as: "a black discoloration, approximately 3 cm deep; tunneling all around the open region; what is striking, is that the whole wound is black including the edges and even coming off the edges onto the epidermis approximately 1 cm around the open region; base is quite hard; including the tunneling, the ulcer is 8 cm long, 5 cm wide and 3 cm deep." In addition, the CNP documented R6 has "pain with repositioning, therefore increasing the Roxanol (narcotic to relieve pain) to 5 mg every 4 hours

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while awake and once during the night, as well as every 30 minutes as needed prior to movement". The care plan dated 7/15/14 included: ADL self care deficit related to dx of dementia as evidenced by requiring supervision and cueing for daily hygiene and dressing. Interventions identified a toileting schedule of independence during waking hours and visualization with each rounding during the night shift. The care plan also indicated that R6 was to be monitored and offered assistance every hour for safety (initiated 1/13/15).

The care plan updated on 1/26/15, identified the stage 3 PU on the coccyx and included the following interventions: monitor location, size and treatment, and to report abnormalities, failure to heal, signs and symptoms (S/S) of infection, and maceration. Prior to this date, documentation was lacking to indicate that an individualized care plan had been developed and implemented; such as, frequent turning with a planned schedule; use of foam wedges for 30 degree lateral (side lying) positioning; maximal remobilization; protect heels; manage moisture; manage nutrition; manage friction and shear upon discovery of a stage 3 PUon the coccyx on 1/17/15 (9 days prior). Although R6's declining status was known, assessment, planning and implementation of interventions to prevent pressure ulcer development and/or worsening had not been consistently implemented. According to the CNP note dated 1/26/15, R6 had historically preferred back supine lying position when in bed, yet no plan of care had been developed to cue and/or encourage R6 to turn/reposition herself after the stage 3 PU was discovered. Documentation was lacking to indicate that any interventions had been implemented to prevent further breakdown from the time initial discovery on 1/17/15 and the

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F 314	Continued From page 14 updating of the care plan on 1/26/15. Interventions were not consistently implemented to promote healing for R194 who had an area of pressure on his right heel. 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. 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. 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. 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. R194's electronic record was reviewed. R194 was admitted on 12/26/14. A nurse's note dated 1/20/15 at 14:14 (2:14 p.m.) indicated: "Note Text: resident has reddened area on right heel, likely to be a suspected deep tissue injury. Resident denies pain in the area. Will recommend the continued use of off loading boots. Resident was provided education on the importance of repositioning to promote wound healing and prevent further skin damage." The wound data collection form dated 1/20/15 indicated R194 had a red pressure area on the right heel measuring 1.1 centimeters (cm) in length (L) by (x) 0.6 cm in width (W). Review of the physician order dated 1/20/15 included: "Blue Boots to B/L (bilateral) feet Dx (diagnosis) stage 1 pressure ulcer on	F 314		

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right foot." A nurse's note dated 1/23/15 at 12:20 p.m., regarding a telephone order from the APRN (advanced practice registered nurse) included: "Change DX of right heel to suspected deep tissue trauma."

Review of the care plan dated 1/14/15 included: "Blue Boots on B/L feet while in bed."

When interviewed on 1/28/2015, at 10:12 a.m. 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. 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 independently remove the blue boots while in bed. RN-C stated being unsure whether that is what occurred prior to the surveyor's observations.

On 1/28/2015, at 2:56 p.m. surveyor and RN-D observed R194 lying on his back in bed with socks only on his feet. The resident had a pillow under his lower legs with heels floating. RN-D removed the resident's sock from the right foot. The pressure area was observed to be intact, dark red in color with no discharge present. RN-D measured the pressure area which measured 1 cm (L) x 0.7 cm (W). R194 was then

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F 314	Continued From page 16 interviewed during this observation and confirmed he wore the heel boots in bed at night but sometimes would remove them as they became uncomfortable. When asked whether he wore the boots during the day when lying in bed, R194 shrugged his shoulders and stated, "Sometimes, but sometimes they forget". R194 confirmed that staff had not offered the heel boots to be worn that day nor had they been placed on his feet. RN-D stated she would need to follow-up with staff. When interviewed on 1/28/2015, at 3:41 p.m. the director of nursing (DON) confirmed that R194 should have been wearing the blue boots when in bed as defined in the care plan.	F 314		

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	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING _____	**01/28/2015**

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K 000	INITIAL COMMENTS FIRE SAFETY THE FACILITY'S POC WILL SERVE AS YOUR ALLEGATION OF COMPLIANCE UPON THE DEPARTMENT'S ACCEPTANCE. YOUR SIGNATURE AT THE BOTTOM OF THE FIRST PAGE OF THE CMS-2567 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	K 000	EPOC	

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

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K 000	Continued From page 1 By email to: Marian.Whitney@state.mn.us and Angela.Kappenman@state.mn.us THE PLAN OF CORRECTION FOR EACH DEFICIENCY MUST INCLUDE ALL OF THE FOLLOWING INFORMATION: 1. A description of what has been, or will be, done to correct the deficiency. 2. The actual, or proposed, completion date. 3. The name and/or title of the person responsible for correction and monitoring to prevent a reoccurrence of the deficiency. Good Samaritan Society - Albert Lea, is a 1-story building. The building was constructed at 6 different times. The original building was constructed in 1965 and was determined to be of Type II(111) construction. In 1968, an addition was constructed and was determined to be of Type II(111) construction. In 1975, an addition was constructed and was determined to be of Type II (111) construction. In 1980, an addition was constructed and was determined to be of Type II(111) construction. In 1997, an addition was constructed and was determined to be of Type II(111) construction In 1998, an addition was constructed and was determined to be of Type II(111) construction Because the original building and the 5 additions meet the construction type allowed for existing buildings, the facility was surveyed as one building. The building is automatic sprinkler protected. The facility has a fire alarm system with full corridor	K 000		

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	245441	A. BUILDING **01 - ALBERT LEA GOOD SAMARITAN CENTER** B. WING _____	**01/28/2015**

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K 000	Continued From page 2 smoke detection and spaces open to the corridors that is monitored for automatic fire department notification. The facility has a capacity of 108 beds and had a census of 104 at time of the survey. The requirement at 42 CFR, Subpart 483.70(a) is NOT MET as evidenced by:	K 000		
K 050 SS=D	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 This STANDARD is not met as evidenced by: Based on documentation review and staff interview, the facility failed to assure fire drills were conducted once per shift per quarter for all staff under varying times and conditions as required by 2000 NFPA 101, Section 19.7.1.2. This deficient practice could affect all 104 residents. Findings include: On facility tour between 9:30 AM and 1:30 PM on 01/28/2015, the review of the fire drill documentation for the past 12 months (January	K 050	Environmental Services/ Maintenance binder updated to include a chart for specific fire drill times for each quarter. Audits done weekly X4 monthly X3.	2/27/15

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K 050	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* Gary Schroeder, Life Safety Code Spc.	K 050		

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 only a suggestion 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

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(s)

cc: Original - Facility
Licensing and Certification File

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: _____ B. WING _____	01/29/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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2 000	Initial Comments *****ATTENTION****** NH LICENSING CORRECTION ORDER In accordance with Minnesota Statute, section 144A.10, this correction order has been issued pursuant to a survey. If, upon reinspection, it is found that the deficiency or deficiencies cited herein are not corrected, a fine for each violation not corrected shall be assessed in accordance with a schedule of fines promulgated by rule of the Minnesota Department of Health. Determination of whether a violation has been corrected requires compliance with all requirements of the rule provided at the tag number and MN Rule number indicated below. When a rule contains several items, failure to comply with any of the items will be considered lack of compliance. Lack of compliance upon re-inspection with any item of multi-part rule will result in the assessment of a fine even if the item that was violated during the initial inspection was corrected. You may request a hearing on any assessments that may result from non-compliance with these orders provided that a written request is made to the Department within 15 days of receipt of a notice of assessment for non-compliance. INITIAL COMMENTS: On January 26th thru 29th 2015, surveyors of this 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	2 000	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.	

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2 000	Continued From page 1 Certification Program, P.O. Box 64900 St. Paul, MN 55164-0900	2 000	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 which 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.	
2 565	MN Rule 4658.0405 Subp. 3 Comprehensive Plan of Care; Use Subp. 3. Use. A comprehensive plan of care must be used by all personnel involved in the care of the resident. This MN Requirement is not met as evidenced	2 565		3/2/15

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GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

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2 565	Continued From page 2 by: SUGGESTED METHOD OF CORRECTION: The director of nursing (DON) or designee could develop, review, and/or revise policies and procedures to ensure the facility develops care plans according to the residents individualized needs. The director of nursing (DON) or designee could educate all appropriate staff on the policies and procedures.The director of nursing (DON) or designee could develop monitoring systems to ensure ongoing compliance. TIME PERIOD FOR CORRECTION: Twenty-one (21) days.	2 565	The care plans of all residents with skin concerns will be reviewed to ensure that the appropriate interventions are included in the plan of care. Updates will be made as appropriate. Nursing staff education was provided on 2/19/15 regarding the facilities procedures related to following care planned interventions to ensure appropriate interventions are in place to maximize the residents functioning and well-being. Random audits to ensure that care plans are being followed will be conducted by nursing management for residents that are at risk for skin breakdown or who have current skin issues. Audits will be completed weekly x 4, then monthly x 3. Audit results will be referred to the Quality Assurance Performance Improvement Team.	
2 900	MN Rule 4658.0525 Subp. 3 Rehab - Pressure Ulcers Subp. 3. Pressure sores. Based on the comprehensive resident assessment, the director of nursing services must coordinate the development of a nursing care plan which provides that: A. a resident who enters the nursing home without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates, and a physician authenticates, that they were unavoidable; and B. a resident who has pressure sores receives necessary treatment and services to	2 900		3/2/15

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	00131	A. BUILDING: _____ B. WING _____	01/29/2015

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2 900	Continued From page 3 promote healing, prevent infection, and prevent new sores from developing. This MN Requirement is not met as evidenced by: Based on observation, interview, and document review the facility failed to comprehensively assess, plan for, and implement interventions to prevent pressure ulcers from development/reoccurence for 2 of 3 residents (R6 & R194) reviewed who had pressure ulcers. Findings include: R6 had been a resident at the facility since 813/2001. R6 had been admitted to hospice services on 9/24/14, with diagnoses including: breast cancer, poor appetite with weight loss, senile dementia with delusional features, and chronic kidney disease with mixed incontinence. Record review, including nursing notes, hospice notes, the care plan and nurse practitioner notes, indicated R6 had recently declined in her ability to participate with activities of daily living (ADLs), and that her nutritional intake had declined. During an evening observation on 1/26/15, at 6:00 p.m. R6 was noted to be lying in a supine position (on her back) on her bed. During an observation the following day on 1/27/15, at 3:00 p.m. R6 was assisted to the toilet and then back into bed by nursing assistant (NA)-B. R6 was positioned onto her back in bed (supine). At that time, NA-B indicated R6 preferred to lie on her back and commented that R6 would remove the pillows staff utilized for repositioning R6 onto either side. During interview on 1/28/15, at 9:22 a.m. NA-B stated R6 requested staff assistance with	2 900	The care plans of all residents with risk for or current pressure ulcers will be reviewed to ensure that appropriate prevention/treatment interventions are in place. Updates will be made as appropriate. Nursing staff education was provided on 2/19/15 regarding the facilities process of notifying the appropriate personnel regarding changes in resident□s condition and/or ability to participate in ADL□s. Education was also provided to the nursing staff on initiating appropriate assessments at the time changes are noted and to make updates to the care plan in a timely manner. Random audits to ensure compliance in these processes will be conducted by nursing management for residents that are at risk for skin breakdown or who have current pressure ulcers. Audits will be completed weekly x 4, then monthly x 3. Audit results will be referred to the Quality Assurance Performance Improvement Team.	

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2 900	Continued From page 4 transferring and toileting, but previously had been more independent. She indicated R6 had been more independent prior to experiencing an increase in pain. NA-B also stated R6 had "not been eating much lately," and stated staff attempted to reposition R6 using pillows, but R6 would remove the pillows and lay on her back or would refuse to allow repositioning. During a subsequent interview on 1/28/15, at 9:31 a.m. NA-B reviewed documentation related to hourly checks completed for R6 however, verified the checks being documented were related to safety and staff assistance with transfers/toileting, and not related to a repositioning schedule. NA-B verified the nursing assistants' care plan did not include reminders and/or attempts to maintain R6 on a repositioning schedule/program to reduce skin breakdown. During an observation on 1/28/15, at 10:16 a.m. licensed practical nurse (LPN)-A was observed to perform a dressing change to a stage 3 pressure ulcer located on R6's coccyx. A urine soaked incontinent brief was removed, and LPN-A performed appropriate hand hygiene and donned gloves. LPN-A then removed an adhesive pad covering the stage 3 pressure ulcer located on the coccyx. A moderate amount of light brown drainage was noted on both the soiled dressing and the gauze strip (approximately 12 inches in length) used to pack the wound. LPN-A stated the pressure ulcer had recently developed tunneling (the ulcer continued to grow under intact skin) which extended 1 centimeter (cm) from the wound edges. LPN-A further verified the wound size had increased in size daily and stated she had performed R6's dressing change four days prior (1/24/15) and at that time there had been no tunneling evident. The wound edges were observed to be dark gray/black in color and the wound bed had dark gray/black discoloration,	2 900		

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2 900	Continued From page 5 extending the full surface of the wound bed. R6's skin surrounding the wound was dark pink in color. No additional open areas were noted on the skin. LPN-A cleansed the wound, repacked the ulcer with a gauze strip and reapplied the foam dressing using proper infection control technique. Upon completion of the dressing change, a clean incontinent brief was applied. An interview with registered nurse (RN)-E on 1/28/15, at 12:20 p.m. verified R6, as did each of the facility's residents, had a pressure relief mattress on her bed. In addition, RN-E stated R6 had a pressure relieving gel cushion placed in her wheelchair. RN-E stated R6's status had declined in the past month and that R6 required increased staff assistance with her ADL's. During an interview on 1/29/15, at 11:00 a.m. RN-E verified initial assessment documentation of the stage 3 pressure ulcer (PU) on R6's coccyx was dated 1/17/15. Description of the wound bed at that time was 90% yellow slough, 10% granulation with a minimal amount of serosanguinous drainage noted on the dressing. The assessment identified measurements of the pressure ulcer on the coccyx as: 1.5 centimeter (cm) long x 3 cm wide x 1 cm deep with a yellow center. R6 also had a scratch on her right buttock that measured 1 cm. long x 0.2 cm wide. Also included in the intial assessment of the wound, under the section titled; Modifications to Interventions, the RN had checked the areas that were applicable: (1) repositioning/turning and (2) wound treatment. The section titled, Physician Notification and Documentation,was left blank, included the following choices: (1) continue with current plan of treatment, (2) physician was notified regarding wound status, (3) modifications to treatment plan received and (4) care plan updated. Under the Comment section the RN had documented, "resident is able to move	2 900		

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2 900	Continued From page 6	2 900		

independently; she was educated on the need for frequent repositioning to promote wound healing and prevent further skin breakdown". However, review of the resident's care plan revealed no revisions had been made to R6's care plan after the initial identification of the newly developed stage 3 PU.
During an interview with the hospice RN on 1/29/15, at 11:15 a.m. she stated R6 had been losing approximately 1 lb. (pound)/week and had been slowly declining in health status. The hospice RN added that R6 had not experienced pain until the development of the coccygeal pressure ulcer. The hospice RN further stated the development of a pressure ulcer was unexpected due to R6's ability to reposition independently.
Documentation on the Braden Assessment (Prediction of Pressure Sore Risk) dated 12/22/14, identified that R6 had a score of 15-18, which indicated mild risk for skin breakdown. In addition this Braden assessment form included documentation which identified additional risk factors including: poor dietary protein intake, advanced age, and hemodynamic instability. According to the Braden, these additional factors would increase R6's total score to moderate risk for skin breakdown. Interventions identified on the form for Moderate breakdown included: frequent turning with a planned schedule; use of foam wedges for 30 degree lateral (side lying) positioning; maximal remobilization; protect heels; manage moisture; manage nutrition; manage friction and shear. However, R6 had not been assessed nor identified as moderate risk for skin breakdown nor had any of the interventions listed been implemented according to the care plan.
Following the initial assessment 1/17/15, the next entry describing the PU was dated 1/19/15, at 11:55 a.m. and identified R6 as having an open area on her coccyx which was likely a stage 3

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2 900	Continued From page 7 PU. The wound bed description included: 90% slough with 10% granulation. A minimal amount of serosanguinous drainage was noted. R6 also had an open area on the right buttock, the wound bed is 100% granulation and no drainage was noted. A new physician order on 1/19/15 had been received: Hydrocolloid to coccyx ulcers, change every 5 days and prn (as needed) until healed. Nursing notes included no additional pressure ulcer documentation. On 1/26/15 (one week later) another wound assessment had been completed by RN-F, who identified the coccyx ulcer as unstageable. Ulcer measurements were recorded as 8 cm long x 3 cm wide x 5 cm deep. The stage 3 PU was described as the wound edges being black in color and indicated R6 had experienced pain, related to the stage 3 PU. The progress note dated 1/26/15, indicated R6 was educated on the need to reposition to promote wound healing and prevent further breakdown. There was no documentation of education provided to the resident and/or guardian regarding risks verses benefits of resident refusal to allow repositioning to relieve pressure on buttocks/coccyx. The most recent quarterly Minimum Data Set (MDS) dated 12/22/14, documented a Brief Interview for Mental Status (BIMS) assessment score of 4/15, which indicated severe cognitive impairment. A nursing note dated 1/13/15 included: demonstrates poor safety judgement after staff noted bruises on left hip and left forehead after a fall on 1/9/15; and a fall on 1/14/15, in which R6 complained of pain on her "bottom". According to ADL (activity of daily living) documentation, R6 had required intermittent physical assist from one staff on 1/19; 1/22; 1/23; 1/24; 1/25; 1/27 and 1/28/15. Documentation by the certified nurse practitioner	2 900		

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2 900	Continued From page 8 (CNP) who assessed the wound on 1/26/15, included the following notation: Previously, there was another pressure ulcer noted an area on the buttocks that appears to have merged with the wound located on R6's coccyx. The CNP added a diagnosis of-"end of life skin failure". A progress note documented by the CNP 1/29/15 included: "The patient was seen today with staff for observation of coccyx ulcer. This is significantly worsened in the last week despite frequent repositioning and appropriate treatment. The patient is on hospice for suspected breast cancer. She has been losing weight. Due to her dementia, she will not stay repositioned. She historically and presently prefers back supine lying position. Last week the ulcer was a few cm in diameter. It was stage 2 to 3 with erythematous base. However, ..it has changed to a blackened discoloration and enlarged significantly. There is a small amount of serosanguineous drainage on the front of the wound. The patient denies pain with asking. However, with just slight repositioning to inspect the wound, she complains of quite a bit of pain". The CNP described the wound as: "a black discoloration, approximately 3 cm deep; tunneling all around the open region; what is striking, is that the whole wound is black including the edges and even coming off the edges onto the epidermis approximately 1 cm around the open region; base is quite hard; including the tunneling, the ulcer is 8 cm long, 5 cm wide and 3 cm deep." In addition, the CNP documented R6 has "pain with repositioning, therefore increasing the Roxanol (narcotic to relieve pain) to 5 mg every 4 hours while awake and once during the night, as well as every 30 minutes as needed prior to movement". The care plan dated 7/15/14 included: ADL self care deficit related to dx of dementia as evidenced by requiring supervision and cueing for	2 900		

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2 900	Continued From page 9 daily hygiene and dressing. Interventions identified a toileting schedule of independence during waking hours and visualization with each rounding during the night shift. The care plan also indicated that R6 was to be monitored and offered assistance every hour for safety (initiated 1/13/15). The care plan updated on 1/26/15, identified the stage 3 PU on the coccyx and included the following interventions: monitor location, size and treatment, and to report abnormalities, failure to heal, signs and symptoms (S/S) of infection, and maceration. Prior to this date, documentation was lacking to indicate that an individualized care plan had been developed and implemented; such as, frequent turning with a planned schedule; use of foam wedges for 30 degree lateral (side lying) positioning; maximal remobilization; protect heels; manage moisture; manage nutrition; manage friction and shear upon discovery of a stage 3 PUon the coccyx on 1/17/15 (9 days prior). Although R6's declining status was known, assessment, planning and implementation of interventions to prevent pressure ulcer development and/or worsening had not been consistently implemented. According to the CNP note dated 1/26/15, R6 had historically preferred back supine lying position when in bed, yet no plan of care had been developed to cue and/or encourage R6 to turn/reposition herself after the stage 3 PU was discovered. Documentation was lacking to indicate that any interventions had been implemented to prevent further breakdown from the time initial discovery on 1/17/15 and the updating of the care plan on 1/26/15. Interventions were not consistently implemented to promote healing for R194 who had an area of pressure on his right heel. On 1/27/2015, at 3:42 p.m. R194 was observed	2 900		

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2 900	Continued From page 10 lying on his back in bed with stockings only on his feet and both heels resting on the bed. 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. 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. 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. R194's electronic record was reviewed. R194 was admitted on 12/26/14. A nurse's note dated 1/20/15 at 14:14 (2:14 p.m.) indicated: "Note Text: resident has reddened area on right heel, likely to be a suspected deep tissue injury. Resident denies pain in the area. Will recommend the continued use of off loading boots. Resident was provided education on the importance of repositioning to promote wound healing and prevent further skin damage." The wound data collection form dated 1/20/15 indicated R194 had a red pressure area on the right heel measuring 1.1 centimeters (cm) in length (L) by (x) 0.6 cm in width (W). Review of the physician order dated 1/20/15 included: "Blue Boots to B/L (bilateral) feet Dx (diagnosis) stage 1 pressure ulcer on right foot." A nurse's note dated 1/23/15 at 12:20 p.m., regarding a telephone order from the APRN (advanced practice registered nurse) included: "Change DX of right heel to suspected deep tissue trauma." Review of the care plan dated 1/14/15 included: "Blue Boots on B/L feet while in bed."	2 900		

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2 900	Continued From page 11 When interviewed on 1/28/2015, at 10:12 a.m. 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. 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 independently remove the blue boots while in bed. RN-C stated being unsure whether that is what occurred prior to the surveyor's observations. On 1/28/2015, at 2:56 p.m. surveyor and RN-D observed R194 lying on his back in bed with socks only on his feet. The resident had a pillow under his lower legs with heels floating. RN-D removed the resident's sock from the right foot. The pressure area was observed to be intact, dark red in color with no discharge present. RN-D measured the pressure area which measured 1 cm (L) x 0.7 cm (W). R194 was then interviewed during this observation and confirmed he wore the heel boots in bed at night but sometimes would remove them as they became uncomfortable. When asked whether he wore the boots during the day when lying in bed, R194 shrugged his shoulders and stated, "Sometimes, but sometimes they forget". R194 confirmed that staff had not offered the heel boots to be worn that day nor had they been placed on his feet. RN-D stated she would need to follow-up with	2 900		

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2 900	Continued From page 12 staff. When interviewed on 1/28/2015, at 3:41 p.m. the director of nursing (DON) confirmed that R194 should have been wearing the blue boots when in bed as defined 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 CORRECTION: Twenty-one (21) days.	2 900		
21840	MN St. Statute 144.651 Subd. 12 Patients & Residents of HC Fac.Bill of Rights Subd. 12. Right to refuse care. Competent residents shall have the right to refuse treatment based on the information required in subdivision 9. Residents who refuse treatment, medication, or dietary restrictions shall be informed of the likely medical or major psychological results of the refusal, with documentation in the individual medical record. In cases where a resident is incapable of understanding the circumstances but has not been adjudicated incompetent, or when legal requirements limit the right to refuse treatment, the conditions and circumstances shall be fully documented by the attending physician in the resident's medical record.	21840		3/2/15

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21840	Continued From page 13 This MN Requirement is not met as evidenced by: Based on observation, interview and document review the facility failed to ensure the risks verses (vs) benefits of refusing repositioning were addressed and documented for 1 of 1 resident (R6) reviewed with a stage 3 pressure ulcer and refused care. Findings include: R6 had been a resident at the facility since 813/2001. R6 had been admitted to hospice services on 9/24/14, with diagnoses including: breast cancer, poor appetite with weight loss, senile dementia with delusional features, and chronic kidney disease with mixed incontinence. Record review, including nursing notes, hospice notes, the care plan and nurse practitioner notes, indicated R6 had recently declined in her ability to participate with activities of daily living (ADLs), and that her nutritional intake had declined. The progress notes dated 1/19/15, and timed at 11:55 a.m identified that R6 had an open area on her coccyx, likely a stage 3 pressure ulcer (PU). There was no documented evidence that R6 had been informed of risks related to failing to comply with interventions for prevention/treatment of pressure ulcers. A wound assessment completed by RN-F on 1/26/15, identified the coccyx ulcer as unstageable. Ulcer measurements were recorded as 8 centimeter (cm) long x 3 cm wide x 5 cm deep. The certified nurse practitioner (CNP) who assessed R6's coccyx wound on 1/26/15 documented, "Previously, there was another pressure ulcer noted on buttocks that	21840	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. Education was also provided on the process of documentation of teaching on the risks of not complying with treatments as recommended. Random audits to ensure compliance will be conducted by nursing management for 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 results will be referred to the Quality Assurance Performance Improvement Team. Resident R6 was receiving hospice care and passed away on 2/9/15.	

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GOOD SAMARITAN SOCIETY - ALBERT LEA	75507 240TH STREET ALBERT LEA, MN 56007

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
21840	Continued From page 14 appears to have merged with the wound located on resident's (R6's) coccyx". It was observed on 1/27/15, at 3:00 p.m. that R6 was assisted to the toilet and then back into bed by nursing assistant (NA)-B. R6 was positioned on her back in bed (supine). NA-B indicated R6 preferred to lie on her back and commented that R6 would remove the pillows staff used when attempting to reposition R6 onto either side. During interview on 1/28/15, at 9:22 a.m. NA-B stated R6 requested staff assistance with transferring and toileting, and previously had been more independent. She indicated this was prior to R6 experiencing an increase in pain. NA-B also added, R6 "not been eating much lately". NA-B stated staff attempt to reposition R6 using pillows, but R6 would remove the pillows and lay on her back or would refuse to allow repositioning. During a subsequent interview on 1/28/15, at 9:31 a.m. NA-B reviewed documentation related to hourly checks completed for R6 and verified these checks were related to safety and staff assistance with transfers/toileting and not related to a repositioning schedule. The nursing assistants care plan did not include reminders and/or attempts to maintain R6 on a repositioning schedule/program to reduce further skin breakdown. During an interview on 1/29/15, at 11:00 a.m. RN-E verified the assessment dated 1/17/15, was the initial documentation of a stage 3 pressure area located on the right buttock and coccyx areas. The skin assessment identified R6's right buttock and coccyx pressure areas measured-1.5 centimeter (cm) long x 3 cm wide x 1 cm deep and contained a yellow center. R6 also had a scratch on her right buttock that measured 1 cm. long x 0.2 cm wide. The most recent quarterly Minimum Data Set	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	00131	A. BUILDING: _____ B. WING _____	01/29/2015

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21840	Continued From page 15 (MDS) dated 12/22/14, documented a Brief Interview for Mental Status (BIMS) assessment score of 4/15, which indicated severe cognitive impairment. A progress noted dated 1/29/15 by the CNP stated: "The patient was seen today with staff for observation of coccyx ulcer. This is significantly worsened in the last week despite frequent repositioning and appropriate treatment. The patient is on hospice for suspected breast cancer. She has been losing weight. Due to her dementia, she will not stay repositioned. She historically and presently prefers back supine lying position. Last week the ulcer was a few cm in diameter. It was stage 2 to 3 with erythematous base. However, until last week it has changed to a blackened discoloration and enlarged significantly. There is a small amount of sero sanguineous drainage on the front of the wound. The patient denies pain with asking. However, with just slight repositioning to inspect the wound, she complains of quite a bit of pain". In addition, the CNP documented that R6 has "pain with repositioning, therefore was increasing the Roxanol (narcotic to relieve pain) to 5 mg every 4 hours while awake and once during the night, as well as every 30 minutes as needed prior to movement". The care plan was not updated until 1/26/15, which included documentation that R6 had a stage 3 PU located on the coccyx and the interventions identified were: monitor location, size and treatment, and to report abnormalities, failure to heal, signs and symptoms (S/S) of infection, and maceration. Documentation was lacking on the care plan and in the progress notes indicating the resident and/or guardian had been educated on the risk vs. benefits of refusing repositioning to prevent further skin breakdown.	21840		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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21840	Continued From page 16 A SUGGESTED METHOD FOR CORRECTION: The director of nursing (DON) or designee could develop and implement policies and procedures related to resident's rights to refuse treatment after having been educated to potential risks. The DON could develop monitoring systems to ensure ongoing compliance and report the findings to the Quality Assurance Committee. TIME PERIOD FOR CORRECTION: Twenty one (21) days.	21840		